Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 36: Nursing Home and Other Residential Care Services

Effective July 1, 2023

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

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Payment policy: All residential care services

General requirements

The insurer covers:

- Proper and necessary residential care services that require **24 hour institutional care** to meet the worker's needs, abilities, and safety, *and*
- Medically necessary hospice care, comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Services must be:

- Proper and necessary,
- Required due to an industrial injury or occupational disease,
- Requested by the attending provider, *and*
- Authorized by an L&I ONC (occupational nurse consultant) or self-insured employer before care begins.

Prior authorization and reauthorization 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.

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

When care needs change

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 reauthorization of the workers care.

Who must perform these services to qualify for payment

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

- Skilled Nursing Facilities (SNF),
- 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 and Veterans Hospitals using swing beds to provide long term care or sub-acute care,
- Adult Family Homes,
- Assisted Living Facilities,
- Secure Residential Facilities,
- Boarding Homes, *and*
- Hospice care providers.

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

TCUs must obtain a separate provider number from L&I.

Services that aren't covered

Adult day care center facilities or assisted living facilities performing adult day care services

Services provided in adult day care center facilities aren't covered by the insurer.

Pharmaceuticals and durable medical equipment (DME)

Residential facilities can't bill for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed by a pharmacy or DME supplier.

Note: 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.

Requirements for billing

Providers beginning treatment on a workers' compensation 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 chapter. All residential care services should be billed on form F245-072-000 (Statement for Miscellaneous Services).

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

Additional information: Negotiated payment arrangements

Insurers with existing negotiated arrangements made **prior to January 1, 2005** may continue their current arrangements and continue to use billing code **8902H** until the worker's need for services no longer exists or the worker is transferred to a new facility. L&I won't negotiate payment arrangements for admissions after January 1, 2005.

Note: Billing code **8902H** (Negotiated payment arrangements) is a code that pays By Report.

Additional information: Residential services review, periodic independent nursing evaluations

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to:

- Onsite review of the worker, and
- Review of medical records.

All services rendered to workers are subject to audit by L&I.

Links: For more information, see RCW 51.36.100 and RCW 51.36.110.

Payment policy: Assisted living facilities, adult family homes, and boarding homes

Requirements for the Residential Care Assessment Tool

At the insurers' request, a Residential Care Assessment Tool (form F245-377-000) must be completed by an independent Registered Nurse (RN) or an L&I ONC based in the field:

- Within 30 days of admission, *and*
- At least once per year after the initial assessment.

The tool determines the appropriate L&I payment grouping. Facilities being assessed shouldn't submit bills for the assessment; the nurse who completes the form will bill the Department for their services.

Link: If you are a Nurse Case Manager performing an annual care assessment requested by the department, see Chapter 20: Nurse Case Management: Annual Assessments.

For assessments performed by a Home Health Agency RN, see Chapter 11: Home Health Services.

Services that can be billed

The numeric score determined by the Residential Care Assessment Tool will determine which billing code to use. The 3 levels of care will be applied to all nonskilled nursing facility types. The payment rates are daily payment rates (see table below).

Note: Don't bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

If the **assessment score** is…	Then the appropriate **billing code** is…	Which has the following **description**:
6 – 20 Basic level	**8893H**	L&I RF Low
21 – 36 Intermediate level	**8894H**	L&I RF Medium
37 – 57 Advanced/Special level	**8895H**	L&I RF High

Link: For maximum fees (Daily Rates) see the Residential Facility Rates, L&I Payment Group #13 – Boarding Homes, Assisted Living Facilities and Adult Family Homes, on the L&I fee schedule.

Payment policy: Critical Access Hospitals (CAHs) and Veterans Administration Hospitals using swing beds for sub-acute care

Payment methods

Critical Access Hospitals and Veterans Administration Hospitals will be paid for sub-acute care (swing bed services) utilizing a hospital specific POAC rate.

Prior authorization requirements

You must contact an ONC for approval. To obtain information about contacting an ONC, call L&I's Provider Hotline at **1-800-831-5227.**

Requirements for billing

Upon approval from a Labor and Industries ONC, CAHs and Veterans Administration Hospitals should bill their usual and customary charge for sub-acute care (swing bed use) on the UB-04 billing form.

Identify these services in the Type of Bill field (Form Locator 04) with the 018x series (hospital swing beds).

Does this policy apply to self-insured employers?

No. Self-insured employers' payment formula for hospital inpatient services and non-fee schedule hospital outpatient services = *the hospital specific POAC factor x Allowed charges*. Contact your insurer for correct form and payment procedures.

Payment policy: Hospice care

Requirements for billing

Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Hospice programs must bill the following HCPCS codes:

If **hospice care is provided in**…	Then bill for services using **HCPCS code**:	Which has a **maximum fee** of:
Nursing long term care facility	**Q5003**	By Report
Skilled nursing facility	**Q5004**	By Report
Inpatient hospital	**Q5005**	By Report
Inpatient hospice facility	**Q5006**	By Report
Long term care facility	**Q5007**	By Report
Inpatient psychiatric facility	**Q5008**	By Report
Place NOS	**Q5009**	By Report

Payment limits

Hospice claims are paid on a By Report basis (see table above).

Occupational, physical, and speech therapies are included in the daily rate and aren't separately payable.

Payment policy: Skilled nursing facilities

Requirements for the Minimum Data Set Basic Assessment Tracking Form

Within 30 working days of admission, 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. The completed MDS must be sent to the ONC or SIE/TPA for authorization of the appropriate billing code.

This form or similar instrument will also determine the appropriate L&I payment. 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 code 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.

Payment policy: Skilled nursing facility and transitional care unit beds

Payment methods

L&I uses a modified version of the Patient Driven Payment Model (PDPM) through the use of Health Insurance Prospective Payment System (HIPPS) skilled nursing facility (SNF) codes for developing nursing home payment rates.

The fee schedule for SNF and transitional care unit (TCU) beds is a series of HIPPS codes tied to a series of 11 local codes. The items covered include:

- Room rates,
- Therapies, *and*
- Nursing components depending on the needs of the worker.

Payment limits

Medications aren't included in the L&I rate.

Prior authorization requirements

A HIPPS code must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code. For a listing of HIPPS and local code combinations as well as maximum fees, see L&I's fee schedule.

Services that can't be billed

L&I won't pay nursing homes or other residential care when the injured worker isn't present, such as when hospitalized or on vacation.

L&I won't pay bed hold fees.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
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	Fee schedules on L&I's website
Minimum Data Set (MDS) Basic Assessment Tracking Form	Medicare's (CMS's) website
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Statement for Miscellaneous Services form	Statement for Miscellaneous Services form on L&I's website
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100 RCW 51.36.110

Need more help?

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

