

OTHER SERVICES

AFTER HOURS SERVICES

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

- When the provider's office is not regularly open during the time the service is provided
- When services are provided on an emergency basis, out of the office, that disrupt other scheduled office visits

After hours service codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

Only 1 code for after hours services will be paid per patient per day, and a 2nd day may not be billed for a single episode of care that carries over from 1 calendar day to the next.

LOCUM TENENS

- Modifier –Q6 denotes services furnished by a locum tenens physician.
- Modifier –Q6 is **not covered** and L&I **will not pay** for services billed under another provider's account number.

L&I requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered. Refer to WAC 296-20-015 for more information about the requirements.

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the self-insurer makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or self-insurer. Although L&I does not use codes for medical testimony, Self-insurers must allow providers to use CPT® code 99075 to bill for these services. L&I utilizes a separate voucher form titled "A19", which will be provided to you by the Office of the Attorney General, thus providers should not use the CPT® code and L&I cannot provide prepayment for any of these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), but do not include side trips.

The time calculation for testimony, deposition or related work performed in the provider's office or via phone is based upon the actual time used for the testimony or deposition.

The medical witness fee schedule is set pursuant to law, which requires any provider having examined or treated a worker must abide by the fee schedule and testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General or the self-insurer. The Office of the Attorney General or the self-insurer and the provider must cooperate to schedule a reasonable time for the provider's testimony during business hours. Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeal.

The Office of the Attorney General provides a medical provider testimony fee schedule when testimony is scheduled. No service will be paid in advance of the date it is provided. Requests for a non-refundable amount will be denied. Any exceptions to the fee schedule will be on a case by case basis.

The party requesting interpretive services for depositions or testimony is responsible for payment.

Testimony and Related Fees (applied to doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony (live or by deposition)	\$ 100.00/unit* (Maximum of 17 units)
Record review	\$ 100.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	\$ 100.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 100.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to all other health care providers)

Description	Maximum Fee
Medical testimony (live or by deposition)	\$ 22.50/unit* (Maximum of 17 units)
Record review	\$ 22.50/unit* (Maximum of 25 units)
Conferences (live or by telephone)	\$ 22.50/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 22.50/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to vocational providers)

Description	Maximum Fee
Medical testimony (live or by deposition), regular vocational services Medical testimony (live or by deposition), forensic vocational services	\$ 22.50/unit* \$26.25/unit* (Maximum of 17 units)
Record review, regular vocational services Record review, regular vocational services, forensic vocational services	\$ 22.50/unit* \$26.25/unit* (Maximum of 25 units)
Conferences (live or by telephone), regular vocational services Conferences (live or by telephone), forensic vocational services	\$ 22.50/unit* \$26.25/unit* (Maximum of 9 units)
Travel , regular vocational services Travel, forensic vocational services (Paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 22.50/unit* \$26.25/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to all out of state doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony (live or by deposition)	\$ 125.00/unit* (Maximum of 17 units)
Record review	\$ 125.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	\$ 125.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 125.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Attorney General/self-insurer will pay a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Attorney General/self-insurer will not pay a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management (NCM) services require **prior authorization** by the CM or ONC. Contact the insurer to make a referral for NCM services.

Workers with catastrophic work related injuries, and/or workers who have moved out-of-state and need assistance locating a provider, and/or workers with medically complex conditions may be selected to receive NCM services.

NCM is:

- A collaborative process used to meet injured or ill worker's health care and rehabilitation needs.
- Provided by registered nurses:
 - With case management certification
 - Aware of resources in the injured worker's location.

The nurse case manager works with the attending provider, worker, allied health personnel and insurers' staff to assist in locating a provider and/or with coordination of the prescribed treatment plan. Nurse case managers organize and facilitate timely receipt of medical and health care resources and identify potential barriers to medical and/or functional recovery of the worker. They communicate this information to the attending doctor, CM, or ONC to develop a plan for resolving or addressing the barriers.

Nurse case managers must use the following local codes to bill for NCM services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	\$ 9.64
1221M	Visits, per 6 minute unit	\$ 9.64
1222M	Case planning, per 6 minute unit	\$ 9.64
1223M	Travel/Wait, per 6 minute unit (16 hour limit)	\$ 4.74
1224M	Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager	State rate
1225M	Expenses (parking, ferry, toll fees, cab, lodging and airfare) at cost or state per diem rate (meals and lodging). Requires prior authorization from the claim manager (\$725 limit)	By report

NCM services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

Billing Units Information

- Units are whole numbers and not tenths units
- Each traveled mile is 1 unit service
- Each 6 minutes of care coordination or travel/wait time is 1 unit of service
- Each related travel expense is 1 unit of service

Minutes = # of Units	Minutes = # of Units
6 = 1	36 = 6
12 = 2	42 = 7
14 = 3	48 = 8
24 = 4	54 = 9
30 = 5	60 = 10

For State Fund claims, **noncovered** expenses include:

- Nurse case manager training
- Supervisory visits
- Postage, printing and photocopying (except medical records requested by L&I)
- Telephone/fax
- Clerical activity
- Travel time to post office or fax machine
- Wait time exceeding 16 hours
- Fees related to legal work, for example, deposition, testimony. Legal fees may be charged to the requesting party, but not the claim
- Any other administrative costs not specifically mentioned above

Case Management Records and Reports

Case management records must be created and maintained on each claim. The record shall present a chronological history of the worker’s progress in NCM services.

Case notes shall be written when a service is given and shall specify:

- When the service was provided and
- What type of service was provided using case note codes and
- Description of the service provided including subjective and objective data and
- How much time was used during this reporting period.

NCM reports shall be completed monthly. Payment will be restricted to up to 2 hours for initial reports and up to 1 hour for progress and closure reports. For additional information about billing, refer to the “Miscellaneous Services Billing Instructions”. Contact the Provider Hotline at 1-800-848-0811 to request a copy.

Report Format

Initial assessment and monthly reports must include **all** of the following information:

- Type of report (initial or progress)
- Worker name and claim number
- Report date and reporting period
- Worker date of birth and date of injury
- Contact information
- Diagnoses
- Reason for referral
- Present status/current medical
- Recommendations
- Actions and dates
- Ability to positively impact a claim
- Health care provider(s) name(s) and contact information
- Psychosocial/economic issues
- Vocational profile
- Hours incurred to date on the referral

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the insurer. The fees listed below include postage for sending documents to the insurer:

Code	Report/Form	Max Fee	Special notes
CPT® 99080	60-Day Report	\$ 43.51	60-day reports are required per WAC 296-20-06101 and do not need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of 1 per 60 days per claim.
CPT® 99080	Special Report (Requested by insurer or VRC)	\$ 43.51	Must be requested by insurer or vocational counselor. Not payable for records or reports required to support billing or for review of records included in other services. Do not use this code for forms or reports with assigned codes. Limit of 1 per day.
1027M	Loss of Earning Power (LEP)	\$ 18.93	Must be requested by insurer. Payable only to attending provider. Limit of 1 per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	\$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.
1040M	Physician's Initial Report – for Self Insured claims	\$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.

Code	Report/Form	Max Fee	Special notes
1041M	Application to Reopen Claim	\$ 49.18	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.
1055M	Occupational Disease History Form	\$ 183.56	Must be requested by insurer. Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s).
1057M	Opioid Progress Report Supplement or any standardized objective tool to evaluate pain and function	\$ 30.27	Payable only to attending provider. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days. See WACs 296-20-03021, -03022 and the Labor and Industries Medical Treatment Guidelines. Limit of 1 per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	\$ 37.84	Must be requested by insurer. Payable only to attending provider. Limit of 1 per request.
1064M	Initial report documenting need for opioid treatment	\$ 56.77	Payable only to the attending provider. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and the Labor and Industries Medical Treatment Guidelines for what to include in the report.
1065M	Attending Doctor IME Written Report	\$ 28.37	Must be requested by insurer. Payable only to attending provider when submitting a separate report of IME review. Limit of 1 per request.
1066M	Provider Review of Video Materials with report	By report	Must be requested by insurer. Payable once per provider per day. Report must include actual time spent reviewing the video materials. Not payable in addition to CPT [®] code 99080 or local codes 1104M or 1198M.
1073M	Insurer Activity Prescription Form (APF)	\$48.19	Must be requested by insurer. Payable once per provider per worker per day.
1074M	AP response to VRC/Employer request about RTW	\$30.27	For written communication with vocational counselors (VRC) and employers. Team conference, office visit, telephone call, or online communication with a VRC or employer cannot be billed separately.

More information on some of the reports and forms listed above is provided in WAC 296-20-06101. Many L&I forms are available and can be downloaded from <http://www.Lni.wa.gov/FormPublications/> and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the insurer using HCPCS code S9982. Payment for S9982 includes all costs, including postage. S9982 is not payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

S9982 \$0.48

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles. This code requires **prior authorization** and usage is limited to extremely rare circumstances.

Code	Description	Max Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	\$ 4.86

REVIEW OF JOB OFFERS AND JOB ANALYSES

Attending doctors must review the physical requirements of any job offer submitted by the employer of record and determine whether the worker can perform that job. Whenever the employer asks, the attending doctor should send the employer an estimate of physical capacities or physical restrictions and review each job offer submitted by the employer to determine whether or not the worker can perform that job.

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see RCW 51.32.09(4).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, nonwork related skills and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending providers, independent medical examiners (IME) and consultants will be paid for review of job descriptions or JAs. A job description/JA review may be performed at the request of the State Fund employer, the insurer, vocational rehabilitation counselor (VRC) or third party administrator (TPA) acting for the insurer or the employer. Reviews requested by other persons (for example, attorneys or workers) will not be paid. This service does not require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires **prior authorization** and will not be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in WAC 296-19A-170. The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Max Fee	Special notes
1038M	Review of Job Descriptions or JA	\$ 49.18	Must be requested by insurer, employer or vocational counselor. Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Not payable to IME examiner on the same day as the IME is performed. .
1028M	Review of Job Descriptions or JA, each additional review	\$ 36.89	Must be requested by insurer, employer or vocational counselor. Payable to attending provider, IME examiner or consultant. Bill to L&I. For IME examiners on day of exam: may be billed for each additional JA after the first 2. For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using 1038M).

VEHICLE AND HOME MODIFICATIONS

Refer to WAC 296-14-6200 through WAC 296-14-6238 for home modification information. A home modification consultant must be a licensed registered nurse, occupational therapist or physical therapist and trained or experienced in both rehabilitation of catastrophic injuries and in modifying residences. Additional information is available at:

<http://www.Lni.wa.gov/ClaimsIns/Providers/ProviderIndex/homeMod/default.asp>

A vehicle modification consultant must be a licensed occupational or physical therapist, or licensed medical professional with training or experience in rehabilitation and vehicle modification.

Code	Description	Maximum Fee
8914H	Home modification, construction and design. Requires prior authorization based on approval by the assistant director of Insurance Services	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification. Requires prior authorization based on approval by the assistant director of Insurance Services	Maximum payable for all work is ½ the current Washington state average wage. The amount paid may be increased by no more than \$4,000 by written order of the Supervisor of Industrial Insurance RCW 51.36.020(8b).
8916H	Home modification evaluation and consultation. Requires prior authorization	By report
8917H	Home/vehicle modification mileage, lodging, airfare, car rental. Requires prior authorization	State rate
8918H	Vehicle modification, evaluation and consultation. Requires prior authorization	By report
0391R	Travel/wait time per 6 minutes. Requires prior authorization	\$4.83

JOB MODIFICATIONS AND PREJOB ACCOMMODATIONS

The provider of a job modification or pre-job accommodation consultation must be a licensed occupational therapist or physical therapist, vocational rehabilitation provider, or ergonomic specialist. Vocational rehabilitation counselors and interns in the group assigned to the vocational referral must bill 0823V or 0824V. See [Vocational Evaluation](#) on page 156. The following codes **are payable to:**

- Physical therapists
- Occupational therapists
- Ergonomic specialists
- Vocational rehabilitation counselors not associated with the group assigned to the vocational referral
- Authorized equipment vendors

Code	Description	Maximum Fee
0380R	Job modification (equipment, etc.) Requires prior authorization Includes equipment set up and training	Maximum allowable for 0380R is \$5,000 per job or job site.
0385R	Prejob accommodation (equipment, etc.) Requires prior authorization Includes equipment set up and training	Maximum allowable for 0385R is \$5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal cannot exceed \$5,000.
0389R	Prejob or job modification consultation, analysis of physical demands (non-VRC), per 6 minutes. Requires prior authorization	\$ 10.66
0391R	Travel/wait time (non-VRC), per 6 minutes. Requires prior authorization	\$ 4.83
0392R	Mileage (non-VRC), per mile. Requires prior authorization	State rate
0393R	Ferry Charges (non-VRC). Requires prior authorization	State rate

Additional information is available at <http://www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/default.asp>

If services are provided to a worker with an open vocational referral, see Vocational Evaluation and Related Codes for nonvocational providers on page 158.