

Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS) and Provider Bulletins.

If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence

(See WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

FACILITY SERVICES TABLE OF CONTENTS

Hospital Payment Policies	168
Hospital Payment Policies Overview	168
Hospital Billing Requirements	168
Hospital Acquisition Cost	168
Hospital Inpatient Payment Information.....	168
Hospital Inpatient AP DRG Base Rates	169
Hospital Inpatient AP DRG Per Diem Rates.....	169
Additional Hospital Inpatient Rates.....	170
Hospital Outpatient Payment Information.....	170
Ambulatory Surgery Center Payment Policies	172
General Information	172
Who May Bill for ASC Services	172
Becoming Accredited or Medicare Certified as an ASC.....	172
ASC Payments for Services.....	173
ASC Procedures Covered for Payment.....	173
ASC Procedures Not Covered for Payment	173
Process to Obtain Approval for a Noncovered Procedure	173
ASC Billing Information	174
Modifiers Accepted for ASCs	174
Brain Injury Rehabilitation Services	175
Qualifying Providers.....	175
Qualifying Programs.....	175
Authorization Requirements.....	175
Billing Information	176
Documentation Requirements.....	178
Fees.....	178
Nursing Home, Residential and Hospice Care Services	179
Covered Services.....	179
Noncovered Services	179
Prior Authorization Needs	180
Billing Information	181
Fees.....	181
Chronic Pain Management Program	183
Eligibility Requirements.....	183
Return To Work Plan	185
Fees.....	185
Billing for Partial Days in Treatment or Follow-Up Phases	186

HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. Hospital payment policies established by L&I are reflected in Chapters 296-20, 296-21, 296-23 and 296-23A WAC and in the Hospital Billing Instructions. No copayments or deductibles are required or allowed from workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to workers must be submitted on the UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications. Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for patients admitted and discharged the same day, however, may be treated as outpatient bills. For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance. For a current copy of the Hospital Billing Instructions, contact the L&I Provider Hotline at 1-800-848-0811.

HOSPITAL ACQUISITION COST

Any item covered under the acquisition cost policy will be paid using a hospital specific percent of allowed charges (POAC). Non-hospital facilities will be paid a statewide average POAC.

HOSPITAL INPATIENT PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital specific POAC factors for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program Payment Method

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using DSHS POAC factors (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. An All Patient Diagnosis Related Group (AP DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. L&I currently uses AP DRG Grouper version 23.0.
2. A statewide per diem rate for those AP DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A POAC rate for hospitals excluded from the AP DRG system.

The following tables provide a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Services
Hospitals not in Washington	Paid by an out-of-state POAC factor. Effective July 1, 2009 the rate is 57.8% .
Washington excluded Hospitals: <ul style="list-style-type: none"> • Children's Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities 	Paid 100% of allowed charges.
Washington Major Teaching Hospitals; <ul style="list-style-type: none"> • Harborview Medical Center • University of Washington Medical Center 	Paid on a per case basis for admissions falling within designated AP DRGs. ⁽¹⁾ For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: <ul style="list-style-type: none"> • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP DRGs. ⁽¹⁾ For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: <ul style="list-style-type: none"> • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See <http://feeschedules.Lni.wa.gov> for the current AP DRG Assignment List.

Hospital Inpatient AP DRG Base Rates

Effective **July 1, 2009** the AP DRG Base Rates

Hospital	Base Rate
Harborview Medical Center	\$12,293.35
University of Washington Medical Center	\$10,814.90
All Other Washington Hospitals	\$10,279.42

Hospital Inpatient AP DRG Per Diem Rates

Effective **July 1, 2009** the AP DRG per diem Rates are as follows:

Payment Category	Rate⁽¹⁾	Definition
Psychiatric AP DRG Per Diem	\$870.97 Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs 424-432
Chemical Dependency AP DRG Per Diem	\$768.44 Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs 743-751
Rehabilitation AP DRG Per Diem	\$1,486.50 Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRG 462
Medical AP DRG Per Diem	\$2,064.96 Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs identified as medical
Surgical AP DRG Per Diem	\$3,980.57 Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter 296-23A WAC. The AP DRG Assignment List with AP DRG codes and descriptions and length of stay is in the fee schedules section and is available online at <http://feeschedules.Lni.wa.gov>.

Additional Inpatient Hospital Rates

Payment Category	Rate	Definition
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP DRGs average length of stay. If the patient's stay is less than the average length of stay, a per-day rate is established by dividing the AP DRG payment amount by the average length of stay for the AP DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the patient's stay is equal to or greater than the average length of stay, the AP DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost ⁽¹⁾ of the stay is less than 10% of the statewide AP DRG rate or \$555.69 , whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost ⁽¹⁾ of the stay exceeds \$16,788.22 or 2 standard deviations above the statewide AP DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital outpatient care provided to workers covered by self-insurers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program Payment Method

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either DSHS POAC factors or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system. See Chapter 296-23A WAC (Section 4), WACs 296-23A-0220, 296-23A-0700 through 296-23A-0780 for a description of L&I's OPPS system.
2. An amount established through L&I's Professional Services Fee Schedule for items not covered by the APC system
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an out-of-state POAC factor. Effective July 1, 2009 the rate is 57.8%
Washington Excluded Hospitals: <ul style="list-style-type: none"> • Children's Hospitals • Military Hospitals ⁽¹⁾ • Veterans Administration • State Psychiatric Facilities 	Paid 100% of allowed charges
<ul style="list-style-type: none"> • Rehabilitation Hospitals • Cancer Hospitals • Critical Access Hospitals • Private Psychiatric Facilities 	Paid a facility-specific POAC or Fee Schedule amount depending on procedure
All other Washington Hospitals	Paid on a per APC ⁽²⁾ basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC ⁽¹⁾ .

(1) Military hospitals may bill HCPCS code T1015 for all outpatient clinic services.

(2) Hospitals will be sent their individual POAC and APC rates each year.

Pass-Through Devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device has not already been incorporated into an APC. Hospitals will be paid fee schedule or if no fee schedule exists, a hospital-specific POAC for new or current pass-through devices. New or current drug or biological pass-through items will be paid by fee schedule or POAC (if no fee schedule exists).

Hospital OPPS Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Do Not Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Do Not Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC ⁽¹⁾
4. Is the service packaged?	No	Go to question 5
	Yes	Do Not Pay, but total the Costs for possible outlier ⁽²⁾ consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier ⁽²⁾ consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier? ⁽¹⁾	No	No outlier payment
	Yes	Pay outlier amount ⁽³⁾

(1) If only 1 line item on the bill is inpatient (IP), the entire bill will be paid POAC.

(2) Only services packaged or paid by APC are used to determine outlier payments.

(3) Outlier amount is in addition to regular APC payments.

OPPS Relative Weights and Payment Rates

The relative weights used by CMS will be used for the OPPS program. Each hospital's blended per-APC rate was determined using a combination of the average hospital-specific per APC rate and the statewide average per APC rate. Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720. Hospitals will receive

notification of their blended per-APC rate via separate letter from L&I or by accessing <http://feeschedules.Lni.wa.gov> and going to the hospital rates link.

OPPS Outlier Payments

L&I follows the current CMS outlier payment policy. See the most current federal register for a complete description of the policy.

AMBULATORY SURGERY CENTER PAYMENT POLICIES

GENERAL INFORMATION

Information about L&I's ambulatory surgery center (ASC) requirements can be found in Chapter 296-23B WAC.

WHO MAY BILL FOR ASC SERVICES

An ASC is an outpatient facility where surgical services are provided and that meets the following 3 requirements:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure;
2. Must have at least 1 of the following credentials:
 - a. Medicare Certification as an ambulatory surgery center or
 - b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS) and
3. Must have an active ASC provider account with L&I.

BECOMING ACCREDITED OR MEDICARE CERTIFIED AS AN ASC

Providers may contact the following organizations for information:

National Accreditation

American Association for Accreditation of Ambulatory Surgery Facilities

5101 Washington Street, Suite #2F

PO BOX 9500 Gurnee, IL 60031

888-545-5222; www.aaaasf.org/

Accreditation Association for Ambulatory Health Care

3201 Old Glenview Rd., Suite 300

Wilmette, IL 60091

847-853-6060; www.aaahc.org/

American Osteopathic Association

142 East Ontario Street

Chicago, IL 60611

800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities

4891 East Grant Road

Tucson, AZ 85712

888-281-6531; <http://www.carf.org/>

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

630-792-5862; www.jcaho.org/

Medicare Certification

Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47852
Olympia, WA 98504-7852
360-236-2905; e-mail: fslhhacs@doh.wa.gov
Web: www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note it may take 3-6 months to get certification or accreditation.

ASC PAYMENTS FOR SERVICES

The insurer pays the lesser of the billed charge (the usual and customary fee) or L&I's maximum allowed rate.

L&I's rates are based on a modified version of the current system developed by Medicare for ASC services.

ASC Procedures Covered for Payment

L&I uses the CMS list of procedures covered in an ASC plus additional procedures determined to be appropriate. All procedures covered in an ASC are listed online at:

<http://feeschedules.Lni.wa.gov>

L&I expanded the list that CMS established for allowed procedures in an ASC. L&I added some procedures CMS identified as excluded procedures.

ASC Procedures Not Covered for Payment

Procedures not listed in the ASC fee schedule section of MARFS are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Noncovered Procedure

Under certain conditions, the director, the director's designee or self-insurer, at their sole discretion, may determine that a procedure not on L&I's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. The written request must contain:

- A description of the proposed procedure with associated CPT[®] or HCPCS procedure codes,
- The reason for the request,
- The potential risks and expected benefits and
- The estimated cost of the procedure.

The healthcare provider must provide any additional information about the procedure requested by the insurer.

ASC BILLING INFORMATION

Modifiers Affecting Payment for ASCs

-50 Bilateral Procedure

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

-51 Multiple Procedures

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus

50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

-52 Reduced Services

Modifier -52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier -52, signifying that the service is reduced.

Beginning July 1, 2008 a **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that do not require anesthesia (ASCs should use modifier -52 to report such an occurrence).

-73 Discontinued procedures prior to the administration of anesthesia

Modifier -73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedures after administration of anesthesia

Modifier -74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers

Modifier -99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, modifier -99 must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

BRAIN INJURY REHABILITATION SERVICES

QUALIFIED PROVIDERS

Only providers accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) may participate in the Brain Injury Program and provide post-acute brain injury rehabilitation services for workers. When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit proof of CARF accreditation to

Department of Labor & Industries
Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Billing for Separate Services and Therapies

Brain injury and rehabilitation services are currently under review. Until that review is complete and **upon approval** by an ONC, individual services and therapies can be done separately through outpatient services when the attending physician submits a coordinated plan of care. Services can include but are not limited to:

- Psychotherapy services
- Speech therapy
- Language therapy
- Physical therapy
- Occupational therapy

Special L&I Provider Account Number Required

Providers participating in the Brain Injury Program must have a special provider account number for their CARF accredited post-acute brain injury rehabilitation program in order to bill L&I for a complete course of evaluation and treatment. Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at 1-800-848-0811.

NOTE: Providers participating in the Brain Injury Program and billing for State Fund claims for a complete course of evaluation and treatment must bill brain injury rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. Providers billing for individual services and therapies do not need to obtain a special provider account number.

QUALIFYING PROGRAMS

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation
- Treatment
- Follow-up

AUTHORIZATION REQUIREMENTS

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment. State Fund cases requiring post-acute brain injury rehabilitation will be reviewed by the ONCs prior to making a determination or authorization. Call the Provider Hotline at 1-800-848-0811 for authorization.

After an ONC reviews the case the L&I claims manager also needs to review for **prior authorization**.

Approval Criteria

Before a worker can receive treatment all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim; and
- The brain injury is related to the industrial injury or is retarding recovery; and
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program; and
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury; and
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Comprehensive Brain Injury Evaluation Requirements

A Comprehensive Brain Injury Evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in-depth analysis of the workers mental, emotional, social and physical status and functioning.

The evaluation must be provided by a multidisciplinary team that includes a

- Medical physician,
- Psychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist,
- Speech therapist and
- Neuropsychologist.

Additional medical consultations are referred through the program's physician. Each consultation may be billed under the provider account number of the consulting physician and must be **preauthorized** by an L&I ONC.

BILLING INFORMATION

Tests Included in the Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation and **may not be billed separately**. They may be performed in any combination depending on the workers condition

- Neuropsychological Diagnostic Interview(s), testing and scoring
- Initial consultation and exam with the program's physician
- Occupational and Physical Therapy evaluations
- Vocational Rehabilitation evaluation
- Speech and language evaluation
- Comprehensive report

Preparatory Work Included in the Comprehensive Brain Injury Program Evaluation

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is considered part of the provider's administrative overhead. It includes but is not limited to:

- Obtaining and reviewing the workers historical medical records
- Interviewing family members, if applicable
- Phone contact and letters to other providers or community support services
- Writing the final report
- Office supplies and materials required for service(s) delivery

Therapies Included in the Treatment

The following therapies, treatments and/or services are included in the Brain Injury Program maximum fee schedule amount for the full-day or half-day brain injury rehabilitation treatment and **may not be billed separately**:

- Physical therapy and occupational therapy
- Speech and language therapy
- Psychotherapy
- Behavioral modification and counseling
- Nursing and health education and pharmacology management
- Group therapy counseling
- Activities of daily living management
- Recreational therapy (including group outings)
- Vocational counseling
- Follow-up interviews with the worker or family, which may include home visits and phone contacts

Preparatory Work Included in Treatment

Ancillary work, materials and preparation that may be necessary to carry out Brain Injury Program functions and services that are considered part of the provider's administrative overhead and are **not payable separately** include, but are not limited to:

- Daily charting of patient progress and attendance
- Report preparation
- Case management services
- Coordination of care
- Team conferences and interdisciplinary staffing
- Educational materials (for example, workbooks and tapes)

Follow Up Included in Treatment

Follow up care is included in the cost of the full day or half day program. This includes, but is not limited to:

- Telephone calls
- Home visits
- Therapy assessments

DOCUMENTATION REQUIREMENTS

The following documentation is required of providers when billing L&I for post-acute brain injury rehabilitation treatment programs:

- Providers are required to keep a daily record of a workers attendance, activities, treatments and progress
- All test results and scoring must also be kept in the workers medical record. Records should also include:
 - Documentation of interviews with family and
 - Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program
- Progress reports should be sent to L&I regularly, including all preadmission and discharge reports

FEES

Non-Hospital Based Programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs are effective **July 1, 2009**.

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	\$4,297.53
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	\$974.87
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	\$678.97

Hospital Based Programs

The following revenue codes and payment amounts for hospital based outpatient post-acute brain injury rehabilitation treatment programs are effective **July 1, 2009**.

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	\$4,297.53
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	\$974.87
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	\$678.97

NURSING HOME, RESIDENTIAL AND HOSPICE CARE SERVICES

COVERED SERVICES

The insurer covers proper and necessary residential care services that require 24-hour institutional care to meet the workers needs, abilities and safety. The insurer will also cover medically necessary hospice care comprising of skilled nursing care and custodial care for the workers accepted industrial injury or illness.

Prior authorization is required by an L&I ONC or the self-insured employer.

Services must be:

- Proper and necessary and
- Required due to an industrial injury or occupational disease and
- Requested by the attending physician and
- Authorized by an L&I ONC or self-insured employer before care begins.

Facilities

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for 24-hour institutional care including:

- Skilled Nursing Facilities (SNF)
- Nursing Homes (NH)
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital
- Critical Access Hospitals (CAHs) licensed by DOH using swing beds to provide long term care
- Adult Family Homes/Boarding Homes including
 - Assisted Living Facilities
 - Adult Residential Care
 - Enhanced Adult Residential Care
- Hospice care providers

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

NONCOVERED SERVICES

Services in adult day care centers are **not covered** by L&I or by self insurers.

AUTHORIZATION REQUIREMENTS

Initial Admission

Residential care services require **prior authorization**. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator. Call the Provider Hotline at 1-800-848-0811 for authorization.

For authorization procedures on a self-insured claim, contact the self-insurer directly.

Nursing Facilities. Nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker within 10 working days of admission. The form is available from CMS at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment group to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

L&I has a form available that can be substituted for the MDS form. The Resource Utilization Group (RUG) Residential Care Services for injured workers form F245-052-000 is available at <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1623>

Adult Family Homes, Boarding Homes and Assisted Living Facilities.

At the insurers' request, a Long Term Care Assessment Tool must be completed by an independent Registered Nurse (RN) within 10 days of admission. The tool will determine the appropriate L&I payment grouping. Failure to complete the assessment tool may result in delayed or reduced payment. An assessment must be completed at least once per year after the initial assessment.

The tool is available at

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345>

Critical Access Hospitals using swing beds to provide long term care.

Critical Access Hospitals must

- Obtain a long term care provider number from L&I before care can be authorized. Call the L&I provider hotline at 1-800-848-0811 for more information.
- Utilize L&I form F245-052-000 Resource Utilization Group (RUG) Residential Care Services for Injured Workers available at

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1623>

When Care Needs Change

State Fund

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for re-authorization of the workers care.

Self-Insured

Find contact information for self-insured claims at

<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/ImportEmpLists/Default.asp>

BILLING INFORMATION

Billing Requirements

Providers beginning treatment on an L&I claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this section.

The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125, Billing procedures.

All Residential Care Services should be billed on form F245-072-000 Statement for Miscellaneous Services found at <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627>

Pharmaceuticals and Durable Medical Equipment

State Fund

Residential facilities cannot bill for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed separately.



Inappropriate use of CPT[®] and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

L&I REVIEW OF RESIDENTIAL SERVICES

State Fund

L&I, its designee or the self-insured employer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but are not limited to, on-site review of the worker and review of medical records.

All services rendered to workers are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

FEES

Negotiated payment arrangements; Insurers with existing negotiated arrangements:

Code	Description	Maximum Fee
8902H	Negotiated payment arrangements	By report

NOTE: Insurers with existing negotiated arrangements made prior to January 1, 2005 may continue their current arrangements and continue to use code 8902H until the worker's need for services no longer exists or the worker is transferred to a new facility.

Hospice Care

Hospice claims are paid on a By report basis. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following HCPCS codes:

Code	Abbreviated Description	Maximum Fee
Q5003	Hospice Care Prov in Nrsng Lng-Trm Care Facility	By report
Q5004	Hospice Care Prov in Skill Nursing Facility	By report
Q5005	Hospice Care Prov in Inpatient Hospital	By report
Q5006	Hospice Care Prov in Inpatient Hospice Facility	By report
Q5007	Hospice Care Prov in Lng Trm Care Facility	By report
Q5008	Hospice Care Prov in Inpatient Psychiatric Facility	By report
Q5009	Hospice Care Prov in Place NOS	By report

Boarding Homes and Adult Family Homes

For dates of service January 1, 2009 or after:

The numeric score determined by the Long Term Care Assessment Tool will determine which billing code to use. The payment rates below are daily payment rates.

Code	Description	Assessment Score	Maximum Fee
8893H	L&I RF Low	0 - 20	\$164.90
8894H	L&I RF Medium	21 - 36	\$200.23
8895H	L&I RF High	37 - 57	\$235.57

These three levels of care will be applied to all non nursing home facility types. Do not bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

Adult Family Homes with dates of service before January 1, 2009:

Continue to use the following billing code.

Code	Description	Maximum Fee
8891H	L&I Adult & Family Home	\$235.57

Adult Family Homes with continuing residents that predate the January 1, 2009 establishment of the new residential services fee schedule will continue to use billing code 8891H through June 30, 2010.

Nursing Home, Transitional Care Unit and Critical Access Hospital Swing Bed Fees - State Fund

The insurer uses a modified version of the skilled nursing facility prospective payment system for developing the residential facility payment system.

The fee schedule for Nursing Home beds, Transitional Care Unit beds and Critical Access Hospital Swing Beds is a series of daily facility payment rates including room rates, therapies and nursing components depending on the needs of the worker. Medications are not included in the L&I rate.

Fee Schedule – NH, TCU and CAH Swing Beds Effective **July 1, 2009**

Code	Description	Included Medicare RUG Groups	Maximum Fee
		REHAB GROUPS	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	\$650.86
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	\$487.96
8882H	Rehab-High	RMX, RHX, RHL, RHC, RHB, RHA	\$460.15
8883H	Rehab-Medium	RML, RMC, RMB, RMA	\$423.91
8884H	Rehab-Low	RLX, RLB, RLA	\$330.89
		NURSING SERVICES GROUPS	
8885H	Extensive Services	SE3, SE2, SE1	\$412.20
8886H	Special Care	SSC, SSB, SSA	\$307.04
8887H	Clinically Complex	CC2, CC1, CB2, CB1, CA2, CA1	\$305.37
8888H	Impaired Cognition	IB2, IB1, IA2, IA1	\$225.26
8889H	Behavior Only	BB2, BB1, BA2, BA1	\$223.59
		REDUCED PHYSICAL FUNCTION GROUPS	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	\$235.57

CHRONIC PAIN MANAGEMENT PROGRAM

Eligibility Requirements

To provide chronic pain management program services to workers, the provider must be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The term interdisciplinary describes the type of program and not the practice skills of staff members. Providers of chronic pain management program services must work within the scope of practice for their specialty and/or be appropriately certified or licensed for the field in which they work.

Providers must maintain CARF accreditation and provide L&I with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed for administrative reasons.

When a CARF Accredited Provider is not Reasonably Available

In certain circumstances, a CARF accredited provider may not be reasonably available for workers who have moved out of Washington State. In those circumstances, a provider with CARF-like credentials may provide chronic pain management program services to the worker.

For outpatient services, these CARF-like credentials include:

- Patient prescreening is conducted by a physician, a psychiatrist/psychologist, and a physical/occupational therapist. Vocational rehabilitation may be added if the claim manager determines vocational assessment is needed.
- Regular interface occurs between a physician and the worker on a frequent, if not daily basis during treatment
- Treatment includes, at a minimum, medical management, psychiatric testing and/or counseling, physical and occupational therapy, and, if indicated, vocational rehabilitation services with return to work goals as indicated
- Follow-up includes remedial treatment or status checks to determine how well the worker is coping following completion of their treatment

For inpatient services, these CARF-like credentials include:

- The outpatient services credentials listed above and
- Affiliation with a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited hospital.

CARF-like providers will be required to comply with the chronic pain management program policies and fee schedule as well as meet the same reporting requirements as CARF accredited programs. CARF-like providers must also obtain an L&I provider account number. The provider account number for CARF-like providers will be activated for only 9 months.

When to Refer an Injured Worker for a Chronic Pain Management Evaluation

When the attending provider requests a referral to a chronic pain management program, the claim manager may authorize an evaluation if the worker has chronic pain, is not a surgical candidate and meets 1 of the following criteria:

- Has received conservative treatment for approximately 6 months:
 - without significant improvement,
 - has a perceived degree of pain, and
 - has not returned to work, or
- Has not significantly improved or has not returned to work due to pain within 6 months following authorized surgery or
- Has a significant pain medication abuse problem or
- Has returned to work but needs help with chronic pain management.

Chronic Pain Management Phases

A chronic pain management program has an interdisciplinary team that provides appropriate services to rehabilitate persons with chronic pain. Multiple modalities address the psychosocial and cognitive aspects of chronic pain behavior together with physical rehabilitation.

A chronic pain management program consists of three phases with a separate fee for each phase.

The chronic pain management program phases are defined as:

- **Evaluation Phase**
 - This phase consists of an initial evaluation including at a minimum a medical examination, and a psychological evaluation
 - A vocational assessment will be included in the initial evaluation if requested by the claim manager
 - A summary evaluation report is required and must include information from each discipline participating in the evaluation and a return to work action plan if indicated
 - This phase lasts 1 to 2 days
- **Treatment Phase**
 - At a minimum, this phase consists of medical management, psychiatric testing and/or counseling, and physical therapy/occupational therapy
 - Vocational rehabilitation services with return to work goals will be part of this phase if requested by the claim manager
 - Other services provided in this phase may vary as required by the needs of the worker
 - A discharge report is required and must include the findings of each discipline involved in the treatment phase and must list the outcome of the treatment
 - The maximum duration of this phase is 18 treatment days. The 18 treatment days are consecutive (excluding weekends and holidays). Each treatment day lasts 6-8 hours.
- **Follow Up Phase**
 - This phase consists of remedial treatment or status checks as needed to determine how well the worker is coping following completion of the treatment phase. The goal is to extend and reinforce the gains made during the treatment phase. This phase is not a substitute for and cannot serve as a second treatment phase.
 - A follow up report is required including the findings of all disciplines involved in providing the follow up services
 - This phase will last for no more than a total of 5 follow up days during the 3 months immediately following completion of the treatment phase or treatment phase extension (information about the treatment phase extension is provided under the *Treatment Phase Extension Criteria* heading next in this subsection)

The reports required for each phase must be sent to the insurer and to the attending physician. When requested, other reports may be required.

The fee schedule and procedure codes for these phases are listed in the [Fees](#) section on page [185](#). This fee schedule applies to workers in either an outpatient or inpatient program.

Treatment Phase Extension Criteria

The claim manager can authorize up to 10 additional days of treatment for the worker.

Before the claim manager authorizes the treatment phase extension, 1 or both of the following criteria must be documented in the extension request:

- Treatment is steadily progressing toward achievement of a treatment goal and how the extension supports the meeting of the specific treatment goal
- The worker is nearing completion of treatment and needs a few more sessions to achieve the treatment goal

The following factors will be applied when evaluating a request for extending treatment:

- The treatment phase extension is limited to a 1 time basis per referral
- The extension should be on an outpatient basis. Extension of inpatient services will require concurrence of an L&I ONC or self insurer based on their review of the extension request and claim file.
- Extensions are not granted for either the evaluation or follow up phases
- The extension is limited to a specific number of treatment days not to exceed a maximum of 10 consecutive treatment days (excluding weekends and holidays). The start and end dates must be defined prior to start of the treatment phase extension.
- The treatment phase extension request must be based on specific issues requiring further treatment. The request must be supported by documentation of progress made to date in the program.
- The request must clearly state the goals of the treatment phase extension and time needed to meet those goals

RETURN TO WORK ACTION PLAN

If the worker needs assistance in returning to work or becoming employable, the claim manager will authorize admission to the chronic pain management program for treatment after:

- A vocational counselor has been assigned by the claim manager
- The chronic pain management program vocational specialist (program counselor) and the insurer assigned vocational rehabilitation counselor have agreed upon a return to work action plan with a return to work goal acceptable to the insurer and
- The attending provider and the worker approve the return to work action plan with a return to work goal.

The return to work action plan is to provide the focus for vocational services during a workers' participation in a chronic pain management program. The insurer assigned vocational provider will facilitate the review, revision, and approval of the return to work action plan by the attending provider and the worker.

The return to work action plan may be modified or adjusted during the treatment or follow up phase as needed. At the end of the program the listed return to work action plan outcomes must be included with the treatment discharge report.

FEES

Non-Hospital Based Programs

Outpatient chronic pain management programs must bill using the local codes listed in the following table on a CMS-1500 form.

Description	Local Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	2010M	Conducted over 1-2 days	\$1,106.63
Pain Clinic Treatment Phase	2011M	Not to exceed 18 treatment days	\$708.82 per day
Pain Clinic Treatment Extension Phase	2012M	Not to exceed 10 treatment days	\$708.82 per day
Pain Clinic Follow-Up Phase	2013M	Not to exceed 5 follow-up days	\$304.69 per day

Hospital Based Programs

Facility based chronic pain management programs will bill using the revenue codes listed in the following table on a CMS-1450 (UB-04) form.

Description	Revenue Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	0011	Conducted over 1-2 days	\$1,106.63
Pain Clinic Treatment Phase	0012	Not to exceed 18 treatment days	\$708.82 per day
Pain Clinic Treatment Extension Phase	0017	Not to exceed 10 treatment days	\$708.82 per day
Pain Clinic Follow-Up Phase	0013	Not to exceed 5 follow-up days	\$304.69 per day

Inpatient Room And Board Fees

There are occasions when the chronic pain management program evaluation indicates a need for the worker to be treated on an inpatient basis. All inpatient admissions will require **prior authorization**. All State Fund inpatient admissions also require utilization review.

Utilization review for L&I is provided by Qualis Health. Eligible providers will contact Qualis Health at 1-800-541-2894 or fax their request to 1-877-665-0383. Qualis Health will compare the workers' clinical information to established criteria and make a recommendation to approve or deny the inpatient admission request to the claim manager.

For authorization procedures on a self insured claim, contact the self insurer directly.

The claim manager will make the final authorization decision. When the claim manager authorizes treatment on an inpatient basis, the provider will be paid up to \$503.31 per day for room and board costs. These costs should be billed using either revenue code 0129 (semiprivate) or 0149 (private).

An acceptable return to work action plan is a one-page statement included with the chronic pain management program's vocational evaluation report that contains:

- The workers' current vocational status with the employer of injury
- The workers' current level of physical function
- The appropriate U.S. Department of Labor Dictionary of Occupational Titles (DOT) number and physical demands of the job goal common to the immediate labor market
- The actions, timelines, and people responsible for achieving the return to work action plan goal

BILLING FOR PARTIAL DAYS IN TREATMENT OR FOLLOW-UP PHASES

It is expected that the worker will attend the full 6-8 hours each treatment day during the treatment phase. If the worker is unable to complete a full day of treatment due to an emergency or unforeseen circumstance, the provider should bill for that portion of the treatment day completed by the worker.

Example 1: Clinic A requires the worker to be in attendance for 8 hours for each treatment day. The worker had an unforeseen emergency and had to leave the clinic after 2 hours (25% of the treatment day) on one treatment day. The clinic would bill L&I for that day as follows: $\$708.82 \times 25\% = \177.21

For the follow up phase, the provider should bill for that portion of the follow up day that the worker is in attendance.

Example 2: Clinic B scheduled the worker for 3 hours of follow-up services. Clinic B's normal hours of attendance for the worker is 6 hours. Clinic B would bill L&I for those 3 hours of follow-up services as follows: $\$304.69 \times 50\% = \152.35