

GENERAL INFORMATION

COVERED SERVICES

L&I makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a **covered** benefit.

Procedure codes listed as **not covered** in the fee schedules are **not covered** for the following reasons:

1. The treatment is not safe or effective; or is controversial, obsolete, investigational or experimental.
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
3. The procedure or service is payable under another code.

The insurer may pay for procedures in the first 2 categories above on a case-by-case basis. The health care provider must:

- Submit a written request and
- Obtain approval from the insurer prior to performing any procedure in these categories.

The request must contain:

- The reason,
- The potential risks and expected benefits,
- The relationship to the accepted condition and
- Any additional information about the procedure that may be requested by the insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -030, -03001, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that do not specify a time increment or unit of measure is limited to 1 unit per day. For example, only 1 unit is payable for CPT[®] code 97022 regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that does not have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter 296-20 WAC (including the definition section) and to the fee schedules for additional information.

PHYSICIAN ASSISTANTS

Physician assistants (PAs) must be certified and have valid individual L&I provider account numbers to be paid for services. PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of MARFS. For example, to bill for Assistant at Surgery, the PA would use modifier –80, –81 or –82 as appropriate.

Physician assistants may sign any documentation required by the department. Consultations and impairment ratings services related to workers' compensation benefit determinations are not payable to physician assistants as specified in RCW 51.28.100 and WAC 296-20-01501.

Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee. For more information about physician assistant services and payment, see WAC 296-20-12501 and WAC 296-20-01501.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

L&I uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. These services have a fee schedule indicator (FSI) of R in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on:

- Relative value units (RVUs),
- Geographic adjustment factors for Washington State and
- A conversion factor.

The maximum fee for a procedure is obtained by multiplying the adjusted RVU by the conversion factor. The maximum fees are published as dollar values in the Professional Services Fee Schedule.

Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

- The work,
- Practice expense and
- Liability insurance (malpractice expense).

A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU described below.

The conversion factor is published in WAC 296-20-135. It has the same value for all services priced according to the RBRVS. L&I may annually adjust the conversion factor by a process defined in WAC 296-20-132.

Three state agencies, Labor and Industries (L&I), Health Care Authority (HCA) and Department of Social and Health Services (DSHS), use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2008 Medicare Physician Fee Schedule Database (MPFSDB), which was published by CMS in the November 27, 2007 *Federal Register*. The *Federal Register* can be accessed online at

<http://www.gpoaccess.gov/fr/index.html> or can be purchased from the U.S. government in hard copy, microfiche or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents or <http://bookstore.gpo.gov/>
PO Box 371954
Pittsburgh, PA 15250-7954

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2009 are:

- 100.4% of the work component RVU,
- 100.7% of the practice expense RVU and
- 69.7% of the malpractice RVU.

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor,
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth,
3. Multiply the rounded sum by L&I's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.