Washington State Department of
Labor & Industries

# Medical Aid Rules and Fee Schedules (MARFS)

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

## Effective July 1, 2022

This document can be found on the department's website at https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/.

Washington State Department of
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**Payment Policies for Healthcare Services**

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# Chapter 1: Introduction

**Effective July 1, 2022**

## Table of Contents

# General information: About MARFS and this manual

## What is MARFS?

The Medical Aid Rules and Fee Schedules (MARFS) is a package of information about how workers' compensation insurers in Washington State pay for healthcare and vocational services provided to injured workers and crime victims.

MARFS includes three things:

- **Medical aid rules** published in the Washington Administrative Codes (WACs) for industrial insurance (workers' compensation),
- **Fee schedules** for healthcare and vocational professional provider and facility services, *and*
- This **payment policies manual**.

## What is in this manual?

This manual contains 36 chapters of payment policies for healthcare and vocational services provided by individual professional providers or facilities.

A payment policy for a specific service can include information about:

- Prior authorization,
- Who must perform specific services to qualify for payment,
- Services that can be billed or that aren't covered,
- Requirements for billing,
- Payment limits, *and/or*
- Other information, such as payment methods, background information on coverage decisions, unique requirements, and examples to illustrate billing procedures.

**Note**: Not every payment policy includes all of these elements. When one of the above elements isn't included, it is because the information isn't applicable. When the elements do appear, they are consistently presented in the same order.

Beyond this introductory chapter, in this manual you will find:

- One chapter on **general policies and information** for all providers,
- 29 chapters for **professional services**, which contain payment policies for individual professional healthcare and vocational providers, and interpreters, and
- Five chapters for **facility services**, which contain payment policies for healthcare facilities.

**Note**: Within each of the services sections, the chapters appear alphabetically.

## What part of MARFS isn't in this manual?

This manual doesn't include:

- Fee schedules, which contain the maximum fees (payment amounts) for the authorized billing codes providers use to bill for services,
- The field key, which explains the column headings and abbreviations that appear in the fee schedules,
- Medical aid rules, which are the L&I specific WACs, *and*
- Updates and Corrections, which contains any changes to policies and fees that occur between annual publications of this manual (see more about these changes below under: How do I know if a policy is current?).

**Link**: Medical Aid Rules are available in Title 296 WAC on the Washington State Legislature's website.

## How do I know if a policy is current?

The policies in this manual are updated and published at the start of each fiscal year (July 1), and are effective for services provided on or after that date (until the next publication of this manual).

Sometimes changes do occur between publications of this manual. Such changes are communicated to providers through L&I's Medical Provider News email listserv and are also documented on an Updates & Corrections page on L&I's website.

**Link**: For information about how to join the email listserv, see the "General information: All payment policies and fee schedules" section of: Chapter 2: Information for All Providers.

# General information: About the layout and design

## How is each chapter organized?

Payment policies for general types of services are organized into individual chapters. Each chapter contains:

- A title page with a **Table of Contents** for the chapter,
- Followed by **payment policies** for specific services, or **general information**, and
- At the end of the chapter, a table with links to **related topics**.

Some chapters also include **definitions** of key terms, including descriptions of billing code **modifiers**. When a chapter does contain definitions, they appear immediately following the Table of Contents.

## Visual cues

Visual cues and icons appear consistently throughout the payment policies manual. The following is a list of these icons and visual cues, with descriptions of how they are used:

### Bulleting

Bullet lists are used to:

- organize complex information, *and*
- break it up into manageable pieces.

### Link 

Direct links to related information that may be of interest and assistance are provided. These include links to other chapters within the payment policies manual, helpful websites, forms and documents, or specific WACs and RCWs.

### Note 

Notes appear throughout the manual to draw attention to useful information.

### Table of Contents 

The same icon always appears next to the Table of Contents.

### Definitions, Modifiers, or general policy information 

The same icon always appears next to Definitions, Modifiers, or general policies that aren't payment policies.

### Payment policy 

The same icon always appears next to each payment policy.

## Sample pages

Below are illustrations of actual chapter content to show how information appears throughout.

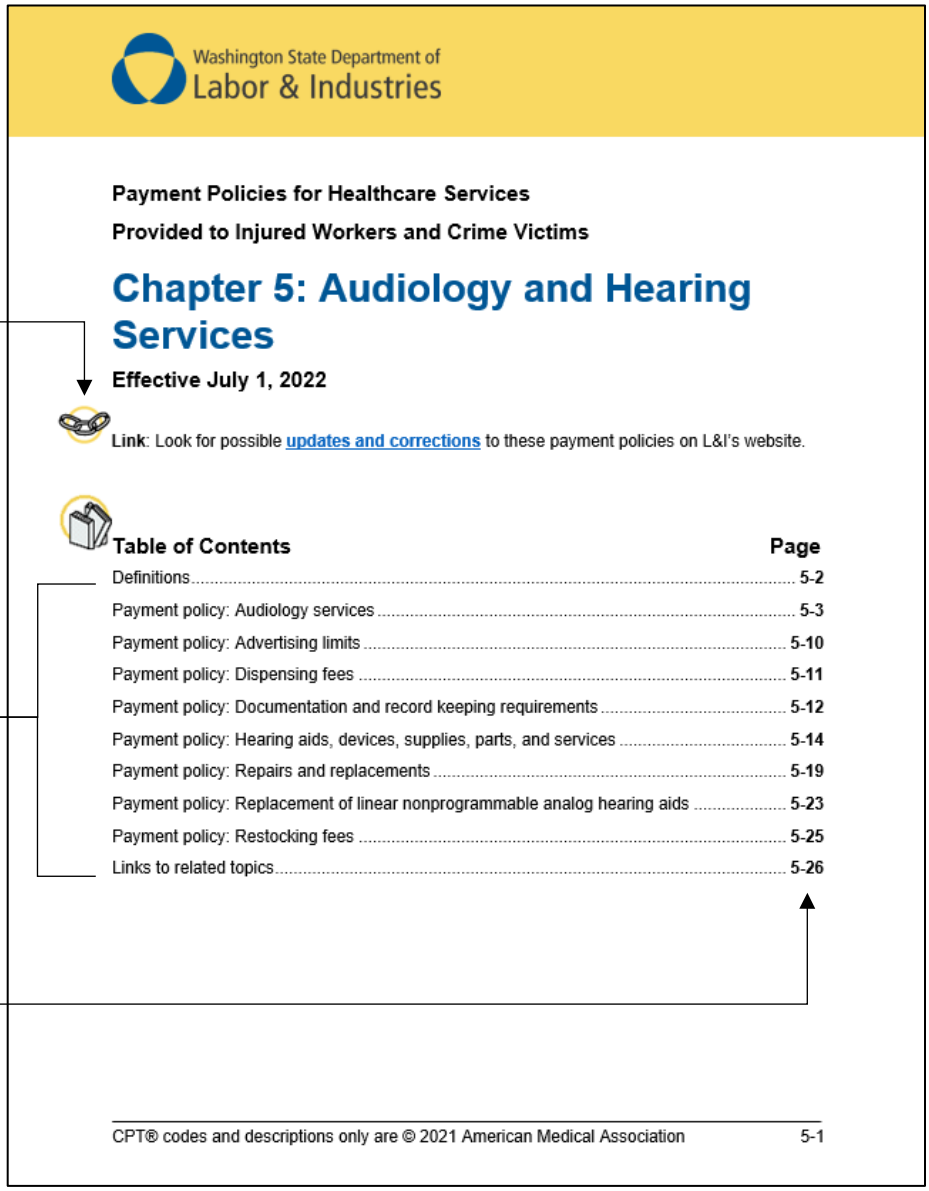
## Sample title page

Each state fiscal year (which begins July 1), L&I publishes updated policies.

Sometimes updates or corrections occur between annual publications. The Link on the title page will bring you to the website that lists such changes.

The Payment policies appear in alphabetical order.

To jump to a specific page, click on a page number.



Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

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# Chapter 5: Audiology and Hearing Services

**Effective July 1, 2022**

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

**Table of Contents** **Page**



 5-1

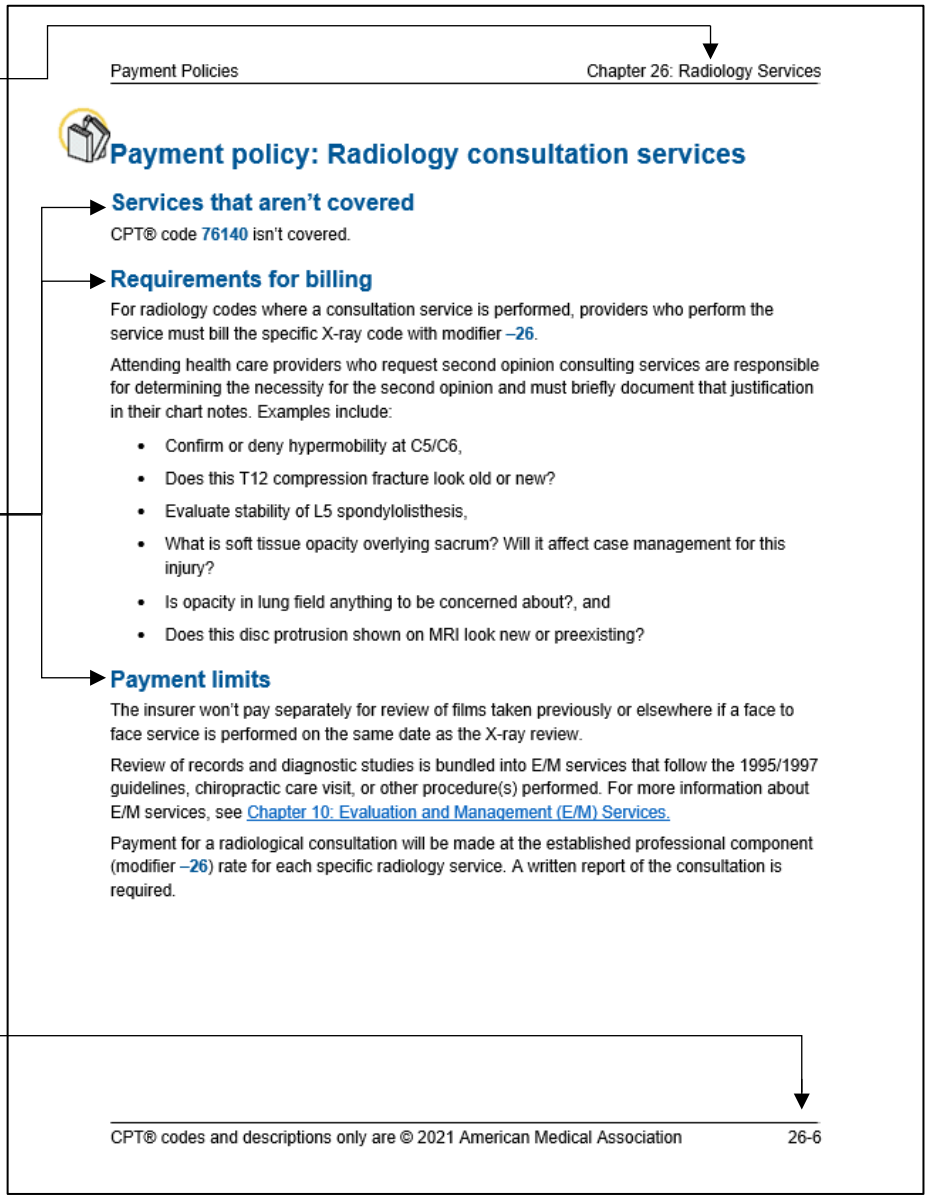
## Sample payment policy page

On every page, the printable version tells you what chapter you're reading.

To help you track down the specific information you need more quickly, each policy topic stands out in large, bold-faced type.

Each page number includes:

- The chapter number,
- A dash, *and*
- The page number.



Payment Policies Chapter 26: Radiology Services

### Payment policy: Radiology consultation services

#### Services that aren't covered

CPT® code 76140 isn't covered.

#### Requirements for billing

For radiology codes where a consultation service is performed, providers who perform the service must bill the specific X-ray code with modifier –26.

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6,
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis,
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?, and
- Does this disc protrusion shown on MRI look new or preexisting?

#### Payment limits

The insurer won't pay separately for review of films taken previously or elsewhere if a face to face service is performed on the same date as the X-ray review.

Review of records and diagnostic studies is bundled into E/M services that follow the 1995/1997 guidelines, chiropractic care visit, or other procedure(s) performed. For more information about E/M services, see Chapter 10: Evaluation and Management (E/M) Services.

Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the consultation is required.

CPT® codes and descriptions only are © 2021 American Medical Association 26-6

# General information: Highlights of policy changes since July 1, 2021

**These highlights are intended for general reference. This isn't a comprehensive list of all the changes in the payment policies or fee schedules.**

For complete code descriptions and lists of new, deleted, or revised codes, refer to the 2021 CPT© and HCPCS coding books.

## Washington Administrative Code (WAC) and payment changes

The following changes to WACs and payment rates occurred:

- Cost of living adjustments were applied to RBRVS and anesthesia services or to most local codes,
- WAC 296-20-135 increases the anesthesia conversion factor to $3.75 per minute ($54.60 per 15 minutes) and the RBRVS conversion factor increases to $59.46,
- WAC 296-23-220 and WAC 296-23-230 increases the maximum daily cap for physical and occupational therapy services to $140.84, and
- WAC 296-23-250 set a daily cap for massage therapy of 75% of the daily cap for PT/OT services. The rate for July 1, 2022 is $105.63.

## Policy & fee schedule additions, changes, and clarifications

### Professional services chapters

Several of the chapters reflect updated telehealth coverage and guidelines.

Chapter 2: Information for All Providers clarifies attending providers are required to collaborate with vocational counselors. ProviderOne information has been included for new providers. The insurer isn't using ProviderOne for billing.

Chapter 9: Durable Medical Equipment (DME) clarifies pneumatic compression device use.

Chapter 10: Evaluation and Management (E/M) Case Management Services now includes employers as the list of appropriate attendees for team conferences with providers.

Chapter 13: Independent Medical Exams has an updated fee schedule.

Chapter 14: Interpreter Services excludes sign languages. See Chapter 22: Other Services for information on arranging sign language interpreters.

Chapter 17: Mental Health Services clarifies rTMS coverage. This chapter also includes an update on residential facilities for mental health services.

Chapter 22: Other Services now includes information for Health Services Coordinators (HSCs).

Chapter 23: Pathology and Laboratory Services details when the insurer covers COVID-19 vaccinations and tests.

Chapter 25: Physical Medicine Services clarifies student involvement in the therapy appointment. Massage therapy requires prior authorization after the initial six visits.

### Facility services chapters

In the facility services chapters, fees including Hospital APR DRG rates have been updated.

The insurer is continuing to update the outpatient code editor (OCE). Notices of future updates will be posted on the Updates & Corrections page on L&I's website.

### Fee schedules

With the exception of the comma delimited files, the Field Keys are integrated into the fee schedules.

The following fee schedules, factors, and rates have been updated:

- Professional fees,
- Durable medical equipment fees,
- Prosthetics and orthotics fees,
- Laboratory fees,
- Pharmacy fees,
- Dental fees,
- Interpreter fees,
- Hospital percent of allowed charge (POAC) factors,
- Hospital rates,
- Hospital ambulatory payment classification (APC) rates,
- Residential fees, and
- Ambulatory surgery center (ASC) fees.

# General information: Tips on finding information in the printable version

## To navigate through this manual

### Table of Contents

In the Table of Contents, the page numbers are links to the page.

### "Bookmarks"

The Bookmarks tab (see the far left of this manual in the PDF viewer) is a feature of Adobe Acrobat. You can use the bookmark links to jump around this manual. If the "Bookmarks" tab isn't open, you can open it by clicking on "Bookmarks":

- Click on any text in the list to go to the information within this manual,
- Click on the plus (+) sign to open each section's list for more information, and
- Click on the minus (-) sign to close the section.

### Search

The Find box is another feature of Adobe Acrobat. Follow the instructions to search for the item or topic you need.

To search for a word, press Ctrl+F. Follow the instructions to search for the item or topic you need. The search function won't find an item if it is misspelled, so check your spelling carefully.

### Hyperlinks

Use the two kinds of hyperlinks within this manual. Internal jump links are similar to the Bookmark links mentioned above.

## To find information on a specific procedure

There are two places to look for information about a specific procedure:

- Review the payment policy (which is inside this manual), or
- Review the fee schedule (which is outside of this manual).

## To print information within this manual

Use the Print icon, which is on the same menu as the Binocular Search icon.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for industrial insurance (workers' compensation) | Washington Administrative Code (WAC) Title 296 |
| **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 professional services | Fee schedules on L&I's website |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

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# Chapter 2: Information for All Providers

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Bundled codes**: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.

**By Report (BR)**: A code listed in the fee schedule as "BR" which doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report (BR), see WAC 296-20-01002.

**Certified or accredited facility or office**: L&I defines a certified or accredited facility or office that has certification or accreditation from one of the following organizations:

- Medicare (CMS – Centers for Medicare and Medicaid Services),
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
- Accreditation Association for Ambulatory Health Care (AAAHC),
- American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF),
- American Osteopathic Association (AOA),
- Commission on Accreditation of Rehabilitation Facilities (CARF).

When services are performed in a facility setting, the insurer makes 2 payments:

- One to the professional provider, and
- One to the facility.

Payment to the facility includes resource costs, such as:

- Labor,
- Medical supplies, and
- Medical equipment.

**Clinic or non-facility**: Procedures performed in a provider's office that are paid at non-facility rates. Includes office expenses. When services are provided in non-facility settings, the professional provider typically bears the costs of:

- Labor,
- Medical supplies, *and*
- Medical equipment.

Separate payment isn't made to a facility when services are provided in a non-facility setting.

**Local code modifiers**: In addition to the modifiers found CPT® or HCPCS, the insurer uses a series of additional local code modifiers. These modifiers are developed specifically for L&I claims.

**Initial Visit**: The first visit to a healthcare provider during which the Report of Accident (Workplace Injury, Accident or Occupational Disease) is completed and the worker files a claim for workers' compensation.

**Medical Records**: Includes all documentation to support the services billed (including but not limited to, chart notes, reports and flow sheets).

**Link**: For more information, see WAC 296-20-01002, WAC 296-20-015, WAC 296-20-025, WAC 296-20-12401, and WAC 296 -20-065.

**Type of Service**: List of codes used for types of service when billing. These codes are based on the provider account type.

- 3 Medical
- 4 Dental
- 9 Miscellaneous services and therapy
- C Chiropractic
- D Naturopathic
- N Nursing
- P Physical therapy
- V Vocational services
- X Outpatient hospital

**Modifiers not allowed:**

**-FR (Two-way, audio-visual direct supervision)**

The supervising practitioner was present through two-way, audio/video communication technology. This isn't covered by the insurer.

# General information: All payment policies and fee schedules

## Effective date of these policies and fee schedules

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2022.

## Who these rules, decisions, and policies apply to and when

### Providers

All providers must follow the administrative rules, medical coverage decisions, and payment policies contained within the MARFS when providing services to injured workers, and when submitting bills to either the State Fund, self-insurers, or Crime Victims.

### Conflicting policies in CPT®, HCPCS, or CDT®

If there are any services, procedures, or text contained in the physicians' Current Procedural Terminology (CPT®), federal Healthcare Common Procedure Coding System (HCPCS), or Dental Procedure Codes (CDT®) coding books that are in conflict with the MARFS, the Department of Labor and Industries' (L&I) rules and policies take precedence.

**Link**: For more information, see WAC 296-20-010.

### Claimants

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

**Links**: For more information on L&I WACs, see to WAC 296.

For more information on the Revised Code of Washington (RCW), see the State legislature's website.

Questions may be directed to the:

- Provider Hotline at **1-800-848-0811** or PHL@lni.wa.gov, or
- Crime Victims Compensation Program at **1-800-762-3716**, or
- Self-Insurance Section at **360-902-6901**.

## 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).

### MARFS updates and corrections

On occasion, between annual publications, updates and corrections are made to either the policies or the fee schedules. L&I publishes such updates and corrections on their website.

### L&I Medical Provider News email listserv

To receive notices about payment policy and fee schedule updates and corrections, you can join the L&I Medical Provider News email listserv. Via email, listserv participants will receive:

- Updates and changes to the Medical Aid Rules and Fee Schedules, *and*
- Notices about courses, seminars, and new information available on L&I's website.

## How state agencies develop fee schedules and payment policies

To be as consistent as possible in developing billing and payment requirements for healthcare providers, Washington State government payers coordinate the development of their respective fee schedules and payment policies. The state government payers are:

- The Washington State Fund Workers' Compensation Program (administered by L&I), *and*
- The State Medicaid Program (administered by the Health Care Authority), *and*
- The Public Employees Benefits Board (administered by the Health Care Authority), *and*
- The Department of Corrections.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own funding source, benefit contracts, rates, and conversion factors.

## Maximum fees, not minimum fees

L&I establishes maximum fees for services; it doesn't establish minimum fees.

RCW 51.04.030(1) states that L&I shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule.

WAC 296-20-010(2) reaffirms that the fees listed in the fee schedule are maximum fees.

## Payment review (audits)

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

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

## Workers' choice of healthcare provider

Workers are responsible for choosing their healthcare providers. If provider network requirements apply, the worker may choose any network provider.

The provider must be an approved network provider to be eligible for payment of services beyond the **initial visit**.

At the same time, the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow L&I and self-insured employers (collectively known as the insurer) to recommend particular providers or to contract for services:

- RCW 51.04.030(1) allows the insurer to recommend to the worker particular healthcare services or providers where specialized or cost effective treatment can be obtained; however,
- RCW 51.28.020 and RCW 51.36.010 stipulate that workers are to receive proper and necessary medical and surgical care from licensed providers of their choice.

# General information: Becoming a provider

## Provider Accounts and Credentialing

### General information

All providers must have an active L&I provider account to bill for services. L&I is transitioning to ProviderOne in phases beginning in 2022 for provider enrollment and credentialing. Visit the ProviderOne website for the most up to date information.

**Note**: L&I isn't using ProviderOne for billing. Use ProviderOne for enrollment and credentialing.

### Medical Provider Network (MPN)

As part of Workers' Compensation Reform laws passed by the 2011 Washington Legislature, L&I created a statewide workers' compensation MPN. Network requirements apply to care delivered in Washington State. Network requirements don't apply to Crime Victim services.

Providers practicing in Washington State must be in the MPN to care for injured workers beyond the initial office or emergency-room visit. This includes treatment for workers of businesses covered by L&I as well as those employed by self-insured employers. The following provider types must enroll in the MPN:

- Physicians (MD & DO),
- Osteopathic physicians,
- Naturopathic physicians,
- Podiatric physicians,
- Physician assistants,
- Chiropractors,
- Dentists,
- Advanced registered nurse practitioners, and
- Optometrists.

**Note**: Out-of-state providers and other types of providers are exempt and may continue to treat injured workers without joining the network. They must have a provider number and abide by the insurer's fee schedules and payment policies.

**Links**: For more information on the MPN, see:

RCW 51.36.010, which establishes the legal framework of the network, *and*

WAC 296-20-01010, which establishes the scope of the network, *and*

WAC 296-20-01020 through WAC 296-20-01090, available in WAC 296-20, *and*

The ProviderOne webpage and the Join the Network webpage, which includes application materials as well as current information for affected providers, *and*

The Provider Network and COHE Expansion webpage, which includes complete information on the network and the new standards.

## Treating Washington injured workers

A provider must have an active L&I provider account number to treat Washington's injured workers and receive payment for medical services. This includes all types of providers, regardless of whether they are required to join the network. For State Fund claims, this proprietary account number is necessary for L&I to accurately set up its automated billing systems.

The federally issued National Provider Identifier (NPI) must be registered with L&I before billing or sending correspondence to the insurer.

## Applying for provider account numbers

Providers who aren't required to enroll in the network can apply for L&I provider account numbers by completing the Provider Account Application form (F248-011-000).

The following providers have additional application requirements:

- Vocational provider and firm
- Work hardening provider
- Masters Level Therapist (MLT Pilot)
- PGAP® Activity Coach
- Schools and Training Programs

HIPAA covered entity health care providers will need a NPI to apply.

**Links**: These L&I provider account forms and information on how to apply or make changes to your provider account are available online or can be requested by contacting L&I's Provider Accounts and Credentialing section.

Network Providers - email: ProvNet@Lni.wa.gov

All other provider types - email: PACMail@Lni.wa.gov

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

See more details about the provider account application process in WAC 296-20-12401.

Providers can apply for NPIs online.

## Requirements of providers

All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure they are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

### Attending providers must communicate with vocational rehabilitation counselors (VRCs)

All L&I attending providers (APs) must abide by WAC 296-19A-030 in the following areas by:

- Maintaining open communication with the worker's assigned vocational rehabilitation provider and referral source,
- Responding to all request for information necessary to evaluate a worker's ability to work, need for vocational services, and ability to participate in a vocational retraining plan, *and*
- Doing all that is possible to expedite the vocational rehabilitation process.

Review Chapter 27: Reports and Forms for VRC specific forms that may be requested.

## Billing for services

Once the L&I provider account number is established, and the federally issued NPI is registered with L&I, either number can be used on bills and correspondence submitted to L&I.

For State Fund providers with multiple accounts under the same tax ID, include the individual account number for the location billing in box 24J of the CMS 1500. This reduces payment delays.

L&I isn't using ProviderOne for billing.

**Link**: For additional information on electronic billing:

Go to L&I's Provider Express Billing website, or

Contact the Electronic Billing Unit at:

Phone: 360-902-6511
Fax: 360-902-6192

Email: ebulni@Lni.wa.gov

### Find a Doctor (FAD) website

If you have an active L&I provider account number, you may be listed on the searchable, online FAD database.

### Keep your provider account up-to-date

To prevent payment delays, keep the insurer informed of any changes to your account information.

For providers who are required to use ProviderOne, update your account with us online.

All other providers are required to complete a Provider Account Change Form (F245-365-000).

Accurate information helps ensure smooth communication between:

- Providers,
- L&I,
- Workers, and
- Employers.

## Self-insured employer accounts

For information about setting up provider account(s) to bill for treating self-insured injured workers, see the "General information: Self-insured employers (SIEs)" section of this chapter, below.

## Crime Victims Compensation Program accounts

Healthcare providers can use the same L&I provider number to bill for treating State Fund injured workers and crime victims.

Crime Victims providers are exempt from the provider network. Counselors that treat crime victims, but can't treat injured workers, must obtain a provider number through the Crime Victims Compensation program.

New providers can sign up for both programs at the same time using one provider application.

**Links**: You can contact the Crime Victims Compensation Program at **1-800-762-3716**, or email: CrimeVictimsProgram@Lni.wa.gov, or

Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520

Provider resources for the Crime Victims Compensation Program are available on L&I's website.

# General information: Charting format

## Required format: SOAP-ER

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, and Plan and progress) format (see below). In workers' compensation, there is a unique need for work status information. To meet this need, the insurer requires the addition of **ER** (Employment and Restrictions) to the SOAP format, and that chart notes document the worker's status at the time of each visit. Chart notes must document:

### S - Subjective complaints

- What the worker states about the illness or injury.
- Those symptoms perceived only by the senses and feelings of the person examined, which can't be independently proven or established.

**Link**: For more information, refer to WAC 296-20-220(1)(j).

### O - Objective findings

- What is directly observed and noticeable by the medical provider.
- This includes factual information, for example, "physical exam – skin on right knee is red and edematous", "lab tests – positive for opiates", "X-rays – no fracture".
- Essential elements of the injured worker's medical history, physical examination and test results that support the attending provider's diagnosis, the treatment plan and the level of impairment.
- Those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examining physicians.

**Link**: For more information, refer to WAC 296-20-220(1)(i).

### A - Assessment

What conclusions the medical provider makes after evaluating all the subjective and objective information. Conclusions may appear as:

- A definite diagnosis (dx.),
- A "Rule/Out" diagnosis (R/O), or
- Simply as an impression.

This can also include the:

- Etiology (ET), defined as the origin of the diagnosis, and/or
- Prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

### P - Plan and Progress

- The provider must recommend a plan of treatment. This is a goal directed plan based on the assessment. The goal must state the expected outcome from the prescribed treatment, and the plan must state how long the treatment will be administered.
- Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to workers.

### E - Employment issues

- Has the worker been released for or returned to work? Include a record of the worker’s physical and medical ability to work.
- When is release to work anticipated? Include information regarding any rehabilitation that the worker may need to enable them to return to work
- Is the worker currently working, and if so, at what job?

### R - Restrictions to recovery

- Describe the physical limitations (temporary and permanent) that prevent or limit return to work.
- What other limitations, including unrelated conditions, are preventing return to work?
- Are any unrelated condition(s) impeding recovery?
- Can the worker perform modified work or different duties while recovering (including transitional, part time, or graduated hours)?
- Is there a need for return to work assistance?

Office notes/chart notes, progress notes, and 60-day reports should include the SOAPER contents.

The insurer has additional reporting and documentation requirements. These requirements are described in the provider specific payment policy chapters of this document (MARFS) and in WAC 296-20-06101.

**Link**: For more information, refer to WAC 296-20-010(8), WAC 296-20-06101, and WAC 296-20-01002 (Chart notes).

# General information: Documentation requirements; how improper documentation could impact payment for services

## Documentation of services

Providers are required to submit notes that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation must contain the pertinent history and the pertinent findings found during an exam. Providers must maintain documentation in workers' individual records to verify the level, type, and extent of services provided to workers.

Chart notes:

- Must be written for a single date of service, *and*
- Must include a full description of treatment rendered as well as documentation of the area of the body treated.

Documentation must include the amount of time spent for each time-based service performed when:

- Procedures have a timed component in their descriptions, *and*
- Time is a determining factor in choosing the appropriate code.

All documentation to support the service billed must be received by the insurer prior to submitting your bill or within 30 days of the date of service, whichever comes first. The insurer may recoup, deny or reduce a provider's level of payment for a specific visit or service if the required documentation isn't provided or the level or **type of service** doesn't match the procedure code billed. Refer to WAC 296-20-015.

### Limitations

Chart notes must be submitted for each individual date of service and by each individual provider. Joint chart notes of any kind aren't acceptable.

No additional amount is payable for documentation required to support billing.

Documenting a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

## Required content

The insurer won't pay for services unless the documentation includes the name and title of the person performing the service.

Providers can submit forms with a signature stamp or an electronic signature.

**Links**: For the legal definition of Chart notes, see WAC 296-20-01002.

## Requirements in addition to CPT®

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. These requirements are described in the provider specific payment policy chapters of this document (MARFS) and/or in WAC 296-20-06101.

The insurer may pay separately for specialized reports or forms required for claims management.

"Narrative report" merely signifies the absence of a specific form.

Level of service is based on the documentation of services and the medical/clinical complexity as defined in the CPT® coding requirements.

Office/chart notes are expected to be legible and in the SOAP-ER format.

**Links**: For more information, see WAC 296-20-06101.

## Changes to medical records

Changes made **after bill submission** won't be accepted. If a change to the medical record is made after bill submission, only the original record will be considered in determining appropriate payment of services billed to the insurer.

Changes to the **medical records** amended **prior to bill submission** may be considered in determining the validity of the services billed. All changes to **medical records** must be made according to the rules below. This policy is based on American Health Information Management Association (AHIMA) and Centers for Medicare & Medicaid Services (CMS) guidelines.

**Late entries, addendums, or corrections** to a medical record are legitimate occurrences in documentation of services. A late entry, addendum, or correction to the medical record must:

- Note the current date of that entry, *and*
- Be signed by the person making the addition or change.

## Late entries

A late entry may be necessary to supply additional information that was omitted from the original entry or to provide additional documentation to supplement entries previously written. The late entry must:

- Note the current date,
- Be added as soon as possible, *and*
- Be written by the provider who performed the original service and only if the provider has total recall of the omitted information.

To document a late entry:

- Identify the new entry as a "late entry," *and*
- Enter the current date and time – don't try to give the appearance that the entry was made on a previous date or an earlier time, *and*
- Identify or refer to the date and incident for which the late entry is written, *and*
- If the late entry is used to document an omission, validate the source of additional documentation as much as possible.

## Addendums

An addendum is used to provide information that wasn't available at the time of the original entry.

To document an addendum:

- Identify the entry as an "addendum" and state the reason for the addendum referring back to the original entry, *and*
- Document the current date and time, *and*
- Identify any sources of information used to support the addendum.

## Corrections

A correction to the medical record requires that these proper error correction procedures are followed:

- Draw a line through the entry, making sure the inaccurate information is still legible, *and*
- Initial and date the entry, *and*
- State the reason for the error, *and*
- Document the correct information.

## Falsified documentation

Deliberately falsifying **medical records** is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creating new records when records are requested, *or*
- Backdating entries, *or*
- Postdating entries, *or*
- Predating entries, *or*
- Writing over, *or*
- Adding to existing documentation (except as described in late entries, addendums, and corrections, above).

**Links**: For more information, see RCW 51.48.270, RCW 51.48.290 and RCW 51.48.250.

## Documentation requirements when referring worker for care outside of the local community

Whenever it is necessary to refer an injured worker for specialty care or for services outside of the local community, include in the medical notes:

- The medical reason for the referral, *and*
- A statement of why it is reasonable or necessary to refer outside of the community.

## Special reports and documentation for industrial insurance claims

In addition to the documentation requirements published by the American Medical Association in the Current Procedural Terminology (CPT®) book, L&I or the self-insurer has additional reporting and documentation requirements to adequately manage industrial insurance claims.

See Chapter 27: Reports and Forms for a list of reports and forms that may be requested by the insurer. L&I's Report of Accident or the self-insurer's Provider's Initial Report are payable separately.

**Links**: For more information about the SOAP-ER format, see the "General information: Charting format" of Chapter 2: Information for All Providers.

For any additional information on documentation requirements, see WAC 296-20-06101.

# General information: Language Access Services

## How providers arrange for interpretive services

Under the Civil Rights Act of 1964, the healthcare or vocational provider will determine whether effective communication is occurring. The insurer covers the cost of an interpreter for all visits, even if a worker's claim is rejected, up until the date of rejection. The healthcare or vocational provider will determine, with the worker, if the assistance of an interpreter is needed for effective communication to occur.

You may choose to use any of the following interpretation options for covered, billable treatment or services provided to the worker:

- In-person interpretation,
- Over the phone interpretation,
- Video remote interpretation.

For in-person appointments, the healthcare or vocational provider will schedule an interpreter to provide medical interpretation during an appointment using interpretingWorks. The healthcare or vocational provider may not select the same interpreter for every appointment scheduled by the worker, unless there are extenuating circumstances.

Indicate the use of an interpreter in your chart notes. Include the name of the interpreter and the language. Sign the Interpreter Services Appointment Record (ISAR) for the interpreter (for on-demand or emergency or urgent care or walk-in visits only), to verify the services provided.

For over the phone interpretation or video remote interpretation, the healthcare or vocational provider will use the insurer's contracted vendor CTS Language Link.

Interpreter services aren't covered for administrative purposes, such as scheduling or rescheduling an appointment.

**Links**: For more information on interpreter services see:

Chapter 14: Language Access Services.

Chapter 22: Other Services

How providers arrange interpretive services.

Interpreter Lookup Service online tool to help you find a face-to-face interpreter for on-demand appointments, such as emergency visits, urgent care, or walk-ins.

For prescheduled appointments, use L&I's vendor interpretingWorks.

# General information: Recordkeeping requirements

## Which records a provider must keep

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. In the records you keep for each worker, you must include:

- Subjective and objective findings,
- Records of clinical assessment (diagnoses),
- Reports,
- Interpretations of X-rays,
- Laboratory studies,
- Other key clinical information in patient charts, *and*
- Any other information to support the level, type and extent of services provided.

## How long a provider must keep records

### All records

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years.

L&I may request records before, during or after the delivery of services to ensure workers receive proper and necessary medical care and to ensure provider compliance with the department's MARFS. The provider must submit the requested records within 30 calendar days from receipt of the request. Failure to do so may result in denial or recoupment of bill payment(s).

**Link**: For more information, see WAC 296-20-02005 and WAC 296-20-02010.

### X-rays

Providers are required to keep all X-rays for a minimum of 10 years.

**Link**: For more information, see WAC 296-20-121 and WAC 296-23-140.

# General information: Self-insured employers (SIEs)

## How Self-Insurance works in Washington

SIEs or their third party administrators (TPA) administer their own claims instead of paying premiums to the State Fund for L&I to administer.

SIEs must authorize treatment and pay bills according to Title 51 RCW and the Medical Aid Rules (WACs) and Fee Schedules of the state of Washington (WAC 296-15-330(1)), including the payment policies described in this manual.

For SIE claims, healthcare providers should send their bills, reports, requests for authorization, and other correspondence directly to the SIE/TPA.

**Links**: A list of SIE/TPAs is available online.

## SIE/TPA provider identification numbers

To bill SIE/TPAs for workers' compensation claims, contact the individual insurer directly for their provider identification number requirements.

Medical Provider Network providers should use their individual NPI in Box 24J of the CMS 1500 form to facilitate prompt payment.

## Special SIE claim forms

### Self-Insurer Accident Report (SIF-2)

SIEs use the SIF-2 to establish a new claim and assign a claim number.

Only the SIE and the worker complete the SIF-2.

### Provider's Initial Report (PIR)

PIR forms are supplied to providers to assist self-insured injured workers in filing claims. The PIR is used in the same way the Report of Accident (ROA) form is used for State Fund covered workers.

Only the provider and the worker complete the PIR.

## Providers may bill for interest on medical bills for self-insured claims only

Providers are entitled to bill interest for late payment of any proper medical bills on self-insured claims (RCW 51.36.085).

- Use Local Code **1159M** to bill for interest.
- Use the Self-Insurance Medical Bill Interest Calculator to calculate the correct interest due. Call (360) 902-6938 with questions.

## Disputes between providers and SIEs

The Self-Insurance (SI) Program of L&I regulates the SIEs for compliance with RCW, WAC, policies, and fee schedules.

If a dispute arises between a provider and an SIE, the provider may ask the SI program to intervene and help resolve the dispute. For disputes related to:

- **Treatment authorization or nonpayment of bills**, the SI Claims Adjudicator assigned to the claim will handle the dispute. Call the Self-Insurance Program's receptionist at 360-902-6901 to be directed to the appropriate claim adjudicator.
- **Underpayments of bills**, the SI section medical compliance consultant will handle the dispute. Complete and submit Self-Insurance Medical Provider Billing Dispute form (F207-207-000). Call 360-902-6938 with questions.

# General information: Submitting claim documents to the State Fund

## How to submit

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. The imaging system can't read some types of paper and has difficulty passing other types through automated machinery.

**Bills should never be faxed to the Department.**

Documents faxed to the Department are automatically routed to the claim file; paper documents are manually scanned and routed to the claim file.

### Do this

When submitting documents:

- Do submit documents on white 8 ½ x 11-inch paper (one side only), *and*
- Do leave ½ inch at the top of the page blank, *and*
- Do put the patient's name and claim number in the upper right hand corner of each page, *and*
- Do, if there is no claim number available, substitute the patient's social security number, *and*
- Do reference only one worker/patient in a report or letter, *and*
- Do staple together all documents pertaining to one claim, *and*
- Do emphasize text using asterisks or underlines, *and*
- Do include a key to any abbreviations used, *and*
- Do submit legible information.

### Don’t do this

When submitting documents:

- Don’t use colored paper, especially hot or intense colors, *and*
- Don’t use thick or textured paper, *and*
- Don’t send carbonless paper, *and*
- Don’t use any highlighter markings, *and*
- Don’t place information within shaded areas, *and*
- Don’t use italicized text, *and*
- Don’t use paper with black or dark borders, especially on the top border, *and*
- Don’t staple documents for different workers/patients together.

## Where to submit

Submitting State Fund bills, reports, and correspondence to the correct addresses or fax numbers:

- Helps L&I process your documents promptly and accurately,
- Can prevent significant delays in claim management,
- Can help you avoid repeated requests for information you have already submitted, *and*
- Helps L&I pay you promptly.

**Link**: Attending providers have the ability to send secure messages through the Claim and Account Center.

The following table shows where you may fax or send correspondence and reports.

| If you are **submitting**… | Then you can **fax** to: | Or send to this **State Fund mailing address**: |
|---|---|---|
| **Report of Accident (ROA) Workplace Injury or Occupational Disease**<br>(also known as "Accident Report" or "ROA")<br>(F242-130-000) | **360-902-6690** or<br>**800-941-2976**<br><br>Hot ROA Fax for hospital admissions<br>**360-902-4980**<br><br>**These fax numbers are for ROAs only!** | Department of Labor & Industries<br>PO Box 44299<br>Olympia, WA 98504-4299 |
| **Correspondence**,<br>Activity Prescription Forms (**APFs**),<br>**Reports and chart notes** for State Fund Claims, and<br>**Claim related documents** other than bills. | **360-902-4567** | Department of Labor & Industries<br>PO Box 44291<br>Olympia, WA 98504-4291<br><br>**Reports and chart notes must be submitted separately from bills.** |
| Provider Account information **updates** | **360-902-4484** | Department of Labor & Industries<br>PO Box 44261<br>Olympia, WA 98504-4261 |

| If you are **submitting**… | Then you can **fax** to: | Or send to this **State Fund mailing address**: |
|---|---|---|
| **Bills**, including:<br>• UB-04 forms,<br>• CMS 1500 forms,<br>• Retraining & job modification bills,<br>• Home nursing bills,<br>• Miscellaneous bills,<br>• Pharmacy bills,<br>• Compound prescription bills, and<br>• Requests for adjustment. | **Don't fax bills!** | Department of Labor & Industries<br>PO Box 44269<br>Olympia, WA 98504-4269 |
| State Fund **refunds** (attach copy of remittance advice) | N/A | Cashier's Office<br>Department of Labor & Industries<br>PO Box 44835<br>Olympia, WA 98504-4835 |

**Link**: These and other forms are available at L&I's Billing Forms and Publications website.

# Payment policy: All professional services

## Coverage of procedures

### Medical coverage decisions

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

### Procedure codes that aren’t covered

Procedure codes listed as “not covered” in the fee schedules aren’t covered for the following reasons:

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

On a case-by-case basis, the insurer may pay for procedures in the first two categories above. To be paid, the healthcare 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.

**Links**: For more information on coverage decisions and covered services, refer to WAC 296-20-01505, WAC 296-20-02700 through -02850 available in WAC 296-20, WAC 296-20-030 through -03002 available in WAC 296-20, and WAC 296-20-1102.

# Requirements for billing

## Unlisted procedure codes

Some covered procedures don't have a specific code or payment level listed in the fee schedule. When reporting such a service, the appropriate unlisted procedure code must be billed. Within the chart notes or surgical report, supporting documentation including a full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using the established procedure codes. Modifiers must be included. The provider also must list the most similar procedure code or codes to the services performed including units of service.

No additional payment is made for the supporting documentation.

**Links**: For more information, refer to WAC 296-20-01002 and to the fee schedules.

For more information about licensed nursing services and payment, see WAC 296-23-245.

## Physician Assistants (PA)

To be paid for services, PAs must:

- Be certified and have valid individual L&I provider account numbers referencing their supervising physician, *and*
- Bill for services using their provider account numbers, *and*
- Use the appropriate billing modifiers.

**Note**: Services performed by a PA and co-signed by the supervising physician must be submitted under the PA's individual L&I provider account number.

# Payment limits

## Units of service

Payment for billing codes that don't specify a time increment or unit of measure is limited to one unit per day. For example, only one unit is payable for CPT® code **97022** regardless of how long the therapy lasts.

## Physician Assistants (PAs)

Physician Assistant services are paid to the supervising physician or employer up to a maximum of 90% of the allowed fee. The fee schedules for DME, supplies, and materials applies equally to all providers. There is no reduction for these supplies and equipment if prescribed by a PA.

PAs may sign any documentation required by the department for services they provide.

Consultations and impairment rating services related to workers' compensation benefit determinations aren't payable to physician assistants.

**Links**: For more information about physician assistant services and payment, see WAC 296-20-12501, RCW 51.28.100, and WAC 296-20-01501.

# Payment policy: Billing codes and modifiers

## Procedure codes used in the fee schedules

L&I's fee schedules use the federal HCPCS and agency unique local codes (see more information, below).

## Procedure codes and modifiers

**The descriptions and complete coding information are found in the current CDT®, CPT®, or HCPCS manuals.**

The fee schedule lists all covered codes (including **bundled**, **By Report** and the maximum fee) and some non-covered codes. If a code isn't listed in the fee schedule, it isn't covered.

**Link**: For more information, please see our complete fee schedule.

## Code description limits

Due to space limitations, only partial descriptions of HCPCS or CDT® codes appear in the fee schedules.

Due to copyright restrictions, there aren't descriptions for CPT® codes in the fee schedules.

## Providers' responsibility when billing

Providers must bill according to the full text descriptions published in the CDT®, CPT®, and HCPCS books. These books can be purchased from private sources.

**Link**: For more information, refer to WAC 296-20-010(1).

## CPT® codes (HCPCS Level I codes)

### Codes

HCPCS (commonly pronounced "hick picks") Level I codes are the CPT® codes developed, updated, and copyrighted annually by the American Medical Association (AMA). There are three categories of CPT® codes:

- **CPT® Category I codes** are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, and don't include newly emerging technologies. The codes consist of five numbers (for example, **99202**), and

- **CPT® Category II codes** are optional and used to facilitate data collection for tracking performance measurement. The codes consist of four numbers followed by an F (for example, **0001F**), and
- **CPT® Category III codes** are temporary and used to identify new and emerging technologies. The codes consist of four numbers followed by a T (for example, **0001T**).

### Modifiers

HCPCS Level I modifiers are the CPT® modifiers developed, updated, and copyrighted by the AMA. These modifiers are used to indicate that a procedure or service has been altered without changing its definition.

These modifiers consist of two numbers (for example, **–22**). L&I does not use modifiers with five digits.

**Note**: L&I doesn't accept the five digit modifiers.

## HCPCS Level II codes and modifiers

### Codes

HCPCS Level II codes (usually referred to simply as "HCPCS codes") are updated by the Center for Medicare & Medicaid Services (CMS). HCPCS codes are used to identify:

- Miscellaneous services,
- Supplies,
- Materials,
- Drugs, and
- Professional services.

These codes begin with one letter, followed by four numbers (for example, **K0007**).

Codes beginning with D are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3®).

### Modifiers

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered.

These modifiers consist of either:

- Two letters (for example, **–AA**), *or*
- One letter and one number (for example, **–E1**).

## Local codes and modifiers

### Codes

Local codes are used to identify unique services or supplies.

These codes consist of four numbers followed by one letter (except F and T). For example, **1040M**, which must be used to code completion of the State Fund's Report of Accident and Self-Insurer's Provider's Initial Report forms.

L&I will modify local code use as national codes become available.

### Modifiers

Local code modifiers are used to identify modifications to services.

These modifiers consist of one number and one letter (for example, **–1S**).

L&I will modify local modifier use as national modifiers become available.

Local modifiers for contracted services are only listed in the specific contract.

## Quick reference guide for all billing codes and modifiers

| If the **billing code type** is… | Then the **purpose** of the code is: | And the **code format** is: | And the **modifier format** is: | And the **source** of the code is: |
|---|---|---|---|---|
| HCPCS Level I: **CPT® Category I** | Professional services, pathology and laboratory tests. | 5 numbers | 2 numbers | AMA / CMS |
| HCPCS Level I: **CPT® Category II** | Tracking codes, to help collect data for tracking performance measurement. | 4 numbers followed by F | N/A | AMA / CMS |
| HCPCS Level I: **CPT® Category III** | Temporary codes for new and emerging technologies. | 4 numbers followed by T | N/A | AMA / CMS |

| If the **billing code type** is… | Then the **purpose** of the code is: | And the **code format** is: | And the **modifier format** is: | And the **source** of the code is: |
|---|---|---|---|---|
| **HCPCS Level II** (HCPCS code) | Miscellaneous services, supplies, materials, drugs, and professional services. | 1 letter followed by 4 numbers | 2 letters, or 1 letter followed by 1 number | AMA / CMS |
| **Local code** (unique to L&I) | L&I unique services, materials, and supplies. | 4 numbers followed by 1 letter (but not F or T) | 1 number followed by 1 letter | L&I |

# Payment policy: Billing instructions and forms

## Who to bill (which insurer)

Each insurer uses a unique format for claim numbers. This will help you identify which insurer to bill for a specific claim:

**State Fund** claims either begin with:

- The letters A, B, C, F, G, H, J, K, L, M, N, P, X, Y or Z followed by six digits, *or*
- Double alpha letters (example AA) followed by five digits.

**Self-insured** claims either begin with:

- S, T, or W followed by six digits, *or*
- Double alpha letters (example SA) followed by five digits.

**Crime Victims** claims either begin with:

- V followed by six digits, or
- Double alpha letters (example VA) followed by five digits.

### Special cases

Claims for contractors hired to clean up the Hanford Nuclear Reservation for the Department of Energy (US) are self-insured.

Federal claims begin with A13 or A14.

**Link**: Questions and billing information about federal claims should be directed to the U.S. Department of Labor at **202-693-0036**, **206-470-3100**, or **866-692-7487** (Northwest district) or their website.

## Medicare claims

If a worker has an allowable workers' compensation injury or illness, workers' compensation is always the sole insurer for the injury or illness.

- Medicare is never a secondary payer for workers' compensation claims. The workers' compensation insurer's payment is the full payment.
- Medicare can't be billed for allowed workers' compensation claims.
- If Medicare is incorrectly billed for a workers' compensation claim, the provider is required to reimburse all payments made by Medicare. Covered services provided to injured workers may only be billed to L&I or the self-insurer.

## Report of Accident (ROA/PIR) requirements

A Report of Accident (ROA/PIR) may **only** be filed as part of an in-person physical examination of the injured worker. This service may **not** be done via telemedicine.

All information voluntarily provided by the worker in the Worker and Employer sections of the Report of Accident (ROA) must be included in electronic data submissions. All fields in the Provider section of the ROA must be completed and must be included in electronic data submissions. These requirements must be met to qualify for the $10 financial incentive for electronic submission of ROAs.

Providers now have the option to file State Fund ROAs online via FileFast or through Health Information Exchange (HIE).

Online filing of the State Fund accident report reduces delays in claim management. Benefits of filing a ROA online include:

- Immediate confirmation of receipt.
- Faster authorization for treatment and prescription refills.
- Increased accuracy (reduces common mistakes).
- The provider is instantly assigned to the claim.
- Pharmacists can fill additional prescriptions.
- Quick access to the claim.
- $10 additional reimbursement for online filing (code **1040M**).

ROAs/PIRs submitted within 5 business days after an injured worker's **initial visit** are paid at a higher rate than ROAs/PIRs submitted after 5 business days. The insurer pays for completion of ROAs/PIRs on a graduated scale based on when they are received by the insurer following the "Initial visit"/"This exam date" (box 15b on the paper ROA form, and box 3 on the PIR form).

| | Within 5 days | 6-8 days | 9 days or more |
|---|---|---|---|
| Max fee via paper or fax | **$44.44** | **$33.44** | **$23.44** |
| Max fee via FileFast/HIE – State Fund only (additional $10 incentive; add to your bill when submitting) | **$54.44** | **$44.44** | **$34.44** |

**Note**: When filing State Fund ROAs via FileFast make sure to add the $10 web incentive to your bill.

**Link**: Information about online filing options is available on our FileFast website or by calling **877-561-3453**.

Information is available online about filing through the Health Information Exchange (HIE).

## Payment adjustments on State Fund claims

Providers must bill their usual and customary charges. For ROAs received more than 5 business days from "This exam date" (box 15b on paper ROA), L&I's payment system automatically reduces the ROA payment.

Payments are increased for participation in the Centers of Occupational Health and Education (COHE) or for online claim filing (FileFast).

### Penalties starting in July 2023

Starting in July 2023, providers may be subject to fines for failure to submit an ROA or PIR within five days of treatment. See RCW 51.48.060 and RCW 51.48.095 for details. In early 2023, the Department will announce how providers may offer feedback on these penalties. Subscribe to GovDelivery to receive announcements about this and other pending changes.

## Who may be paid for completion of the ROA/ Providers Initial Report (PIR)

A provider with a valid provider account number may be paid for completing an ROA or PIR if they are licensed as one of the following:

- Advanced Registered Nurse Practitioner (ARNP)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Medical Doctor (MD)
- Naturopathic Doctor (ND)
- Doctor of Optometry (OD)
- Physician Assistant Certified (PA-C)

## Billing requirements

Bill only one ROA or PIR per claim, using local code **1040M**.

Submit the ROA or PIR to the insurer immediately following the “Initial visit” (which the ROA and PIR calls “This exam date”).

Complete the ROA F242-130-000 (English) using the instructions on the form.

Complete the PIR using instructions on the back of form F207-028-000. If you need additional space, attach the information to the application, and include the claim number at the top of the page.

Reimbursement amount is based on the date the healthcare provider includes in box 15b of the paper ROA, and in box 3 of the PIR, Attending Health Care Provider section, (This exam date). If that box is blank, the department’s payment system will look at box 16 of the paper ROA (Signature of the health care provider) and the self-insurer will look at box 13, (Date) in the Attending Health Care Provider section. To ensure correct payment, make sure the ROA/PIR is filled out completely.

## Billing procedures

Information on billing procedures is outlined in WAC 296-20-125.

## Billing manuals and billing instructions

The General Provider Billing Manual (F248-100-000) and L&I’s provider specific billing instructions contain:

- Billing guidelines,
- Reporting and documentation requirements,
- Resource lists, and
- Contact information.

Additional billing manuals:

- CMS 1500 Billing Manual (F245-423-000)
- Crime Victims Direct Entry Billing Manual (F800-118-000)
- Direct Entry Billing Manual (F245-437-000)
- Home Health Services Billing Manual (F245-424-000)
- Hospital Services Billing Manual (F245-425-000)
- Mental Health Fee Schedule and Billing Guidelines (F800-105-000) (For the Crime Victims Program)

- Miscellaneous Services Billing Manual (F245-431-000)
- Pharmacy Billing Manual (F245-433-000)
- Retraining and Job Modification Billing Manual (F245-427-000)

## Billing workshops

L&I offers providers free billing workshops to help you save time and money by:

- Learning to bill L&I correctly,
- Getting new tools for doing business with L&I, *and*
- Meeting your Provider Support and Outreach Representatives.

## Electronic billing for State Fund bills

Electronic billing is available to all providers of services to injured workers covered by the State Fund. Electronic billing is helpful because it:

- Allows greater control over the payment process,
- Eliminates entry time,
- Allows L&I to process payments faster than paper billing,
- Reduces billing errors, *and*
- Decreases the costs of bill processing.

Your correspondence and reports may be faxed to L&I, but **bills can't be faxed**. There are three secure ways providers can bill L&I electronically:

1. Free online billing form with Direct Entry submission through Provider Express Billing (PEB) (no specific software/clearinghouse required), *or*
2. Upload bills using your software (the department doesn't supply billing software for electronic billing), *or*
3. Use an intermediary/clearinghouse.

**Note**: Don't fax bills to L&I.

### Where to find electronic billing information

Fax numbers can be found in the "Submitting claim documents to the State Fund" payment policy section (earlier in this chapter) or on L&I's website.

For additional information on electronic billing, go to our Provider Express Billing website or contact the Electronic Billing Unit at:

Phone: **360-902-6511**

Fax: **360-902-6192**

Email: ebulni@Lni.wa.gov

Information on Crime Victims compensation is available on L&I's website.

## Billing forms

Providers must use L&I's current billing forms. **Using out-of-date billing forms may result in delayed payment.**

**Links**: Medical provider forms can be found on L&I's website.

## When to submit a billing adjustment vs. a new bill to the State Fund

**Submit a new bill** when an entire bill was previously denied.

**Submit an adjustment** when you were paid for part of previously submitted bill.

If the provider identifies an overpayment or underpayment, an adjustment or refund is required. Per WAC 296-20-02015, if the provider receives payment they're not entitled to, the provider must repay the excess payment (possibly with interest).

- Submit a refund for situations in which the entire date of service is an overpayment. You can obtain a fillable Refund Notification form.
- Submit an adjustment form to correct billing errors associated with all other partial under or overpayments. You can obtain a fillable Provider's Request for Adjustment form.

**Link**: Additional information on adjustments is available on our website.

## Billing for missed appointments

Workers are expected to attend scheduled appointments.

WAC 296-20-010(5) states: L&I or self-insurers won't pay for a missed appointment unless the appointment is for an examination arranged by L&I or the self-insurer.

A provider may bill a worker for a missed appointment per WAC 296-20-010(6) if the provider:

- Has a missed appointment policy that applies to all patients regardless of payer, *and*
- Routinely notifies all patients of the missed appointment policy.

Providers must notify the claim manager immediately when an injured worker misses an appointment.

The insurer isn't responsible or involved in the implementation and/or enforcement of any provider's missed appointment policy.

# Payment policy: Current coverage decisions for medical technologies and procedures

## Coverage decisions for medical technologies and procedures

Before providing services to injured workers, please review L&I's published coverage decisions to determine whether the treatment or medical technology is covered and if there are any specific restrictions or conditions.

# Payment policy: Overview of payment methods

## Ambulatory Surgery Center (ASC) payment methods

### ASC rate calculations

Insurers use a modified version of the ASC payment system developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC.

**Links**: For more information on this payment method, see Chapter 32: Ambulatory Surgery Centers (ASCs) or refer to WAC 296-23B.

### By report

Insurers pay for some covered services on a **By Report** basis. Fees for **By Report** services may be based on the value of the service as determined by the report.

### Maximum fees

For services covered in ASCs that aren't priced with other payment methods, L&I establishes maximum fees.

## Hospital inpatient payment methods

The following is an overview of the hospital inpatient payment methods. For more information, see Chapter 35: Hospitals or refer to WAC 296-23A.

### Self-insurers

Self-insurers use Percent of Allowed Charges (POAC) to pay for all hospital inpatient services.

**Link**: For more information, see WAC 296-23A-0210.

### All Patient Refined Diagnosis Related Groups (APR DRG)

State Fund uses All Patient Refined Diagnosis Related Groups (APR DRGs) to pay for most inpatient hospital services.

**Link**: For more information, see WAC 296-23A-0200.

### Per diem

State Fund uses statewide average per diem rates for five APR DRG categories:

- Chemical dependency,
- Psychiatric,
- Rehabilitation,
- Medical, and
- Surgical.

Hospitals paid using the APR DRG method are paid per diem rates for APR DRGs designated as low volume.

### Percent of Allowed Charges (POAC)

State Fund uses a POAC payment method:

- For some hospitals exempt from the APR DRG payment method, and
- As part of the outlier payment calculation for hospitals paid by the APR DRG.

## Hospital outpatient payment methods

The following is an overview of the hospital outpatient services payment methods. For more information, see Chapter 35: Hospitals or refer to WAC 296-23A.

### Self-insurers

Self-insurers use the maximum fees in the Professional Services Fee Schedule to pay for:

- Radiology,
- Pathology,
- Laboratory,
- Physical therapy, and
- Occupational therapy services.

Self-insurers use POAC to pay for hospital outpatient services that aren't paid with the Professional Services Fee Schedule.

**Link**: For more information, see WAC 296-23A-0221.

### Ambulatory Payment Classifications (APC)

State Fund pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

**Link**: For more information, see WAC 296-23A-0220.

### Professional Services Fee Schedule

State Fund pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

### Percent of Allowed Charges (POAC)

Hospital outpatient services are paid by a POAC payment method **when they aren't paid**:

- With the APC payment method, *or*
- The Professional Services Fee Schedule, *or*
- By L&I contract.

### Out-of-state hospital payment methods

For information on out-of-state hospital outpatient, inpatient, and professional services payment methods, see WAC 296-23A-0230.

## Pain management payment methods

### Chronic Pain Management Program fee schedule

Insurers pay for Chronic Pain Management Program Services using an all-inclusive, phase based, per diem fee schedule.

## Professional provider payment methods

The following is an overview of the payment methods for professional provider services. For more information, see the relevant payment policy chapters or refer to WAC 296-20, WAC 296-21, and WAC 296-23.

The Professional Services Fee Schedule is available online.

### Resource Based Relative Value Scale (RBRVS)

Insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services.

Services priced according to the RBRVS fee schedule have a fee schedule indicator of R in the Professional Services Fee Schedule.

**Links**: More information about RBRVS is contained in Chapter 31: Washington RBRVS Payment System.

### Anesthesia fee schedule

Insurers pay for most anesthesia services using anesthesia base and time units.

**Link**: For more information, see Chapter 4: Anesthesia Services.

### Pharmacy fee schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule.

**Link**: For more information, see Chapter 24: Pharmacy Services.

### Drugs paid using Average Wholesale Price (AWP)

L&I's maximum fees for some covered drugs administered in or dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug.

Drugs priced with an AWP method have **AWP** in the "Dollar Value" columns and a D in the fee schedule indicator (FSI) column of the Professional Services Fee Schedule.

**Links**: For more information, see Chapter 24: Pharmacy Services.

For a definition of "Average Wholesale Price" (AWP), see WAC 296-20-01002.

### Clinical laboratory fee schedule

L&I's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS.

Services priced according to L&I's clinical laboratory fee schedule have an FSI of "L" in the Professional Services Fee Schedule.

### Flat fees

L&I establishes rates for some services that are priced with other payment methods.

Services priced with flat fees have an FSI of “F” in the Professional Services Fee Schedule.

### State Fund contracts

State Fund pays for utilization management services by contract.

Services paid by contract have an FSI of “C” in the Professional Services Fee Schedule.

The Crime Victims Compensation Program doesn’t contract for any services listed with an FSI of “C” on the fee schedule.

### By report

Insurers pay for some covered services on a **By Report** (BR) basis. Fees for BR services may be based on the value of the service as determined by the report.

Services paid BR have an FSI of “N” in the Professional Services Fee Schedule and BR in other fee schedules.

### Program only

Insurers pay for some unique services under specific programs. Example programs include:

- Centers for Occupational Health Education (COHE), *and*
- Progressive Goal Attainment Program (PGAP), *and*
- Orthopedic and Neurological Surgeon Quality Program.

## Residential facility payment methods

### Boarding Homes and Adult Family Homes

Insurers use per diem fees to pay for medical services provided in Boarding Homes and Adult Family Homes.

### Nursing Homes and Transitional Care Units utilizing swing beds for long term care

Insurers use a modified version of the Patient Directed Payment Model (PDPM) utilizing Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facilities (SNF) codes to develop daily per diem rates to pay for Nursing Home Services.

### Critical Access Hospitals and Veterans Hospitals utilizing swing beds for sub-acute care or long term care

Insurers use hospital specific POAC rates to pay for sub-acute care (swing bed) services.

# Payment policy: Split billing – treating two separate conditions

## Requirements for billing

Providers treating both the accepted industrial condition(s) and unaccepted condition(s) must split charges on the bill equally with another payer. See WAC 296-20-010. Don't bill the insurer for treatment of unaccepted conditions. When treating multiple accepted conditions on multiple claims, list all claim numbers on the bill.

For exception for physical therapy split billing, see Chapter 25: Physical Medicine Services.

**Links**: For more information, see WAC 296-20-010, WAC 296-20-06101(10), and the General Provider Billing Manual (F245-432-000), and Chapter 10: Evaluation and Management (E/M) Services

# Payment policy: Students and student supervision

## General information

This policy applies to all provider types for whom the Washington State Department of Health (DOH) has established rules for student supervision (exception: certain types of physical medicine students have special rules. See Chapter 25: Physical Medicine Services for details).

Unless otherwise specified, students of provider types that do not have DOH rules for student supervision may not perform services for injured workers or crime victims.

## Definitions

**Student**: As part of their clinical training, a **student** is a person who is enrolled and participating in an accredited educational program to become a licensed provider. An accredited educational program must have Washington State Department of Health rules or regulations. Students includes senior students, associate or interim permitted students who have completed their training but aren't yet fully licensed, and clinical post-graduate trainees.

### Who does not qualify as a student

Providers with temporary or interim professional licenses are not considered students and this policy does not apply to them.

Agency-affiliated counselors are not considered students and this policy does not apply to them. They may not treat injured workers or crime victims.

**Supervising provider**: A **supervising provider** is a licensed provider with an active L&I Provider ID who has entered into a private agreement with a student and their educational institution to provide hands-on training, instruction and supervision during the clinical phase of the student's coursework. A supervising provider can only supervise a student within their discipline. They are responsible for all services provided to injured workers or crime victims by their students.

**Student supervision**: **Student supervision** is the act of supervising a student who is treating an injured worker or crime victim. Supervising providers must comply with all Washington State Department of Health rules regarding the supervision of students within their discipline.

## Services students may perform

Students may perform any services allowed under the corresponding DOH rules for delegation of services for their profession. The supervising provider shall be responsible for determining the competence of the student to perform the delegated services.

Students must be supervised by their supervising provider in accordance with DOH rules while performing services for injured workers or crime victims. Supervising providers are responsible for all treatment, documentation, and treatment plans.

## Services that aren't covered

Students may not perform any services that fall outside their scope of practice, level of education, or any other requirements for students in their discipline laid out by the DOH. Students may not perform any services which L&I's Medical Aid Rules and Fee Schedules (MARFS) prohibit.

Direct supervision must occur in person with the student and isn't allowed when performed via two-way audio/visual (modifier –FR).

## Billing requirements

Students may not bill L&I for their services. Supervising providers bill using their own Provider ID for services performed by students they supervise. All chart notes and documentation must be co-signed by the supervising provider, indicating they have reviewed and approved of the documentation.

# Related Topics: Modifiers that affect payment

Modifiers that affect payment are listed in the applicable chapters. Refer to current CPT® and HCPCS books for a complete list of modifiers, with their descriptions and instructions.

## Local code modifiers

**–1S (Surgical dressings for home use)**

Bill the appropriate HCPCS code for each dressing item using this modifier –1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

**–7N (X-rays and laboratory services in conjunction with an IME)**

When X-rays, laboratory, and other diagnostic tests are provided with an exam, identity the service(s) by adding the modifier – 7N to the usual procedure number.

**–8R (COHE modifier for case management codes and consultations)**

Identifies when COHEs bill for these codes and adjusts payments.

**–8S (COHE modifier for health services coordinators (HSCs))**

This modifier allows HSCs to bill for some services more than once per day.

**–FT (Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.)**

Use to report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.

For instance, this modifier may be used for critical care performed by a surgeon during a global period; however, the critical care must be unrelated to the procedure/surgery done.

**Link**: Procedure codes are listed in the L&I Professional Services Fee Schedules, Radiology and Laboratory Sections.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for Ambulatory Surgery Center (ASC) payment methods | Washington Administrative Code (WAC) 296-23B |
| **Administrative rules** for average wholesale price (AWP) | WAC 296-20-01002 |
| **Administrative rules** for Advanced Registered Nurse Practitioners (ARNP) | WAC 296-23-245 |
| **Administrative rules** for billing procedures | WAC 296-20-125 |
| **Administrative rules** for charting requirements | WAC 296-20-220<br>WAC 296-20-01002 |
| **Administrative rules** for coverage decisions | WAC 296-20-01505<br>WAC 296-20-02700 through -02850 available in WAC 296-20<br>WAC 296-20-030 through -03002 available in WAC 296-20<br>WAC 296-20-1102 |
| **Administrative rules** for documentation requirements | WAC 296-20-06101 |
| **Administrative rules** for hospital payment methods | WAC 296-23A |
| **Administrative rules** for initial visit | WAC 296-20-01002<br>WAC 296-20-015<br>WAC 296-20-025<br>WAC 296-20-12401<br>WAC 296-20-065 |
| **Administrative rules** for Medical Aid | WAC 296-20-010 |

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for missed appointments (worker no shows) | WAC 296-20-010(5) and (6) |
| **Administrative rules** for Physician Assistants (PAs) | WAC 296-20-01501 |
| **Administrative rules** for provider credentialing and compliance | WAC 296-20-01010 through WAC 20-01090 available in WAC 296-20<br>WAC 296-20-12401 |
| **Administrative rules** for recordkeeping requirements | WAC 296-20-121<br>WAC 296-20-02005<br>WAC 296-20-02010<br>WAC 296-23-140 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing adjustments** | Billing adjustments on L&I's website |

| If you're looking for more information about… | Then see… |
|---|---|
| **Billing Manuals** | CMS 1500 Billing Manual (F245-423-000)<br>Crime Victims Direct Entry Billing Manual (F800-118-000)<br>Direct Entry Billing Manual (F245-437-000)<br>Home Health Services Billing Manual (F245-424-000)<br>Hospital Services Billing Manual (F245-425-000)<br>Mental Health Fee Schedule and Billing Guidelines (F800-105-000) for Crime Victims Compensation program<br>Miscellaneous Services Billing Manual (F245-431-000)<br>Pharmacy Billing Manual (F245-433-000)<br>Retraining and Job Modification Billing Manual (F245-427-000) |
| **Billing workshops** for providers | Billing workshops on L&I's website |
| **Crime Victims Compensation Program** | Crime Victims Compensation Program on L&I's website |
| **Coverage decisions** for medical technologies and procedures | Conditions and treatment guidelines on L&I's website |
| **Electronic billing** | Provider Express Billing on L&I's website |
| Fax numbers for **sending correspondence** to the State Fund | Billing L&I on L&I's website |
| **Federal injured worker claims** | U.S. Department of Labor website |
| Federally issued **National Provider Identifier (NPI)** | National Plan & Provider Enumeration System (NPPES) website |

| If you're looking for more information about… | Then see… |
|---|---|
| **Fee schedules** for all healthcare and vocational services | Fee schedules on L&I's website |
| **FileFast** website | FileFast on L&I's website |
| **Find a Doctor (FAD)** website | Find a Doctor (FAD) on L&I's website |
| General information about **WACs and RCWs** | Washington State Legislature's website |
| **General Provider Billing Manual** | F245-432-000 |
| **Interpreter Lookup Service** | Interpreter Lookup Service on L&I's website |
| How providers arrange **interpretive services** | Interpreter services on L&I's website |
| **Join the Network** | Become A Provider on L&I's website |
| **Laws** (from Washington state Legislature) for documentation requirements | Revised Code of Washington (RCW) 51.48.290<br>RCW 51.48.270<br>RCW 51.48.250 |
| **Laws** for Medical Aid | RCW 51.04.030(2)<br>RCW 51.28.020<br>RCW 51.36.010<br>RCW 51.36.100<br>RCW 51.36.110 |
| **Laws** for Physician Assistants (PAs) | RCW 51.28.100 |
| **L&I's Claim and Account Center** | Claim and Account Center on L&I's website |
| **L&I Medical Provider News** electronic mailing list | L&I Medical Provider News on L&I's website |
| Payment policies for **Ambulatory Surgery Centers (ASCs)** | Chapter 32: Ambulatory Surgery Centers (ASCs) |

| If you're looking for more information about… | Then see… |
|---|---|
| Payment policies for **anesthesia services** | Chapter 4: Anesthesia Services |
| Payment policies for **hospitals** | Chapter 35: Hospitals |
| Payment policies for **interpreters** | Chapter 14: Language Access Services |
| Payment policies for **other services** | Chapter 22: Other Services |
| Payment policies for **pharmacy services** | Chapter 24: Pharmacy Services |
| Payment policies for **physical medicine services** | Chapter 25: Physical Medicine Services |
| Payment policies for **radiology services** | Chapter 26: Radiology Services |
| Payment policies for the Resource Based Relative Value Scale (**RBRVS**) | Chapter 31: Washington RBRVS Payment System |
| **Provider Change** Form | F245-365-000 |
| **Provider's Initial Report** form | Provider's Initial Report |
| **Provider Network and COHE Expansion** | COHE Expansion on L&I's website |
| **ProviderOne** | ProviderOne |
| Receiving **email updates on Provider News** | Subscribe to L&I's ListServ |
| **Report of Accident (ROA) Workplace Injury or Occupational Disease** form (also known as "Accident Report" or "ROA") | F242-130-000 |
| **Self-Insurer Accident Report** (SIF-2) form | F207-228-000 |
| **Self-insured employer (SIE) or third party administrator (TPA)** contact information | Self-insured employer list on L&I's website |
| **Utilization Review** | What requires UR |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 3: Ambulance, Taxi, and Other Transportation Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Bed confined**: The worker is:

- Unable to get up from bed without assistance, *and*
- Unable to ambulate, *and*
- Unable to sit in a chair or wheelchair.

**Destination**: Nearest place of proper treatment.

**Loaded miles**: Miles traveled from the pickup of the worker(s) to their arrival at the destination.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**-GM** (**Multiple patients on one ambulance trip)**

# Payment policy: All ambulance services

## When these services are paid

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated.

Payment is based on the level of medically necessary services provided, not only on the vehicle used.

## How mileage is paid

The insurer pays for mileage (ground and/or air) based only on **loaded miles**, which are the miles traveled from the pickup of the worker(s) to their arrival at the **destination**.

## Vehicle and crew requirements

To be eligible to be paid for ambulance services for workers, the provider must meet the criteria for vehicles and crews established in WAC 246-976 Emergency Medical Services and Trauma Care Systems and other requirements as established by the Washington State Department of Health for emergency medical services.

Key sections of this WAC include:

- **General**: WAC 246-976-260 Licenses required,
- **Ground ambulance vehicle requirements**:
  - WAC 246-976-290 Ground ambulance vehicle standards,
  - WAC 246-976-300 Ground ambulance and aid vehicles—Equipment,
  - WAC 246-976-310 Ground ambulance and aid vehicles--Communications equipment,
  - WAC 246-976-390 Trauma verification of prehospital EMS services,
- **Air ambulance services**: WAC 246-976-320 Air ambulance services,
- **Personnel**:
  - WAC 246-976-182 Authorized care,
  - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines.

 

## Services that can be billed

| HCPCS code | Description | Fee schedule |
|---|---|---|
| **A0425** | Ground mileage, per statute mile | **$15.03** per mile |
| **A0426** | Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1) | **$744.54** |
| **A0427** | Ambulance service, advanced life support, level 1 (ALS 1-emergency) | **$772.77** |
| **A0428** | Ambulance service, basic life support, nonemergency transport (BLS) | **$406.72** |
| **A0429** | Ambulance service, basic life support, emergency transport (BLS – emergency) | **$650.76** |
| **A0430** | Ambulance service, conventional air services, transport, one way (fixed wing) | **$6,640.25** |
| **A0431** | Ambulance service, conventional air services, transport, one way (rotary wing) | **$7,720.24** |
| **A0433** | Advanced Life Support, Level 2 (ALS 2) | **$1,118.50** |
| **A0434** | Specialty care transport (SCT) | **$1,321.85** |
| **A0435** | Fixed wing air mileage, per statute mile | **$36.95** per mile |
| **A0436** | Rotary wing air mileage, per statute mile | **$85.87** per mile |
| **A0999** | Unlisted ambulance service | By Report restrictions:<br>1. Reviewed to determine if a more appropriate billing code is available, *and*<br>2. Reviewed to determine if medically necessary. |

# Payment policy: Arrival of multiple providers

## Payment limits

When multiple providers respond to a call for services:

- Only the provider that transports the worker(s) is eligible to be paid for the services provided, *and*
- No payment is made to the other provider(s).

# Payment policy: Emergency air ambulance transport

## Payment limits

Air ambulance transportation services, either by helicopter or fixed wing aircraft, will be paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that couldn't have been provided by ground ambulance, *or*
- The point of pickup is inaccessible by ground vehicle, *or*
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

# Payment policy: Multiple patient transportation

## Payment limits

The insurer pays the appropriate base rate for each worker transported by the same ambulance.

When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported.

## Requirements for billing

The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

The provider must use HCPCS code modifier **–GM** (Multiple patients on one ambulance trip) for the appropriate mileage billing codes.

 

# Payment policy: Nonemergency transport

## Who may arrange for these services

Only medical providers may arrange for nonemergency ambulance transportation.

**Note**: Workers may not arrange nonemergency ambulance transportation.

## Medical necessity requirements

Nonemergency transportation by ambulance is appropriate if:

- The worker is **bed confined** and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated, *or*
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Nonemergency transportation may be provided on a **scheduled** (repetitive or non-repetitive) or **unscheduled** basis:

- **Scheduled**, nonemergency transportation may be repetitive (for example, services regularly provided for diagnosis or treatment of the worker's accepted medical condition) or non-repetitive (for example, single time need).
- **Unscheduled** services generally pertain to nonemergency transportation for medically necessary services.

The insurer reserves the right to perform a post audit on any nonemergency ambulance transportation billing to ensure medical necessity requirements are met.

# Payment policy: Proper facilities

## What makes a facility a place of proper treatment

To be a place of proper treatment, the facility must be generally equipped to provide the needed medical care for the worker.

A facility isn't considered a place of proper treatment if no bed is available when inpatient medical services are required.

## Payment limits

The insurer pays the provider for ambulance services to the nearest place of proper treatment.

# Payment policy: Taxi, wheelchair van and other transportation services

## When these services are paid

Other transportation services including taxi and wheelchair services are payable when pre-authorized by the insurer.

## Services that aren't covered

- No shows *and*,
- Local code **0414A** for direct claimant taxi reimbursement (not payable to taxi and other transportation service providers).

## How mileage is paid

The insurer pays for mileage based on miles traveled from the pickup of the worker(s) to their arrival at the medical or vocational authorized **destination** only.

## Documentation requirements for billing

To be eligible to be paid for non-emergent transportation services for workers, the provider must provide an itemized statement (invoice) or trip ticket documenting the following:

- Claim number
- Worker name (name of worker transported)
- Date of trip
- Pick up time
- Pick up address
- **Destination** (drop off) address
- Wait time
- Drop off time
- Driver name (First, Last)
- Driver operator or cab number
- Rates (see WAC 296-20-01002 Definitions - "By Report")
- Total cost of trip

## Services that can be billed

| HCPCS Code | Description | Fee schedule |
|---|---|---|
| **A0100** | Taxi, non-emergency | By Report |
| **A0110** | Transportation and bus, intra or interstate carrier, non-emergency | By Report |
| **A0120** | Mini-bus, mountain area transports, or other transportation systems, non-emergency | By Report |
| **A0130** | Wheel-chair van, non-emergency | By Report |
| **A0140** | Air travel (private or commercial) intra or inter state, non-emergency | By Report |
| **A0170** | Transportation ancillary: parking fees, tolls, other | By Report |
| **0304R** | Vocational Retraining Plan Transportation (Taxi) | By Report |
| **1270M** | Independent Medical Examination (IME) Transportation (Taxi) Services | By Report |

**Link**: For the legal definition of By Report (BR), see WAC 296-20-01002.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for ambulance services | Washington Administrative Code (WAC) 246-796 |
| **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 professional services (including ambulance services) | Fee schedules on L&I's website |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 4: Anesthesia Services

**Effective July 1, 2022**

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

## Table of Contents

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**–47 (Anesthesia by surgeon)**

**–99 (Multiple modifiers)**

This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only modifier –99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

**–AA (Anesthesia services performed personally by anesthesiologist)**

**–P1 (A normal healthy patient)**

**–P2 (A patient with mild systemic disease)**

**–P3 (A patient with severe systemic disease)**

**–P4 (A patient with severe systemic disease that is a constant threat to life)**

**–P5 (A moribund patient who is not expected to survive without the operation)**

**–P6 (A declared brain-dead patient whose organs are being removed for donor purposes)**

**–QK (Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals)**

**–QX (CRNA service: with medical direction by a physician)**

**–QY (Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist)**

**–QZ (CRNA service: without medical direction by a physician)**

 

# Payment policy: All anesthesia services

## Who must perform these services to qualify for payment

Payment for anesthesia services will only be made to:

- Anesthesiologists, *and*
- Certified registered nurse anesthetists.

## Services that can be billed

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes **00100** through **01999** and the appropriate anesthesia modifier.

Some selected services are paid using the RBRVS method.

For information on **base and time units** and **RBRVS** methods for anesthesia services, see other payment policy sections of this chapter.

## Services that aren't covered

Anesthesia isn't payable for procedures that aren't covered.

The insurer doesn't cover anesthesia assistant services.

Payment for CPT® codes **99100**, **99116**, **99135**, and **99140** is considered bundled and isn't payable separately.

CPT® physical status modifiers (**–P1** to **–P6**) and CPT® 5-digit modifiers aren't accepted.

## Requirements for billing

### Anesthesia add-on codes

Anesthesia add-on codes must be billed with a primary anesthesia code. There are three anesthesia add-on CPT® codes: **01953**, **01968**, and **01969**:

- Add-on code **01953** should be billed with primary code **01952**,
- Add-on codes **01968** and **01969** should be billed with primary code **01967**,
- Add-on codes **01968** and **01969** should be billed in the same manner as other anesthesia codes paid with base and time units.

**Note**: Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the **CMS 1500** form (F245-127-000).

### Anesthesia for burn excisions or debridement (CPT® add-on code 01953)

The anesthesia add-on code for burn excision or debridement must be billed as follows:

| If the **total body surface area** is… | Then the **primary code** to bill is: | And the **units to bill of add-on code** 01953 is: |
|---|---|---|
| Less than 4 percent | **01951** | None |
| 4 - 9 percent | **01952** | None |
| Up to 18 percent | **01952** | 1 |
| Up to 27 percent | **01952** | 2 |
| Up to 36 percent | **01952** | 3 |
| Up to 45 percent | **01952** | 4 |
| Up to 54 percent | **01952** | 5 |
| Up to 63 percent | **01952** | 6 |
| Up to 72 percent | **01952** | 7 |
| Up to 81 percent | **01952** | 8 |
| Up to 90 percent | **01952** | 9 |
| Up to 99 percent | **01952** | 10 |

### Anesthesia base units

List only the time in minutes on your bill. Don't include the base units (L&I's payment system automatically adds the base units).

**Link**: The anesthesia codes, base units, and base sources are listed in the Professional Services Fee Schedule.

### Anesthesia time

Anesthesia must be billed in one-minute time units. Anesthesia time:

- **Begins** when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent), and
- **Ends** when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision).

 

## Anesthesia billing code modifiers for anesthesia paid with base and time units

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs should use the CPT® or HCPCS modifiers in the following table. For complete modifier descriptions and instructions, refer to a current CPT® or HCPCS book.

Except for modifier **–99**, the modifiers listed in the following table aren't valid for anesthesia services paid by the RBRVS method.

| For use by: | CPT® or HCPCS code modifier | Brief description | Notes |
|---|---|---|---|
| Anesthesiologists and CRNAs | **–99** | Multiple modifiers | Use this modifier when 5 or more modifiers are required.<br>Enter **–99** in the modifier column on the bill.<br>List individual descriptive modifiers elsewhere on the billing document. |
| Anesthesiologists | **–AA** | Anesthesia services performed personally by anesthesiologist | — |
| | **–QK** | Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual | Payment based on policies for team services (see Team care payment policy at the end of this chapter). |
| | **–QY** | Medical direction of 1 CRNA for a single anesthesia procedure | Payment based on policies for team services (see Team care payment policy at the end of this chapter). |
| CRNAs(1) | **–QX** | CRNA service: with medical direction by a physician | Payment based on policies for team services (see Team care payment policy at the end of this chapter). |
| | **–QZ** | CRNA service: without medical direction by a physician(1) | Maximum payment is 100% of the maximum allowed for physician services. |

## Payment limits

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure.

Patient acuity doesn't affect payment levels.

Services billed with modifier **–47** (anesthesia by surgeon) are considered bundled and aren't payable separately.

Services billed with CPT® 5-digit modifiers and physical status modifiers (**–P1** through **–P6**) aren't paid.

**Links**: For licensed nursing rules, see WAC 296-23-240.

For licensed nursing billing instructions, see WAC 296-23-245.

For detailed billing instructions, including examples of how to submit bills, refer to L&I's General Provider Billing Manual (F245-432-000).

### CRNA payment limits

CRNA services shouldn't be reported on the same CMS-1500 form used to report anesthesiologist services.

Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services (see Team care payment policy at the end of this chapter).

# Payment policy: Base and time units payment method for anesthesia

## How to calculate anesthesia payment paid with base and time units

Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

For services provided on or after July 1, 2022 the anesthesia conversion factor is **$56.25** per 15 minutes (**$3.75** per minute).

The maximum payment for anesthesia services paid with base and time units is calculated using the:

- Base value for the procedure, *and*
- Time the anesthesia service is administered, *and*
- L&I anesthesia conversion factor.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15, *then*
2. Add the value from step 1 to the total number of whole minutes, *then*
3. Multiply the result from step 2 by **$3.75**.

### Example

CPT® code **01382** (anesthesia for knee arthroscopy) has three anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. 3 base units x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x **$3.75** = **$393.75**.

**Link**: The anesthesia conversion factor is published in WAC 296-20-135.

# Payment policy: RBRVS payment method for anesthesia

## Which services are paid using the RBRVS method

Some services commonly performed by anesthesiologists and CRNAs are paid using the RBRVS payment method, including:

- Anesthesia evaluation and management services, and
- Most pain management services, and
- Other selected services.

## Injection code treatment limits

| If the **injection type** is… | Then the **treatment limit** is: |
|---|---|
| Epidural and caudal injections of substances other than anesthetic or contrast solution | **Limited to 2** injections, same side, per date of service<br>**Limited to 3** injections per 6 months; 3rd requires documented improvement<br>**Limited to 4** injections per 365 day-period |
| Facet injections | **Not covered**, except in preparation for facet neurotomy. Limited to 2 joint levels bilaterally, or 3 unilaterally per day of service. |
| Intramuscular injections of steroids and other nonscheduled medications. | **Maximum of 6** injections per patient are allowed. |
| Dry needling and trigger point injections without medications | **Maximum of 6** sessions per patient per claim. |

Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations, as opposed to the distant points or meridians used in acupuncture.

**Links**: Details regarding treatment guidelines and limits for the injections listed above can also be found in WAC 296-20-03001(7) (for example, dry needling follows the same rules as trigger point injections).

For information on billing for medications, see: Chapter 16: Medication Administration and Injections.

## Requirements for billing

Dry needling of trigger points should be billed using trigger point injection codes.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action.

When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed in the Units column (Field 24G on the CMS-1500 form).

When using modifiers:

- Anesthesia modifiers **–AA**, **–QK**, **–QX**, **–QY**, and **–QZ** aren't valid for services paid by the RBRVS method.

For a complete list of modifiers and descriptions, see a current CPT® or HCPCS book.

An E/M service is payable on the same day as a pain management procedure only when:

- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service appending the **–25** modifier.

The use of E/M codes on days after the procedure is performed is subject to the global surgery policy.

**Links**: For more information, see the Global surgery payment policy section of Chapter 29: Surgery Services.

For more information on using the **–25** modifier, see the All E/M services payment policy section of Chapter 10: Evaluation and Management (E/M) Services.

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.

# Payment limits

## Anesthesia teaching physicians

Teaching physicians may be paid at the personally performed rate when the physician is involved in the training of physician residents in:

- A single anesthesia case, *or*
- Two concurrent anesthesia cases involving residents, *or*
- A single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

# Payment policy: Team care (Medical direction of anesthesia)

## Requirements for medical direction of anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, *and*
- Prescribe the anesthesia plan, *and*
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, *and*
- Make sure any procedures in the anesthesia plan that he/she doesn't perform are performed by a qualified individual as defined in program operating instructions, *and*
- Monitor the course of anesthesia administration at frequent intervals, *and*
- Remain physically present and available for immediate diagnosis and treatment of emergencies, *and*
- Provide indicated post anesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, *and*
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

## Documentation requirements for team care

The physician must document in the patient's medical record that the medical direction requirements were met.

## Requirements for billing

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate CMS-1500 forms using their own provider account numbers,
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (**–QK** or **–QY**),
- CRNAs should use modifier **–QX**.

## How to calculate payment for team care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services (see the How to calculate anesthesia payment paid with base and time units in the payment policy for Base and time units payment method for anesthesia section of this chapter),
- The maximum payment to the physician is 50% of the maximum payment for solo physician services,
- The maximum payment to the CRNA is 50% of the maximum payment for solo physician services.

### Additional information: How team care policies are established

L&I follows CMS's policy for team care (medical direction of anesthesia).

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for acupuncture services non-coverage | Washington Administrative Code (WAC) 296-20-03002(2) |
| **Administrative rules** for anesthesia | WAC 296-20 |
| **Administrative rules** for licensed nursing | WAC 296-23-240 |
| **Administrative rules** for licensed nursing billing instructions | WAC 296-23-245 |
| **Administrative rules** for treatment guidelines for injections | WAC 296-20-03001(7) |
| Anesthesia **conversion factor** | WAC 296-20-135 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Coverage decisions** for spinal injections | Spinal injections coverage decision |
| Payment policies for **billing for medications** | Chapter 16: Medication Administration and Injections |
| Payment policies for **global surgery** | Chapter 29: Surgery Services |
| Payment policies for using **billing code modifier –25** | Chapter 10: Evaluation and Management (E/M) Services |
| Professional Services **Fee Schedules** | Fee schedules on L&I's website |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 5: Audiology and Hearing Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Bundled codes**: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.

**By Report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report, see WAC 296-20-01002.

**Restocking fees**: The Washington State Department of Health statute (RCW 18.35.185) and rule (WAC 246-828-290) allow hearing instrument fitter/dispensers and licensed audiologists to retain $150.00 or 15% of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee sometimes is called a "restocking fee."

Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds the purchase agreement.

**Links**: For more information, see WAC 246-828-290 and RCW 18.35.185.

# Payment policy: Audiology services

## Worker responsibilities

### Worker responsible for devices that aren't medically necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given and wants to purchase different hearing aids, **the worker** then becomes completely responsible for the purchase of:

- The hearing aid, *and*
- Any future repairs.

### Worker responsible for some repairs, losses, damages

Workers are responsible to pay for repairs of hearing aids that aren't authorized by the insurer.

The worker is also responsible for non-work related losses or damages to their hearing aids (for example, the worker's pet eats/chews the hearing aid, etc...). In no case will the insurer cover this type of loss or damage. In these instances, the worker will be required to buy a new (not used) hearing aid consistent with current L&I guidelines outlined in this chapter.

After the worker's purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

## Services that can be billed

The insurer will only purchase hearing aids, devices, supplies, parts, and services described in the fee schedule (see Additional information: Audiology fee schedule, below.)

A physician or ARNP may be paid for a narrative assessment of work-relatedness to the hearing loss condition.

When filing a Report of Accident, Otolaryngologists or Occupational Medicine physicians should also bill **1190M** if they perform a Comprehensive Hearing Loss Exam (see Chapter 12: Impairment Ratings for more information). If auditory testing is performed, the person performing the test will bill the appropriate procedure codes.

## Services that aren't covered

The insurer doesn't pay any provider or worker to fill out the:

- Occupational Disease Employment History Hearing Loss form (F262-013-000), or
- Occupational Hearing Loss Questionnaire (F262-016-000).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period.

The insurer won't pay for the reprogramming of hearing aids.

The insurer won't cover disposable shells ("ear molds" in HCPCS codes).

The insurer doesn't cover parts and supplies (e.g. clips and cords, mic covers, etc.) that aren't deemed medically necessary.

Hearing aids, supplies or parts may not be billed using **E1399**.

## Requirements for billing

### Hearing aid parts and supplies paid at acquisition cost

Parts and supplies must be billed and will be paid at acquisition cost including volume discounts (manufacturers' wholesale invoice). Acquisition cost and the amount on the invoice must reflect the cost of the item being dispensed to the worker, not the invoice of the replacement to stock.

If the supplies or parts were bought in bulk, the individual cost per part or supply will be calculated based on the manufacturers' invoice.

Don't bill your usual and customary fee. (See specific billing instructions for these items in the following table.)

| If you are billing for… | Then these can be: |
|---|---|
| Supply items for hearing aids, including:<br>• Tubing,<br>• Wax guards, and<br>• Ear hooks. | Billed within the warranty period. |
| Parts for hearing aids, including:<br>• Switches,<br>• Controls,<br>• Filters,<br>• Battery doors, and<br>• Volume control covers. | Billed as replacement parts only, but not within the warranty period. |
| Shells ("ear molds" in HCPCS codes) | Billed separately at acquisition cost<br>(the insurer doesn't cover disposable shells). |

| If you are billing for… | Then these can be: |
|---|---|
| Hearing aid extra parts, options, circuits, and switches (for example, T-coil and noise reduction switches) | Only billed when the manufacturer doesn't include these in the base invoice for the hearing aid. |

## Payment limits

### Batteries

The insurer will pay the cost of battery replacement for the life of an authorized hearing aid.

Only a maximum of 60 batteries are authorized within each 90 day period. Providers must document the request for batteries by the worker and maintain proof that the worker actually received the batteries.

**Note**: Sending workers batteries that they haven't requested and for which they don't have an immediate need violates L&I's rules and payment policies.

### Wax Guards

The insurer will pay the cost of wax guards for the life of the authorized hearing aid.

Wax guards are reimbursed up to a maximum of 104 per calendar year. Wax guards are billed using code **5095V**. This service can't be billed as part of a repair.

### Tubes and Domes

Tubes and domes are used with some hearing aids. Replacement of tubes and domes is considered maintenance.

The insurer will reimburse service for in office replacement of tubes and domes. This amount includes binaural replacement. This service:

- can be billed a maximum 18 times per calendar year,
- can be billed in conjunction with a quarterly cleaning visit,
- can't be billed as part of a repair, *and*
- can't bill more than 1 unit per date of service.

Tubes and domes are billed using code **5094V**.

## Additional information: Audiology fee schedule

| HCPCS code | Description | Maximum fee |
|---|---|---|
| V5008 | Hearing screening | **$89.92** |
| V5010 | Assessment for hearing aid | **Bundled** |
| V5011 | Fitting/orientation/checking of hearing aid | **Bundled** |
| V5014 | Hearing aid repair/modifying visit per ear (bill repair with code 5093V) | **$59.95** |
| V5020 | Conformity evaluation | **Bundled** |
| V5030 | Hearing aid, monaural, body worn, air conduction | Acquisition cost |
| V5040 | Body-worn hearing aid, bone | Acquisition cost |
| V5050 | Hearing aid, monaural, in the ear | Acquisition cost |
| V5060 | Hearing aid, monaural, behind the ear | Acquisition cost |
| V5070 | Glasses air conduction | Acquisition cost |
| V5080 | Glasses bone conduction | Acquisition cost |
| V5090 | Dispensing fee, unspecified hearing aid | Not covered |
| V5100 | Hearing aid, bilateral, body worn | Acquisition cost |
| V5110 | Dispensing fee, bilateral | Not covered |
| V5120 | Binaural, body | Acquisition cost |
| V5130 | Binaural, in the ear | Acquisition cost |
| V5140 | Binaural, behind the ear | Acquisition cost |
| V5150 | Binaural, glasses | Acquisition cost |
| V5160 | Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period) | **$1,702.54** |

 

| HCPCS code | Description | Maximum fee |
|---|---|---|
| **V5171** | Hearing aid, contralateral routing device, monaural, in the ear (ite) | Acquisition cost |
| **V5172** | Hearing aid, contralateral routing device, monaural, in the canal (itc) | Acquisition cost |
| **V5181** | Hearing aid, contralateral routing device, monaural, behind the ear (bte) | Acquisition cost |
| **V5190** | Hearing aid, cros, glasses | Acquisition cost |
| **V5200** | Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period) | **$1,020.46** |
| **V5211** | Hearing aid, contralateral routing system, binaural, ite/ite | Acquisition cost |
| **V5212** | Hearing aid, contralateral routing system, binaural, ite/itc | Acquisition cost |
| **V5213** | Hearing aid, contralateral routing system, binaural, ite/bte | Acquisition cost |
| **V5214** | Hearing aid, contralateral routing system, binaural, itc/itc | Acquisition cost |
| **V5215** | Hearing aid, contralateral routing system, binaural, itc/bte | Acquisition cost |
| **V5221** | Hearing aid, contralateral routing system, binaural, bte/bte | Acquisition cost |
| **V5230** | Hearing aid, bicros, glasses | Acquisition cost |
| **V5240** | Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period) | **$1,020.46** |
| **V5241** | Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period) | **$851.27** |
| **V5242** | Hearing aid, analog, monaural, CIC (completely in the ear canal) | Acquisition cost |
| **V5243** | Hearing aid, monaural, ITC (in the canal) | Acquisition cost |

 

| HCPCS code | Description | Maximum fee |
|---|---|---|
| V5244 | Hearing aid, digitally programmable analog, monaural, CIC | Acquisition cost |
| V5245 | Hearing aid, digitally programmable, analog, monaural, ITC | Acquisition cost |
| V5246 | Hearing aid, digitally programmable analog, monaural, ITE (in the ear) | Acquisition cost |
| V5247 | Hearing aid, digitally programmable analog, monaural, BTE (behind the ear) | Acquisition cost |
| V5248 | Hearing aid, analog, binaural, CIC | Acquisition cost |
| V5249 | Hearing aid, analog, binaural, ITC | Acquisition cost |
| V5250 | Hearing aid, digitally programmable analog, binaural, CIC | Acquisition cost |
| V5251 | Hearing aid, digitally programmable analog, binaural, ITC | Acquisition cost |
| V5252 | Hearing aid, digitally programmable, binaural, ITE | Acquisition cost |
| V5253 | Hearing aid, digitally programmable, binaural, BTE | Acquisition cost |
| V5254 | Hearing aid, digital, monaural, CIC | Acquisition cost |
| V5255 | Hearing aid, digital, monaural, ITC | Acquisition cost |
| V5256 | Hearing aid, digital, monaural, ITE | Acquisition cost |
| V5257 | Hearing aid, digital, monaural, BTE | Acquisition cost |
| V5258 | Hearing aid, digital, binaural, CIC | Acquisition cost |
| V5259 | Hearing aid, digital, binaural, ITC | Acquisition cost |
| V5260 | Hearing aid, digital, binaural, ITE | Acquisition cost |
| V5261 | Hearing aid, digital, binaural, BTE | Acquisition cost |
| V5262 | Hearing aid, disposable, any type, monaural | Not covered |

 

| HCPCS code | Description | Maximum fee |
|---|---|---|
| **V5263** | Hearing aid, disposable, any type, binaural | Not covered |
| **V5264** | Ear mold (shell)/insert, not disposable, any type | Acquisition cost |
| **V5265** | Ear mold (shell)/insert, disposable, any type | Not covered |
| **V5266** | Battery for hearing device | **$1.05** |
| **V5267** | Hearing aid supply/accessory | Acquisition cost |
| **5091V** | Hearing aid **restocking fee** (the lesser of 15% of the hearing aid total purchase price or $150.00 per hearing aid) | **By Report** |
| **5092V** | Hearing aid cleaning visit per ear<br>(1 every 90 days, after the first year) | **$27.96** |
| **5093V** | Hearing aid repair fee. Invoice required | **By Report** |
| **5094V** | Bilateral in office tubes/dome replacement (maximum of 18 times per calendar year) | **$25.00** per unit (limited to 1 unit per date of service) |
| **5095V** | Wax guards (maximum of 104 per calendar year) | **$1.25** each |

**Note**: The insurer will only purchase the hearing aids, devices, supplies, parts, and services described in the fee schedule.

 

# Payment policy: Advertising limits

## False, misleading, or deceptive advertising or representations

L&I can deny a provider's application to provide services, or suspend or revoke an existing provider account if the provider participates in:

- False, misleading, or deceptive advertising, *or*
- Misrepresentations of industrial insurance benefits.

False advertising includes mailers and advertisements that:

- Suggest a worker's hearing aids are obsolete and need replacement, *or*
- Don't clearly document a specific hearing aid's failure, *or*
- Make promises of monetary gain without proof of disability or consideration of current law.

**Links**: For more information, see RCW 51.36.130 and WAC 296-20-015.

# Payment policy: Dispensing fees

## Services that can be billed

Dispensing fees cover a 30 day trial period during which all aids may be returned. Also included:

- Up to four follow up visits (ongoing checks of the aid as the wearer adjusts to it), *and*
- One hearing aid cleaning kit, *and*
- Routine cleaning during the first year, *and*
- All shipping, handling, delivery, and miscellaneous fees.

# Payment policy: Documentation and record keeping requirements

## Documentation to support initial authorization

The provider must keep **all of the following** information in the worker's medical records and submit a copy of each to the insurer:

- Name and title of referring practitioner, if applicable, *and*
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual, *and*
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea, and fever, *and*
- A record of whether the worker has been treated for recent or frequent ear infections, *and*
- Results of the ear examination, *and*
- Results of all hearing and speech tests from initial examination, *and*
- Review and comment on historical hearing tests, if applicable, *and*
- All applicable manufacturers' warranties (length and coverage) plus the make, model and serial number of any hearing aid device(s) supplied to the worker as original or as a replacement, *and*
- Original or unaltered copies of manufacturers' invoices, *and*
- Copy of the Hearing Services Worker Information form (F245-049-000) signed by the worker and provider, *and*
- Invoices and/or records of all repairs.

## Documentation to support repair

The provider who arranges for repairs to hearing aid(s) authorized and purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period. Repair requests for State Fund claims must be sent to the Provider Hotline. A copy of the warranty must be on file with the insurer to ensure payment.
Documentation to support replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement:

- The name and credential of the person who inspected the hearing aid, *and*
- Serial number of the aids to be replaced, *and*
- Date of the inspection, *and*
- Observations (for example, a description of the damage, and specific reasons why the device can't be repaired).

# Requirements for billing

## Correspondence with the insurer

The insurer may deny payment of the provider's bill if the following information hasn't been received:

- Original wholesale invoices from the manufacturer are required to show the acquisition cost, serial numbers, and warranty information, and must be retained in the provider's office records for a minimum of 5 years, *and*
- A copy of the original manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part, or supply costs $250.00 or more, or upon the insurer's request, *and*
- Documentation of the repair and who performed it must be submitted to the insurer.

Electronic billing providers must submit a copy of the original or unaltered manufacturer's wholesale invoice with the make, model, and serial number for individual hearing aids within 5 days of bill submission.

To avoid delays in processing, all correspondence to the insurer must indicate the worker's name and claim number in the upper right hand corner of each page of the document.

Providers are required to send warranty information for:

- **State Fund** claims to:

  Department of Labor and Industries
  PO Box 44291
  Olympia, WA 98504-4291

- **Self-insured** claims to the SIE/TPA. Contact list available at: https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/find-a-self-insured-employer.

 

# Payment policy: Hearing aids, devices, supplies, parts, and services

## General requirements

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards.

All manufacturers and assemblers must hold a valid FDA certificate.

## Self-insurers with purchasing contracts for hearing aids

SIEs that have entered into contracts for purchasing hearing aid related services and devices may continue to use them.

**Link**: For more information, see WAC 296-23-165(1b).

SIEs that don't have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this chapter.

## Types of hearing aids authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). The decision will be based on recommendations from:

- Physicians, *or*
- ARNPs, *or*
- Licensed audiologists, *or*
- Fitter/dispensers.

The insurer covers the following types of hearing aids:

- Behind the ear (BTE),
- Digital or programmable in the ear (ITE),
- In the canal (ITC),
- Completely in the canal (CIC), *and*
- Receiver in Canal (RIC)

Any other types of hearing aids needed for medical conditions will be considered by the insurer based on justifications from the physician, ARNP, licensed audiologist or fitter/dispenser.

- L&I won't purchase used or repaired equipment.
- The insurer won't purchase hearing devices intended for safety protection.

The following table indicates which services and devices are covered by provider type:

| If the **provider** is a… | Then the **services or devices** that can be billed are: |
|---|---|
| Fitter/dispenser | HCPCS codes for all hearing related services and devices. |
| Durable medical equipment (DME) provider | Supply codes, *and*<br>Battery codes. |
| Physician, ARNP, licensed audiologist | HCPCS codes for hearing related services and devices, *and*<br>CPT® codes for hearing-related testing and office calls. |

## Prior authorization

### Initial and subsequent hearing related services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies, and accessories.

The insurer won't pay for hearing devices provided prior to authorization.

To initiate the authorization process for:

- **State Fund** claims, call the claim manager or the State Fund's Provider Hotline at 1-800-848-0811 (in Olympia call 360-902-6500).
- **Self-insured** claims, the provider should obtain prior authorization from the SIE or its TPA.

The insurer will notify the worker in writing when the claim is accepted or denied.

**Links**: For more information, see WAC 296-20-03001 and WAC 296-20-1101.

### Cases of special need

In cases of special need, such as when the worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted.

### Special authorization for hearing aids and masking devices over $900.00 per ear

If the manufacturer's invoice cost of any hearing aid or masking device exceeds $900.00 per ear, special authorization is required from the claim manager.

The cost of ear molds doesn't count toward the $900.00 for special authorization. Initial ear molds may be billed using **V5264** and replacements may be billed using **V5014** with **V5264**. The cost of any external electronic device, such as a remote control or Bluetooth, counts towards the $900.00 limit per hearing aid.

### Masking devices for tinnitus

In cases of accepted tinnitus, the insurer may authorize masking devices. (Also see Requirements for billing, below.)

**Link**: L&I's current tinnitus coverage decision is available online.

### Required documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work related hearing loss.

An SIE/TPA may use these or similar forms to gather information:

- Report of Accident (F242-130-000),
- Occupational Disease Employment History Hearing Loss form (F262-013-000),
- Occupational Hearing Loss Questionnaire (F262-016-000),
- Valid audiogram,
- Medical report, *and*
- Hearing Services Worker Information form (F245-049-000).

# Who must perform these services to qualify for payment

## Authorized testing

Testing to fit a hearing aid may be done by a:

- Licensed audiologist,
- Fitter/dispenser,
- Qualified physician, or
- Qualified ARNP.

The provider must obtain prior authorization for subsequent testing.

Fitter/ dispensers aren't reimbursed for audiograms. The provider performing the service must do the billing.

# Requirements for billing

## All hearing aids, parts, and supplies

All hearing aids, parts, and supplies must be billed using HCPCS codes.

Hearing aids and devices are considered durable medical equipment (DME) and must be billed at their acquisition cost.

**Link**: For more details, refer to the Acquisition Cost Policy in Chapter 28: Supplies, Materials, and Bundled Services.

## Binaural hearing aids

When billing the insurer for hearing aids for both ears, providers must indicate on the CMS-1500 (F245-127-000) or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left), *and*
- The appropriate HCPCS code for binaural aids.

Only bill one unit of service even though two hearing aids (binaural aids) are dispensed.

Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

### Monaural hearing aids

When billing the insurer for one hearing aid, providers must indicate on the CMS-1500 (F245-127-000) or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected, and
- The appropriate HCPCS code for monaural aid.

Only bill one unit of service.

Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

### Tinnitus masking devices

If masking devices are dispensed without hearing aids, providers will bill using code **E1399**.

When dispensed as a component of a hearing aid, providers will bill using code **V5267**.

If masking devices are dispensed without hearing aids, the provider may also bill the appropriate dispensing fee code for monaural or binaural devices.

## Payment limits

### Authorized testing

The insurer doesn't pay for testing after a claim has closed unless related to fitting of replacement hearing aids.

The insurer will pay for hearing screening (**V5008**) only when performed and billed by an audiologist.

The insurer doesn't cover annual hearing tests.

If free initial hearing screenings are offered to the public, the insurer won't pay for these services.

## 30 day trial period

A 30 day trial period is the standard established by RCW 18.35.185. During this time:

- The provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids aren't damaged),
- Follow up hearing aid adjustments are **bundled** into the dispensing fee, and
- If hearing aids are returned within the 30 day trial period, the provider must refund the hearing aid and dispensing fees.

# Payment policy: Repairs and replacements

## Warranties

Hearing aid industry standards provide a minimum of a one year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than one year, the manufacturer's warranty will apply.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is covered under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid according to the warranty. The worker is responsible for any charges outlined in the manufacturer's warranty.

The insurer doesn't purchase or provide additional manufacturers' or extended warranties beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period. The warranty period begins:

- On the date the hearing aid is dispensed to the worker, *or*
- For repairs, when the hearing aid is returned to the worker.

## Prior authorization

### Repairs

Prior authorization is required for all billed repairs. The insurer will repair hearing aids and devices when needed due to normal wear and tear. This does not include tubes, domes, or wax guards. Also note that:

- At its discretion, the insurer may repair hearing aids and devices under other circumstances, *and*
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased, *and*
- If the aid is damaged in a work related incident, the worker must file a new claim to repair or replace the damaged hearing aid.

Providers must submit a written estimate of the repair cost to the State Fund Provider Hotline or the self-insured employer (SIE) claim manager to get prior authorization for:

- In office repairs, *or*
- Repairs by the manufacturer, *or*
- Repairs by an all make repair company.

**Note**: Tubes, domes and wax guards aren't considered repairs.

### Replacements

- Replacement is defined as purchasing a new hearing aid for the worker according to L&I's current guidelines.
- Insurer authorized hearing aids will be replaced upon request 5 years or more after their issue date, *or*
- For hearing aids less than 5 years from the issue date of the current aids, the insurer will replace hearing aids when they aren't repairable due to normal wear and tear.
    - The insurer will require detailed documentation supporting why hearing aids aren't repairable and should be replaced.

Also note that for hearing aids less than 5 years from their current issue date:

- At its discretion, the insurer may replace hearing aids in other circumstances, *and*
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer won't pay for new hearing aids when only new ear shell(s) are needed, *and*
- The insurer won't replace a hearing aid when the hearing aid is working up to the manufacturer's original specifications, *and*
- The insurer won't replace a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on the job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident, *and*
- The insurer won't replace hearing aids based solely on changes in technology, *and*
- The insurer won't pay for new hearing aids for hearing loss resulting from:
    - Noise exposure that occurs outside the workplace, *or*
    - Further coverage exposure, *or*
    - Non-work related diseases, *or*
    - The natural aging process.

Replacement requests may be sent directly to the insurer using the Hearing Aid Repair/Replacement Durable Medical Equipment Provider Hotline Service Authorization Request form (F245-418-000). If this form isn't used, any request must be in writing and include all information required on the form.

State fund replacement requests are made directly to the claim manager. Requests may be mailed or faxed to 360-902-6490.

Documentation that a hearing aid isn't repairable may be submitted by:

- Licensed audiologists, *or*
- Fitter/dispensers, *or*
- All make repair companies, *or*
- FDA certified manufacturers.

The provider must submit written, logical rationale for the claim manager's consideration if:

- Only one of the binaural hearing aids isn't repairable, *and*
- In the professional's opinion, both hearing aids need to be replaced.

**Note**: The condition of the other hearing aid must be documented.

## Who must perform these services to qualify for payment

### Repairs

Audiologists and fitters/dispensers may be paid for providing authorized in office repairs.

## Requirements for billing

### Repairs

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Authorized in-office repairs must be billed using V5014 and V5267. These billings require an invoice and description.

### Additional information

Separate charges for accessories are paid at acquisition cost and aren't to be billed with repair codes.

The insurer won't cover repairs, services and supplies that are offered to the general public at no cost.

If a repair is done in the office and no warranty is available, this information must be included in the written description of the repair.

## Replacements

The worker must sign and be given a copy of the Hearing Services Worker Information form (F245-049-000). The provider must submit a copy of the signed form and the replacement request.

A copy of the manufacturer's warranty and a copy of any additional provider warranty must be submitted to the insurer for all hearing devices and hearing aid repairs. The warranty should include the individual hearing aids:

- Make, *and*
- Model, *and*
- Serial number.

The provider must inform the insurer of the type of hearing aid dispensed and the codes they are billing.

# Payment policy: Replacement of linear nonprogrammable analog hearing aids

## When these hearing aids may be replaced

Linear nonprogrammable analog hearing aids may be replaced with nonlinear digital or analog hearing aid when the worker returns a linear analog hearing aid to their dispenser or audiologist because:

- The hearing aid is inoperable, *or*
- The worker is experiencing an inability to hear, *and*
- The insurer has given prior authorization to replace the hearing aid.

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with nonlinear digital or analog hearing aid is authorized (see Prior authorization, below).

## Prior authorization

Prior authorization must be obtained from the insurer **before** replacing linear analog hearing aids. The insurer **won't pay** for replacement hearing aids issued prior to authorization.

### Authorization documentation and record keeping requirements

Before authorizing replacement, the insurer will require and request the following documentation from the provider:

- Required: A separate statement (signed by both the provider and the injured worker): This linear analog replacement request is sent in accordance with L&I's linear analog hearing aid replacement policy, *and*
- Required for State Fund claims: Completed Hearing Services Worker Information form (F245-049-000), *and*
- Serial number(s) of the current linear analog aid(s), if available, *and*
- Make/model of the current linear analog aid(s), if available, *and*
- Date original hearing aid(s) issued to worker, if available.

For State Fund claims prior authorization:

- Call the claim manager, *or*
- Fax the request to the Provider Hotline at 360-902-6252.

For self-insured claims prior authorization, contact the SIE/TPA for prior authorization.

**Link**: A list of SIEs/TPAs is available online.

## Who must perform these services to qualify for payment

Audiologists, physicians, ARNPs, and fitter/dispensers who have current L&I provider account numbers may bill for hearing aid replacement. These providers may bill for the acquisition cost of the nonlinear aids and the associated professional fitting fee (dispensing fee).

 

# Payment policy: Restocking fees

## Requirements for billing

The insurer must receive a Termination of Agreement (Rescission) form (F245-050-000) or a statement signed and dated by the provider and the worker.

The form must be faxed to L&I at **360-902-6252** or forwarded to the SIE/TPA within five business days of receipt of the signatures.

The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer:

- Either for the **restocking fee** of **$150.00** or **15%** of the total purchase price, whichever is less, *and*
- Using billing code **5091V**.

**Note**: **Restocking fees** can't be paid until the insurer has received the refund.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** and **Washington state laws** for audiology and hearing services | Washington Administrative Code (WAC) 246-828-290<br>WAC 296-20-015<br>WAC 296-23-165<br>Revised Code of Washington (RCW) 18.35.185<br>RCW 51.36.130 |
| **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 professional services (including audiology) | Fee schedules on L&I's website |
| **Hearing Services Worker Information** form | F245-049-000 |
| **Occupational Disease Employment History Hearing Loss** form | F262-013-000 |
| **Occupational Hearing Loss Questionnaire** | F262-016-000 |
| Payment policies for **acquisition cost** | Chapter 28: Supplies, Materials, and Bundled Services |
| Payment policies for **durable medical equipment (DME)** | Chapter 9: Durable Medical Equipment |
| Payment policies for **supplies** | Chapter 28: Supplies, Materials, and Bundled Services |
| **Report of Accident** form | F242-130-000 |
| **Statement for Miscellaneous Services** form | F245-072-000 |

 

| If you're looking for more information about… | Then see… |
|---|---|
| **Termination of Agreement (Rescission)** form | F245-050-000 |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 6: Biofeedback, Electrocardiograms (EKG), Electrodiagnostic Services, and Extracorporeal Shockwave Therapy (ESWT)

**Effective July 1, 2022**

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

## Table of Contents

# Payment policy: Biofeedback

## Prior authorization

Biofeedback treatment requires an attending provider's order and prior authorization.

When the condition is accepted under the industrial insurance claim, the insurer will authorize biofeedback treatment for:

- Idiopathic Raynaud's disease,
- Temporomandibular joint dysfunction,
- Myofascial pain dysfunction syndrome (MPD),
- Tension headaches,
- Migraine headaches,
- Tinnitus,
- Torticollis,
- Neuromuscular reeducation as result of neurological damage in a stroke (also known as "CVA") or spinal cord injury,
- Inflammatory and/or musculoskeletal disorders causally related to the accepted condition.

**Link**: For more information, see WAC 296-21-280.

Twelve biofeedback treatments in a 90 day period will be authorized for the conditions listed above when an evaluation report is submitted documenting all the following:

- The basis for the worker's condition, *and*
- The condition's relationship to the industrial injury, *and*
- An evaluation of the worker's current functional measurable modalities (for example, range of motion, up time, walking tolerance, medication intake), *and*
- An outline of the proposed treatment program, *and*
- An outline of the expected restoration goals.

No further biofeedback treatments will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (for example, range of motion, up time, walking tolerance, medication intake). Also:

- Only one additional treatment block of **12 treatments per 90 days** will be authorized, *and*
- Requests for biofeedback treatment beyond **24 treatments or 180 days** will be granted only after file review by and on the advice of the department's medical consultant.

In addition to treatment, pretreatment and periodic evaluation will be authorized. Follow-up evaluation can be authorized at one, three, six, and 12 months post treatment.

Home biofeedback device rentals are time limited and require prior authorization.

**Link**: Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

## Who must perform these services to qualify for payment

Practitioners must submit a copy of their biofeedback certification or supply evidence of their qualifications to the department or self-insurer to administer biofeedback treatment to workers. Administration of biofeedback treatment is limited to practitioners who:

- Are certified by the Biofeedback Certification Institute of America (BCIA), *or*
- Meet the minimum education, experience, and training qualifications to be certified.

**Link**: For more information, see WAC 296-21-280.

Paraprofessionals who aren't independently licensed must practice under the direct supervision of a qualified, licensed practitioner:

- Whose scope of practice includes biofeedback, *and*
- Who is BCIA certified or meets the certification qualifications.

A qualified or certified biofeedback provider who isn't licensed as a practitioner may not receive direct payment for biofeedback services.

**Links**: For legal definition of licensed practitioner, see WAC 296-20-01002.

## Services that can be billed

CPT® codes **90875** and **90876** are payable to L&I approved biofeedback providers who are clinical psychologists or psychiatrists (MD or DO).

CPT® codes **90901**, **90912**, and **90913** are payable to any L&I approved biofeedback provider.

HCPCS code **E0746** is payable to DME or pharmacy providers (for rental or purchase).

## Requirements for billing

The supervising licensed practitioner must bill the biofeedback services for paraprofessionals.

When biofeedback is performed along with individual psychotherapy, bill using either CPT® code **90875** or **90876**.

Don't bill CPT® codes **90901**, **90912**, or **90913** with the individual psychotherapy codes.

Use evaluation and management codes for diagnostic evaluation services.

## Payment limits

CPT® code **90901** is limited to **one unit of service per day**, **90912** is limited to **one unit per day** and **90913** is limited to **3 units per day** regardless of the number of modalities.

For HCPCS code **E0746**, use of the device in the office isn't separately payable.

 

# Payment policy: Electrocardiograms (EKG)

## Service that can be billed

Separate payment is allowed for electrocardiograms (CPT® codes **93000**, **93010**, **93040**, and **93042**) when an interpretation and report is included. These services may be paid along with office services.

## Services that aren't covered

EKG tracings without interpretation and report (CPT® codes **93005** and **93041**) aren't payable with office services.

## Payment limits

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code **R0076**) is bundled into the EKG procedure and doesn't pay separately.

 

# Payment policy: Electrodiagnostic services

## Who must perform these services to qualify for payment

Prior to performing and billing for these services, physical therapists (PTs) performing electrodiagnostic testing must provide documentation of proper Department of Health (DOH) licensure to L&I's Provider Credentialing.

PTs who meet the requirements of DOH rules may provide electroneuromyographic tests.

**Links**: For information on where to send proper license documentation, contact L&I's Provider Credentialing at PACMail@Lni.Wa.Gov.

To see the DOH rules, refer to WAC 246-915-370.

## Services that can be billed

The insurer covers the use of electrodiagnostic testing, including nerve conduction studies and needle electromyography only when:

- Proper and necessary, *and*
- Testing meets the requirements described in L&I's Electrodiagnostic Testing policy.

Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommended number of tests may be reviewed for quality and whether it is "proper and necessary."

Qualified PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed.

## Services that aren't covered

Electrodiagnostic testing isn't covered when:

- It isn't proper and necessary (see Note and Link, below this list), *or*
- Performed in a mobile diagnostic lab in which the specialist physician isn't present to examine and test the patient, *or*
- Performed with noncovered devices, including:
    - Portable, *and*
    - Automated, *and*
    - "Virtual" devices not demonstrated equivalent to traditional lab based equipment (for example, NC-stat®, Brevio), *or*
- Determined to be outside of AANEM recommended guidelines without proper documentation supporting that the testing is proper and necessary.

In general, repetitive testing isn't considered proper and necessary except if:

- Documenting ongoing nerve injury (for example, following surgery), *or*
- Required to provide an impairment rating, *or*
- Documenting significant changes in clinical condition.

**Link**: The legal definition of "proper and necessary" is available in WAC 296-20-01002.

## Requirements for billing

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels.

**Link**: The complete requirements for appropriate electrodiagnostic testing are available online.

Billing of the technical and professional portions of the codes may be separated. However, the physician billing for interpretation and diagnosis (professional component) must have direct contact with the patient at the time of testing.

**Note**: The insurer may recoup payments made to a provider, plus interest, for NCS and EMG tests paid inappropriately.

### Example: Reasonable limits on units required to determine a diagnosis

The table below was developed by the AANEM and summarizes reasonable limits on units required, per diagnostic category, to determine a diagnosis 90% of the time.

**Note**: Review of the quality and appropriateness (whether the test is "proper and necessary") may occur when testing repeatedly exceeds AANEM recommendations.

Recommended maximum number of studies by indication (from "AANEM Table 1"; recreated and adapted with written permission from AANEM):

| Indication | Needle EMG CPT® 95860-95864, 95867-95870 | NCS CPT® 95907-95913 | Other EMG studies CPT® 95907-95913 | | |
|---|---|---|---|---|---|
| | **# of tests** | **Motor NCS with and without Fwave** | **Sensory NCS** | **H-Reflex** | **Neuromuscular Junction Testing** (repetitive stimulation) |
| **Carpal tunnel** (unilateral) | 1 | 3 | 4 | — | — |
| **Carpal tunnel** (bilateral) | 2 | 4 | 6 | — | — |
| **Radiculopathy** | 2 | 3 | 2 | 2 | — |
| **Mononeuropathy** | 1 | 3 | 3 | 2 | — |
| **Poly/ mononeuropathy multiplex** | 3 | 4 | 4 | 2 | — |
| **Myopathy** | 2 | 2 | 2 | — | 2 |
| **Motor neuronopathy** (for example, ALS) | 4 | 4 | 2 | — | 2 |
| **Plexopathy** | 2 | 4 | 6 | 2 | — |

| Indication | Needle EMG CPT® 95860-95864, 95867-95870 | NCS CPT® 95907-95913 | Other EMG studies CPT® 95907-95913 | | |
|---|---|---|---|---|---|
| | # of tests | Motor NCS with and without Fwave | Sensory NCS | H-Reflex | Neuromuscular Junction Testing (repetitive stimulation) |
| **Neuromuscular Junction** | 2 | 2 | 2 | — | 3 |
| **Tarsal tunnel** (unilateral) | 1 | 4 | 4 | — | — |
| **Tarsal tunnel** (bilateral) | 2 | 5 | 6 | — | — |
| **Weakness, fatigue, cramps, or twitching** (focal) | 2 | 3 | 4 | — | 2 |
| **Weakness, fatigue, cramps, or twitching** (general) | 4 | 4 | 4 | — | 2 |
| **Pain, numbness, or tingling** (unilateral) | 1 | 3 | 4 | 2 | — |
| **Pain, numbness or tingling** (bilateral) | 2 | 4 | 6 | 2 | — |

# Payment policy: Extracorporeal shockwave therapy (ESWT)

## Services that aren't covered

The insurer doesn't cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for biofeedback | Washington Administrative Code (WAC) 296-21-280 |
| **Administrative rules** for the definitions of "licensed practitioner" and "proper and necessary" | WAC 296-20-01002 |
| **Administrative rules** for the policy on rental equipment | WAC 296-20-1102 |
| **Administrative rules** for the requirements on who may provide electroneuromyographic tests | WAC 246-915-370 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Coverage decision** for extracorporeal shockwave therapy | Extracorporeal shockwave therapy coverage decision |
| **Fee schedules** for all healthcare professional services (including chiropractic) | Fee schedules on L&I's website |
| Policy for **electrodiagnostic testing** | Electrodiagnostic testing policy |
| **Sending proper license documentation** to perform electrodiagnostic services | PACMail@Lni.Wa.Gov |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 7: Chiropractic Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Body regions**: One of the factors contributing to clinical decision-making complexity for chiropractic care visits. Body regions include:

- Cervical (includes atlanto-occipital joint),
- Thoracic (includes costovertebral and costotransverse joints),
- Lumbar
- Sacral
- Pelvic (includes sacroiliac joint),
- Extra-spinal (considered one region), which includes
    - Head (includes temporomandibular joint; doesn't include atlanto-occipital), *and*
    - Upper and lower extremities, *and*
    - Rib cage (doesn't include costotransverse and costovertebral joints).

**Chiropractic care visits**: Office or other outpatient visits involving subjective and objective assessment of patient status, management, and treatment.

**Clinical decision-making complexity**: The primary component influencing the level of care for a chiropractic care visit. Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to clinical decision-making complexity for injured workers include:

- The current occupational condition(s),
- Employment and workplace factors,
- Non-occupational conditions that may complicate care of occupational condition,
- Care planning and patient management,
- Chiropractic intervention(s) provided,
- Number of **body regions** involved, *and*
- Response to care.

The number of **body regions** being adjusted is only one of the factors that may contribute to visit complexity, but should be weighted less heavily than other components.

L&I defines clinical decision-making complexity according to the definitions for medical decision-making complexity in the Evaluation and Management Services Guidelines section of the CPT® book.

 

**Complementary and preparatory services**: Interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. For example, the application of heat or cold is considered a complementary and preparatory service.

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Established patient**: One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

**New patient**: One who hasn't received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–22 (Increased Procedural Services)**

Procedures with this modifier will be individually reviewed prior to payment. A report is required for this review and it must include justification for the use of the modifier explaining increased complexity required for proper treatment. Payment varies based on the report submitted.

**–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

 

# Payment policy: Chiropractic care visits

## Prior authorization

Prior authorization for all types of conservative care, including chiropractic, is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

## Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** account for both professional management (clinical complexity) and technical service (manipulation and adjustment). There are three levels of **chiropractic care visits**:

| The primary component is clinical decision-making. If it is… | OR the **number of body regions** adjusted or manipulated is… | and typical **face-to-face time** with patient or family is… | Then the **appropriate billing code** and maximum fee is… |
|---|---|---|---|
| Straightforward | Up to 2 | Up to 15 minutes | **2050A** (Level 1) **$48.38** |
| Low complexity | Up to 3 or 4 | 15-25 minutes | **2051A** (Level 2) **$61.98** |
| Moderate complexity | Up to 5 or more | Over 25 minutes | **2052A** (Level 3) **$75.52** |

### Re-evaluations

Depending on the amount of clinical complexity and services rendered, an E/M code may better capture the level of service performed during a re-evaluation.

If a re-evaluation of a patient meets the CPT® criteria for **established patient** E/M, the provider may bill the appropriate E/M code instead of a chiropractic care local code (**2050A**, **2051A**, or **2052A**). See the Chiropractic evaluation and management (E/M) services payment policy for additional details.

## Services that aren't covered

CPT® chiropractic manipulative treatment (CMT) codes **98940**-**98943** aren't covered.

Instead of using CMT codes, L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop local codes that can be billed for **chiropractic care visits** (see Services that can be billed, above).

Treatment of chronic migraine or chronic tension-type headache with chiropractic manipulation/manual therapy isn't a covered benefit.

**Link**: The coverage decision for Chronic Migraine or Chronic Tension-type Headache is available online.

## Requirements for billing

When billing modifier **–22** with **chiropractic care visit** local codes (**2050A**-**2052A**), submit a report detailing the nature of the unusual service or increased complexity of the service provided and the reason it was required. The report will be reviewed individually, and payment will vary based on the review findings.

## Payment limits

Only one **chiropractic care visit** per day is payable.

Extra-spinal manipulations aren't billed separately from each other (all extremities are considered to be one **body region**).

Modifier **–22** isn't payable when used for non-covered or bundled services (for example, application of hot or cold packs).

Providers may not bill an **established patient** E/M code and a chiropractic care local code (**2050A**, **2051A**, or **2052A**) for the same date of service.

## Examples of chiropractic care levels of complexity

These examples are for illustration only and aren't clinically prescriptive:

| | |
|---|---|
| **Level 1:** | **Straightforward clinical decision-making** (billing code **2050A**) |
| Patient | 26 year old male. |
| Cause of injury | Lifted a box at work. |
| Symptoms | Mild, low back pain for several days. |
| Treatment | Manipulation or adjustment of the lumbar region, anterior thoracic mobilization, and lower cervical adjustment. |

| | |
|---|---|
| **Level 2:** | **Low complexity clinical decision-making** (billing code **2051A**) |
| Patient | 55 year old male, follow-up visit. |
| Cause of injury | Slipped and fell on stairs while carrying heavy object at work. |
| Symptoms | Ongoing complaints of neck and low back pain. New sensation of periodic tingling in right foot. Two days off work. |
| Treatment | Discuss need to minimize lifting and getting assistance when carrying heavier objects. Five minutes of myofascial release prior to adjustment of the cervical, thoracic, and lumbar regions. |

| | |
|---|---|
| **Level 3:** | **Moderate complexity clinical decision-making** (billing code **2052A**) |
| Patient | 38 year old female, follow-up visit. |
| Cause of injury | Moved heavy archive boxes at work over the course of three days. |
| Symptoms | Low back pain with pain at the sacrococcygeal junction, pain in the sacroiliac regions, and right-sided foot drop. Obesity and borderline diabetes. Tried light-duty work last week, but unable to sit for very long, went home. Tried prescribed stretching from last visit, but worker couldn't continue and didn't stretch because of pain. |
| Treatment | Review MRI report with the worker. Discussed obesity and diabetes impact on recovery, 10 minutes. 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/ adjustment to the lumbar, sacroiliac, and sacrococcygeal regions. |

 

# Payment policy: Chiropractic evaluation and management (E/M) services

## Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

## Services that can be billed

### Case management services

Codes and billing instructions for case management services telephone calls, team conferences, and secure email can be found in the Case management services section of: Chapter 10: Evaluation and Management. These codes may be paid in addition to other services performed on the same day.

### Office visits

Chiropractic physicians may bill all levels of office visit codes for **new and established patients**.

For complete code descriptions, definitions, and guidelines, refer to a CPT® book.

**Link**: Fees appear in the Professional Services Fee Schedule.

## Payment limits

A **new patient** E/M office visit code is payable only once for the initial visit.

An **established patient** E/M office visit code isn't payable on same day as a **new patient** E/M.

Modifier **–22** isn't payable with E/M office visit codes for chiropractic services.

For follow-up visits, E/M office visit codes aren't payable when performed on the same day as L&I **chiropractic care visit** codes. Refer to the Chiropractic care visits section of this chapter for policies about the use of E/M office visit codes with L&I codes for chiropractic care visits.

Chiropractic E/M office visits are only payable on the same date as a **chiropractic care visit** when all of the following are met:

- It is the first visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the **chiropractic care visit**), *and*
- Modifier **–25** is added to the E/M code, *and*
- The patient's record contains supporting documentation describing both the E/M and the chiropractic care services.

**Link**: Additional E/M information is available in Chapter 10: Evaluation and Management Services.

# Payment policy: Chiropractic consultations

## General information

Consultations are requested by the attending provider. A chiropractic consultant may render a second opinion for any conservative management of musculoskeletal conditions even if the attending provider is not a chiropractor.

## Prior authorization

While chiropractic consultations don't require prior authorization, consultations do require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer per WAC 296-23-195.

## Who must perform these services to qualify for payment

Only an L&I-approved chiropractic consultant can perform office consultation services to qualify for payment.

## Services that can be billed

Approved consultants may bill all levels of CPT® office consultation codes.

## Additional information: Chiropractic consultations

L&I periodically publishes:

- A policy on consultation referrals, *and*
- A list of approved chiropractic consultants.

**Link**: More information about consultations, how to become a chiropractic consultant, and a list of approved chiropractic consultants is available online.

# Payment policy: Chiropractic independent medical exams (IMEs) and impairment ratings

## Prior authorization

Prior authorization is only required when an IME is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an IME is scheduled.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

## Who must perform these services to qualify for payment

Only an L&I-approved IME examiner can perform IMEs or impairment ratings to qualify for payment.

For an impairment rating, an attending chiropractic physician may:

- Perform the rating on their own patients if the physician is an approved IME examiner, *or*
- Refer to an approved IME examiner for a consultant impairment rating.

**Link**: For more information, see: Chapter 12: Impairment Rating Services

## Services that can be billed

Use the CPT® codes, local codes, and the payment policy for IMEs described in Chapter 13: Independent Medical Exams.

## Additional information: Becoming an approved IME examiner

To apply for approval, chiropractic physicians must complete:

- Two years as an approved chiropractic consultant, *and*
- Impairment rating course approved by the department.

**Links**: For more information, see L&I's Become a Chiropractic Consultant webpage.

# Payment policy: Chiropractic radiology services (X-rays)

## Prior authorization

Medically necessary x-rays performed as part of the initial evaluation don't require prior authorization. All subsequent x-rays require prior authorization.

## Who must perform these services to qualify for payment

Chiropractic physicians in the network may bill for radiographs taken as allowed under their license. It is required that a written x-ray report of radiologic findings and impressions be included in the patient's chart.

Only chiropractic physicians on L&I's list of approved radiological consultants may bill for X-ray consultation services. A chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I to become an approved radiological consultant.

## Services that can be billed

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the Requirements and Payment limits described in Chapter 26: Radiology Services.

Diagnostic ultrasounds performed by the chiropractor are bundled into the E/M service. See Chapter 26: Radiology Services for additional details on ultrasounds and documentation requirements.

## Services that aren't covered

### Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion x-ray, vertebral motional analysis and spinal x-ray digitization.

DSV isn't a covered benefit. Procedure code **76496** shouldn't be used to bill the insurer for these services.

**Link**: For more information about DSV, see the Dynamic Spinal Visualization coverage decision.

# Payment policy: Complementary & preparatory services, and patient education or counseling

## General information

Patient education or counseling includes discussing or providing written information about:

- Lifestyle, *or*
- Diet, *or*
- Self-care and activities of daily living, *or*
- Home exercises.

The application of heat or cold is an example of a **complementary and preparatory service**.

## Payment limits

The following services are bundled into the E/M or chiropractic local codes and aren't separately payable:

- **Complementary and preparatory services**, *or*
- Patient education or counseling.

# Payment policy: Physical medicine treatment

## Services that can be billed

Local code **1044M** for physical medicine modalities or procedures (including the use of traction devices) may only be billed by an attending provider who is not board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

**Link**: For more information, see Chapter 25: Physical Medicine Services.

## Services that aren't covered

CPT® physical medicine codes (**97001**-**97799**) aren't payable to chiropractic physicians.

## Requirements for billing

Documentation of the visit must support billing for local code **1044M**.

## Payment limits

Local code **1044M** is limited to six units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.

After six units, the patient must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment except when the attending provider practices in a remote location. (Refer to WAC 296-21-290 for more information.)

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

### Powered traction devices

The insurer won't pay any additional cost when powered traction devices are used. This policy applies to all FDA-approved powered traction devices.

Published literature hasn't substantially shown that powered traction devices are more effective than other forms of traction, other conservative treatments, or surgery. Powered traction devices are covered as a physical medicine modality under existing physical medicine payment policy. When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider under code **1044M**.

**Link**: For additional information, see powered traction therapy in Chapter 25: Physical Medicine Services.

# Payment policy: Telehealth for chiropractic services

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

## Services that must be performed in person

In-person evaluation is required when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- Consultations requested to determine if conservative care is appropriate, *or*
- A worker files a reopening application, *or*
- A worker requests a transfer of attending provider, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Prior authorization

The prior authorization requirements listed in Chapter 7: Chiropractic Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

## Services that are covered

**Telehealth** procedures and services that are covered include services that don't require a hands on component.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to user their telecommunications equipment for a **telehealth** service with a provider at another location.

To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

 

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

**Note**: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services and Chapter 10: Evaluation and Management (E/M) Services, Telehealth.

## Store and Forward

**G2010** is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the patient provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

## Services that aren't covered

The same services that aren't covered in Chapter 7: Chiropractic Services apply to this policy.

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Services that require physical hands-on and/or attended treatment of a patient, including but not limited to codes **2050A**, **2051A**, or **2052A**,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report),

- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

**Note**: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs any service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| Originating site is… | Worker's home | | |
|---|---|---|---|
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See Chapter 7: Chiropractic Services and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same limits noted in Chapter 7: Chiropractic Services apply regardless of how the service is rendered to the worker.

 

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for physical medicine | Washington Administrative Code (WAC) 296-21-290 |
| **Becoming an Chiropractic Consultant** | Become a Chiropractic Consultant 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 |
| **Chiropractic Services** including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources | IICAC website |
| **Dynamic Spinal Visualization** coverage decision | Dynamic Spinal Visualization coverage decision |
| **Fee schedules** for all healthcare professional services (including chiropractic) | Fee schedules on L&I's website |
| Payment policies for **case management services** | Chapter 10: Evaluation and Management Services |
| Payment policies for **diagnostic X-ray services** | Chapter 26: Radiology Services |
| Payment policies for **durable medical equipment (DME)** | Chapter 9: Durable Medical Equipment |
| Payment policies for **IMEs** | Chapter 13: Independent Medical Exams (IMEs) |
| Payment policies for **impairment ratings** | Chapter 12: Impairment Rating Services |
| Payment policies for **physical medicine treatment** or **powered traction therapy** | Chapter 25: Physical Medicine Services |
| Payment policies for **supplies** | Chapter 28: Supplies, Materials, and Bundled Services |

 

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 8: Dental Services

**Effective July 1, 2022**

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

## Table of Contents

# Payment policy: All dental services

## Prior authorization

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and Crime Victims Compensation (CVC) claims, *or*
- Self-insured employer or their third party administrator.

Only claim managers can authorize dental services for State Fund workers' compensation claims and CVC claims.

For self-insured workers' compensation claims, contact the insurer directly for prior authorization procedure details.

**Link**: A list of self-insured employers' contact information is available online.

### Prior authorization review of treatment plan

Dental services requiring prior authorization require a treatment plan. Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to:

- Restorative,
- Endodontic,
- Prosthodontic,
- Prosthetic,
- Implant,
- Orthodontics,
- Surgery, *and*
- Anesthesia procedures.

In cases presenting complication, controversy or diagnostic/therapeutic problems, the claim manager may request consultation by another dentist to support authorization for procedures.

 

## Who must perform these services to qualify for payment

Dental providers licensed in the state in which they practice may be paid for performing dental services, including:

- Dentists,
- Oral and Maxillofacial surgeons,
- Orthodontists,
- Endodontists
- Periodontists
- Pediatric Dentists
- Prosthodontists
- Denturists,
- Hospitals, *and*
- Dental clinics.

Dental providers **must be enrolled in the provider network** to treat injured workers beyond the initial visit. The initial visit is the first visit to a healthcare provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers compensation. See information about the Medical Provider Network in Chapter 2: Information for All Providers - Becoming a provider. Network requirements do not apply to Crime Victim services.

**Links**: You can find more information about dental services in WAC 296-20-110, WAC 296-23-160, and WAC 296-20-015, and about becoming an L&I provider at Becoming an L&I Provider.

## Services that aren't covered

### Pre-existing conditions

Pre-existing conditions aren't payable unless medically justified as related to the injury. Preauthorization is required for treatment.

### Underlying conditions

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker. It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that won't be covered.

### Periodontal disease

Periodontal disease is an underlying condition that isn't covered because it isn't related to industrial injuries.

**Link**: For more information, see WAC 296-20-110.

## Requirements for billing

Bills must be submitted within one year from the date the service is rendered. See the HCPCS fee schedule for dental billing codes.

**Link**: For more information, see WAC 296-20-125.

All workers' compensation dental claims should be billed using the ADA American Dental Association Dental Claim form (© 2012 American Dental Association J430D), or L&I's Statement for Miscellaneous Services form (F245-072-000).

For Crime Victims Compensation (CVC) claims, dentists should use the ADA American Dental Association Dental Claim form (© 2019 American Dental Association J430D), or CVC's Statement for Crime Victims Miscellaneous Services form (F800-076-000). Failure to use the most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the:

- Full billing code, including the letter D if using a Current Dental Terminology (CDT®) code,
- Materials used, *and*
- Injured tooth number(s).

**Note**: When using Current Dental Terminology (CDT®) codes, please include the D in front of the code billed to avoid delays in claim/bill processing.

## Treatment plan requirements

Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The dentist should outline the extent of the dental injury and the treatment plan. To **obtain authorization** for a treatment plan, all of the following are **required**:

- Causal relationship of injury to condition of the mouth and teeth,
- Extent of injury,
- Alternate treatment plan,
- Time frame for completion, *and*
- Medical history and risk level for success.

Please include:

- Procedure code,
- Tooth number,
- Tooth surface, *and*
- Charge amount.

To avoid delays in treatment, please **exclude** information regarding treatment that isn't directly related to the injury. The ADA American Dental Association Dental Claim form (© 2019 American Dental Association J430) may be attached to treatment plan. Select Request for Predetermination/Preauthorization in section 1 of the ADA form.

In addition, to **avoid delays in authorization** of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number, *and*
- State the condition of the mouth and involved teeth including:
    - Missing teeth, existing caries and restorations, *and*
    - Condition of involved teeth prior to the injury (caries, periodontal status).

**Link**: For more information, see WAC 296-20-110.

## Where to submit a treatment plan

**State Fund** treatment plans (not billing info) may be:

- Faxed to **360-902-4567**, or
- Mailed to:

  Department of Labor & Industries
  PO Box 44291
  Olympia, Washington 98504-4291

**Crime Victims Compensation** (CVC) treatment plans (not billing info) may be:

- Faxed to **360-902-5333**, or
- Mailed to:

  Department of Labor & Industries
  Crime Victims Compensation Program
  PO Box 44520
  Olympia, Washington 98504-4520

Mail **self-insured** treatment plans to the Self-insured employer (SIE) or third party administrator (TPA).

## Documentation and recordkeeping requirements

### Acceptance of a claim

If you are the first provider seen by the injured worker and you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. To initiate the State Fund claim or CVC claim for your patient, send L&I a **Report of Industrial Injury or Occupational Disease** form (F242-130-000) (also known as Accident Report or Report Of Accident (ROA) Workplace Injury, Or Occupational Disease).

**Links**: You can order copies of the **Report Of Accident** (ROA) Workplace Injury, Accident or Occupational Disease (F242-130-000) or by calling **1-800-LISTENS** or **1-360-902-4300**.

To request a supply of the **Provider's Initial Report** (PIR) form used for workers of self-insured employers (F207-028-000), or call **1-360-902-6898**.

### Chart notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service. Legible copies of office notes are required for all initial and follow up visits.

**Links**: For more information, see WAC 296-20-010 and WAC 296-20-06101.

### Attending provider

If dental treatment is the only treatment the injured worker requires and you are directing the care, you will be the attending provider (AP).

Your responsibility as the AP includes documenting employment issues in the injured worker‘s chart notes, including:

- A record of the worker‘s physical and medical ability to work,
- Information regarding any rehabilitation that the worker may need to undergo,
- Restrictions to recovery,
- Any temporary or permanent physical limitations, *and*
- Any unrelated condition(s) that may delay recovery must also be documented.

For ongoing treatment, use the **SOAP-ER** (Subjective, Objective, Assessment, Plan and progress, Employment issues, Restrictions to recovery) format.

**Link**: Information on the Charting format can be found in Chapter 2: Information for All Providers.

## Additional information: L&I’s periodic review of dental services

L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but aren‘t limited to, review of the injured worker‘s dental records.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** Medical Aid | Washington Administrative Code (WAC) 296-20-110<br>WAC 296-20-015<br>WAC 296-20-125<br>WAC 296-20-06101 |
| **Administrative rules** dental services, general information and instructions | WAC 296-23-160 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Charting format (SOAP-ER)** instructions | Chapter 2: Information for All Providers |
| **Fee schedules** for all healthcare professional services (including dental) | Fee schedules on L&I's website |
| Payment policies for **diagnostic X-ray services** | Chapter 26: Radiology Services |
| **Provider's Initial Report (PIR)** form for all State Fund and crime victims claims | F207-028-000 |
| **Report Of Accident** (ROA) Workplace Injury, Accident or Occupational Disease form for all State Fund and crime victims claims | F242-130-000 |
| **Statement for Crime Victims Miscellaneous Services** form for all crime victims claims | F800-076-000 |
| **Statement for Miscellaneous Services** form for all worker's compensation claims | F245-072-000 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 9: Durable Medical Equipment (DME)

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Bundled codes**: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Pharmacy and DME providers can bill HCPCS codes listed as bundled on the fee schedules because, for these provider types, there's not an office visit or a procedure into which supplies and/or equipment can be bundled.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.

**By Report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report, see WAC 296-20-01002.

**Durable medical equipment (DME)**: DME means equipment that:

- Can withstand repeated use, *and*
- Is primarily and customarily used to serve a medical purpose, *and*
- Generally isn't useful to a person in the absence of illness or injury, *and*
- Is appropriate for use in the client's place of residence.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

**Portable oxygen systems**: Portable oxygen systems, sometimes referred to as ambulatory systems, are lightweight (less than 10 pounds) and can be carried by most patients. These systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.

- Small gas cylinders are available as portable systems. Some are available that weigh less than five pounds.
- Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights.

 

**Stationary oxygen systems**: Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems, and oxygen concentrators.

- Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders.
- Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas, but takes up less space and can be transferred more easily to a portable tank.
- Oxygen concentrators are electric devices that extract oxygen from ambient air and compress it to 85% or greater concentration. A backup oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–NU (New purchased DME)**

Use the **–NU** modifier when a new DME item is to be purchased.

**–RR (Rented DME)**

Use the **–RR** modifier when DME is to be rented.

**–LT (Left side)**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

**–RT (Right side)**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

 

# Payment policy: Hot or cold therapy DME

## Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for **DME** providers only and is **bundled** for all other provider types.

## Services that aren't covered

Hot water bottles, heat and/or cold wraps aren't covered.

Hot or cold therapy **DME** isn't covered. Examples include heat devices for home use, including heating pads. These devices either aren't covered or are **bundled**.

Cryotherapy **DME** with or without compression used in a clinical setting aren't payable separately. These modalities are considered to be **bundled** into existing physical medicine services billable under CPT® **97010** and **1044M**. HCPCS code **E1399** isn't appropriate for cryotherapy **DME** in any setting.

**Link**: For more information, see WAC 296-20-1102.

## Payment limits

Application of hot or cold packs (CPT® code **97010**) is **bundled** for all providers.

# Payment policy: Oxygen and oxygen equipment

## Requirements for billing

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes.

Delivery charges, shipping and handling, tax, and fitting fees aren't payable separately. Include these charges in the total charge for the supply.

**Link**: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

## Services that can be billed

To bill for oxygen, if the worker owns a:

- **Portable oxygen system**, bill using either **E0443** (gaseous contents) or **E0444** (liquid contents), *or*
- **Stationary oxygen system**, bill using either **E0441** (gaseous contents) or **E0442** (liquid contents).

## Payment limits

The insurer primarily pays for rental of oxygen equipment and no longer rents to purchase.

If the worker **rents** the oxygen system:

- One monthly fee is paid for oxygen equipment. This fee includes payment for the equipment, contents, necessary maintenance, and accessories furnished during a rental month, *and*
- Oxygen accessories are included in the payment for rented systems. The supplier must provide any accessory ordered by the physician. (See Examples of oxygen accessories, below.)

If the worker **owns** the oxygen system:

- The fee for oxygen contents must be billed once a month, not daily or weekly. One unit of service equals one month of rental, *and*
- Oxygen accessories are payable separately only when they are used with a patient owned system.

## Examples of oxygen accessories

Oxygen accessories include but aren't limited to:

- Cannulas (**A4615**),
- Humidifiers (**E0555**),
- Masks (**A4620**, **A7525**),
- Mouthpieces (**A4617**),
- Regulators (**E1353**),
- Nebulizer for humidification (**E0580**),
- Stand/rack (**E1355**),
- Transtracheal catheters (**A4608**),
- Tubing (**A4616**).

# Payment policy: Pneumatic compression devices

## General information

Pneumatic compression devices are used in the following ways:

- During surgery only, *or*
- During surgery and after surgery, either in the facility or at home, *or*
- At home only.

Pneumatic compression devices used during surgery and subsequently sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and is not separately payable, even to **DME** suppliers.

## Services that can be billed

Pneumatic compression devices are considered **DME** and are separately billable using code **E0650** if and only if all the following conditions are met:

- The device is not used during surgery in any capacity, *and*
- The claimant's risk for developing venous thromboembolism (VTE) has been evaluated and documented using a validated thrombosis risk factor assessment tool, *and*
- The surgeon provides a statement of medical necessity to the insurer indicating the device is medically necessary to prevent VTE based on the results of the screening tool and is intended for home use only following a procedure.

## Services that aren't covered

Pneumatic compression devices are considered surgical supplies and aren't separately billable when any of the following conditions are met:

- The device is used during surgery in any capacity, *or*
- The device is used following surgery while the worker is in the facility, *or*
- The device is not prescribed by the surgeon.

CPT® code **99070** isn't covered.

HCPCS code **E0676** isn't covered.

# Payment policy: Prosthetic and orthotic services

## Prior authorization

### Required

Prior authorization is required for:

- Prosthetics, surgical appliances, and other special equipment described in WAC 296-20-03001, *and*
- Replacement of specific items on closed claims as described in WAC 296-20-124.

**Note**: If **DME** or orthotics requires prior authorization and it isn't obtained, then bills may be denied.

For prior authorization for:

- **State fund** claims, contact the Provider Hotline at **1-800-848-0811**.
- **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

**Link**: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization.

### Not required

Providers aren't required to obtain prior authorization for orthotics or **DME** when:

- The provider verifies that the claim is open/allowed on the date of service, *and*
- The orthotic/**DME** is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, *and*
- The fee schedule prior authorization indicator field is blank (see fee schedule).

 

## Who qualifies for payment for custom made devices

The insurer will only pay for custom made (sometimes called “custom fabricated”) prosthetic and orthotic devices manufactured by these providers specifically licensed to produce them:

- Prosthetists,
- Orthotists,
- Occupational therapists,
- Certified hand specialists, *and*
- Podiatrists.

**Link**: To determine if a prosthetic or orthotic device is in this category, see the “license required” field in the fee schedule.

## Requirements for billing

An itemized invoice showing total cost for the item must be submitted to support charges for any custom prosthetic or orthotic device paid **By Report**. Each By Report code billed should be listed with its individual price. Sales tax and shipping and handling charges aren’t paid separately and must be included in the total charge. Bills without an invoice may be denied.

**Link:** For information on where to send bills and invoices, see Chapter 2: Information for All Providers.

For covered prosthetics that pay **By Report**, providers must bill their usual and customary fees.

**Links**: For more information on billing usual and customary fees, see WAC 296-20-010 (2).

To find out which codes pay **By Report**, see the HCPCS section of the Professional Services Fee Schedule.

## Payment limits

For **By Report** prosthetic items, the insurer will pay 80% of the billed charge.

# Payment policy: Purchasing or renting DME

## General information

### Purchased DME

Purchased **DME** belongs to the worker.

State fund and Crime Victims Compensation Program won't purchase used **DME**.

Self-insured employers may purchase used **DME**.

### Rented DME

During the authorized rental period, the **DME** belongs to the provider.

When the **DME** is no longer authorized:

- It will be returned to the provider.
- If unauthorized **DME** isn't returned to the provider within 30 days, the provider can bill the worker for charges related to **DME** rental, purchase, and supplies that accrue after the insurer denies authorization for the **DME**.

**Link**: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

## Prior authorization

### Required

If prior authorization is required but isn't obtained, then bills may be denied. Prior authorization is required for:

- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).
- Replacement of specific items on closed claims (see WAC 296-20-124).

**Link**: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization; these codes include the HCPCS E codes and the HCPCS K codes.

For prior authorization for:

- **State fund** claims, contact the Provider Hotline at **1-800-848-0811**.
- **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

### Not required

Providers aren't required to obtain prior authorization for orthotics or **DME** when:

- The provider verifies that the claim is open/allowed on the date of service, *and*
- The orthotic/**DME** is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, *and*
- The fee schedule prior authorization indicator field is blank.

## Requirements for billing

All providers must submit documentation to support billing for the purchase or rental of any DME. Documentation must include a full description of the item(s) dispensed. Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes. Errors will result in suspension and/or denial of payment.

Delivery charges, shipping and handling, tax, and fitting fees aren't separately payable.

If the **DME** is rented for:

- **One day**: use the same date for the first and last dates of service.
- **More than one day**: use the actual first and last dates of service.

Always include a modifier with a **DME** HCPCS code. Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, for example **–LT** or **–RT**, in conjunction with the mandatory modifiers if appropriate (up to four modifiers may be used with any one HCPCS code).

The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which **DME** items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).
    - **Example**: **E0117-NU** (Underarm spring-assist crutch) is only purchased (there isn't an **–RR** modifier for that code).

### Modifier exception

Repair codes **K0739** and **K0740** don't require modifiers.

# Payment limits

## Rented DME

The maximum allowable rental fee is based on a per month period. Rental of one month or less is equal to one unit of service.

Rental payments won't exceed 12 months because:

- At six months:
  - The insurer may review rental payments and decide to purchase the equipment at that time, *and*
  - If purchased, the **DME** belongs to the worker.
- At the 12th month of rental, the worker owns the equipment.

**Negative Pressure Wound Therapy (NPWT)** is covered when the wound is related to an injury or illness allowed on the claim. Prior authorization is required before starting NPWT, and every 30 days thereafter. See the Department's coverage decision on the requirements for authorization.

**Equipment limits for E2402**: Patients are allowed one NPWT pump per episode (a pump may be used for more than one wound at the same time). Supplies should be limited to 15 dressing kits (**A6550**) per wound per month, and 10 canister sets (**A7000**) per month.

**Miscellaneous DME** (**E1399**) will be paid **By Report**:

- The miscellaneous item must be appropriate relative to the injury or type of treatment received by the worker.
- **E1399** is payable only for **DME** that doesn't have a valid HCPCS code.
- All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).
- A description must be on the paper bill or in the remarks section of the electronic bill.

## Rental exceptions

**Continuous passive motion exercise devices**, **E0935** (for use on knee only) and **E0936** (for use other than knee), are rented on a per diem basis up to 14 days, with 1 unit of service = 1 day.

**Extension/flexion devices** (**E1800-E1818**, **E1825-E1840**) are rented for one month. If needed beyond one month, the insurer's authorization is required.

**Wound Therapy devices** (**E2402**) are rented per day. 1 unit of service = 1 day.

 

## Services that aren't covered

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of **DME** and won't be reimbursed as **DME**.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and is not separately payable, even to **DME** suppliers.

## DME purchase after rental period of less than 12 months

For equipment rented for less than 12 months and permanently required by the worker:

- For **State fund** claims, the provider will retrieve the rental equipment and replace it with the new **DME** item.
    - The provider should bill the usual and customary charge for the new replacement **DME** item. The billed HCPCS code requires a **–NU** modifier.
    - L&I will pay the provider the new purchase price for the replacement **DME** item up to no more than the maximum fee in the **DME** fee schedule.
- For **self-insured** claims, self-insurers may purchase the equipment and receive rental credit toward the purchase.

 

# Payment policy: Repairs and non-routine services, and warranties

## Requirements for billing

### Repairs and non-routine services

**DME** repair codes (**K0739**, **K0740**) must be billed per each 15 minutes. One unit of service in the Units field equals 15 minutes.

- **Example**: 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with 3 units of service.

### Submitting a warranty to the insurer

A copy of the original warranty is required on each repair service completed and must be submitted to the insurer. **Payment will be denied** if no warranty is received or if the item is still under warranty.

Repair, non-routine service, and maintenance on purchased equipment that is out of warranty will be paid **By Report**.

When submitting the warranty to the insurer, write the claim number in the upper right hand corner of the warranty document, and send a copy:

- **State fund** claims to:

  Department of Labor and Industries
  PO Box 44291
  Olympia, WA 98504-4291

- **Self-insured** claims to the SIE/TPA.

**Link**: For more information on miscellaneous services and appliances, see WAC 296-23-165.

# Payment limits

## Purchased equipment repair

Repair or replacement of **DME** is the responsibility of the worker when the item is:

- Damaged due to worker abuse, neglect, misuse, *or*
- Lost or stolen.

## Rented equipment repair

Repair, non-routine service, and maintenance are included as part of the monthly rental fee on **DME**. No additional payment will be provided. This doesn't include disposable and nonreusable supplies. (See required warranty coverage in table below.)

# Warranty coverage requirements

| If the **DME item type** is… | Then the **required warranty coverage** is: |
|---|---|
| **DME** purchased new (excluding disposable and nonreusable supplies) | Limited to the manufacturer's warranty |
| Rented **DME** | Complete repair and maintenance coverage is provided as part of the monthly rental fee |
| Power operated vehicle (3-wheel or 4-wheel non-highway Scooter) | Minimum of one year or manufacturer's warranty, whichever is greater |
| Wheelchair frames (purchased new) and wheelchair parts | |
| Wheelchair codes **K0004**, **K0005**, and **E1161** | Lifetime warranty on side frames and cross braces |

# Payment policy: Ventilator management services

## Services that can be billed

The insurer pays for **either but not both** of the:

- Ventilation management service code (CPT® codes **94002-94005**, **94660**, and **94662**), *or*
- E/M service (CPT® codes **99202-99499**),

## Payment limits

The insurer doesn't pay for ventilator management services when the same provider reports an E/M service on the same day. If a provider bills a ventilator management code and an E/M service for the same day, payment:

- Will be made for the E/M service, *and*
- Won't be made for the ventilator management code.

 

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** (Washington state laws) for purchasing or renting DME | Washington Administrative Code (WAC) 296-20-1102 |
| **Administrative rules** for miscellaneous services and appliances | WAC 296-23-165 |
| **Administrative rules** for payments for rejected and closed claims | WAC 296-20-124 |
| **Administrative rules** for treatments requiring authorization | WAC 296-20-03001 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Negative Pressure Wound Therapy** coverage and treatment | Negative Pressure Wound Therapy coverage decision |
| Professional Services **Fee Schedules** | Fee schedules on L&I's website |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 10: Evaluation and Management (E/M) Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Consultant**: A consultant is a physician or other qualified health care professional who has not agreed to accept transfer of care before an initial evaluation.

**Consultation**: A type of evaluation and management service provided at the request of an attending provider, the department, self-insurer, or authorized department representative to either recommend care for a specific condition or problem, or to determine whether to accept a patient for further treatment. See WAC 296-20-045.

L&I doesn't use the CPT® definitions for consultation services with respect to who can request a consultation service, when a consultation can be requested, and requirements for when to bill a consultation vs. an established or new patient codes. In addition, while chiropractic consultations don't require prior authorization, they do require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer per WAC 296-23-195.

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Established patient**: One who has received professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

When advance registered nurse practitioners and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

**New patient**: One who hasn't received any professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

**Online communications**: Electronic communication conducted over a secure network, including but not limited to electronic mail (email), patient portals, or Claim and Account Center (CAC). Must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

 

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren’t appropriate without a video connection.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)**

Used to indicate an E/M service unrelated to the surgical procedure was performed during a postoperative period. Documentation to support the service must be submitted. Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

**–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**–GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

 

# Payment policy: All E/M services

## Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

**Link**: For more information, see WAC 296-20-030(1).

## Requirements for billing

### All E/M services

Chart notes must contain documentation that justifies the level, type and extent of service billed. (See Documentation guidelines, below.)

### Determining level of visit: New, established or consultation evaluation and management service

If a patient presents with a work related condition and meets the definition in a provider's practice as:

- A **new patient**, then a **new patient** E/M service should be billed, *or*
- An **established patient**, then an **established patient** E/M service should be billed, even if the provider is treating a new work related condition for the first time, *or*
- A **consultation** that has been requested by the attending physician, the department, self-insurer or authorized department representative and all requirements for a **consultation** service has been met, then a **consultation** E/M service should be billed.

Per WAC 296-20-051 providers may **not** bill **consultation** codes for **established patients**.

**Links**: For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

### Using CPT® billing code modifier –25

Modifier **–25** must be appended to an E/M code when reported with another procedure on the same date of service. This applies to all E/M services.

The E/M visit and the procedure must be documented separately.

To be paid, modifier **–25** must be reported in the following circumstances:

- Same patient, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Patient condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

Scheduling back-to-back appointments doesn't meet the criteria for using modifier **–25**.

### Consultations

In accordance with WAC 296-20-051, in cases presenting diagnostic or therapeutic problems to the attending provider, a **consultation** with a specialist may be requested without prior authorization. Consultations can only be requested by the attending provider, the department, self-insurer, or authorized department representative.

The **consultant** must submit their findings and recommendations to the attending provider and the department or self-insurer. The report must be received by the insurer within 15 days from the date of the **consultation**, per WAC 296-20-051. Note that this is different from the requirement noted in Chapter 2: Information for All Providers which states that documentation to support the service billed must be received prior to bill submission or within 30 days of the date of service, whichever comes first.

**Consultation** codes may only be reported by a physician or other qualified health care professional who has not agreed to accept transfer of care before an initial evaluation. **Consultation** services will not be reimbursed for workers who are currently, or have been, under the provider's care within the last three years or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. Such services should be billed as **established patient** E/M services, as listed in the fee schedules.

**Note**: Prior notification to the insurer is required for chiropractic consultants. Refer to Chapter 7: Chiropractic Services for more information regarding the requirements for Chiropractic Consultants.

### Behavioral Health Interventions

Behavioral Health Interventions are a brief course of care with a focus on addressing psychosocial barriers that impede a worker's recovery and improve their ability to return to work. For more information, see Chapter 22: Other Services.

## Documentation guidelines

### SOAP-ER note requirements

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.

Providers are required to submit notes that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation must contain the pertinent history and the pertinent findings found during an exam. These requirements apply regardless of which guidelines the provider is following.

The American Medical Association (AMA) made substantial changes to the **New** and **established patient** E/M services effective January 1, 2021. The insurer has chosen to adopt these changes with slight modification as of July 1, 2021. For example, separately billable services and split billing have their own policies. The insurer doesn't allow shared billing. All other E/M services follow the "1995 Documentation Guidelines for Evaluation and Management Services," or the "1997 Documentation Guidelines for Evaluation and Management Services."

### New and established patients (CPT® 99202-99215)

Select the appropriate level of E/M service based on either:

- Time, *or*
- Medical decision making.

As defined by AMA, Physician/other qualified healthcare professional time includes the following activities, when performed:

- Preparing to see patient (e.g., review of tests),
- Obtaining and/or reviewing separately obtained history,
- Performing a medically appropriate exam and/or evaluation,
- Counseling and educating the patient/family/caregiver,
- Ordering medications, tests, or procedures,
- Referring and communicating with other health care professionals,

- Documenting clinical information in the electronic or other health record,
- Independently interpreting results (when not represented by its own CPT® code),
- Communicating results to the patient/family/caregiver,
- Care coordination.

Only time spent in covered activities by the physician on the calendar day of the visit (midnight to 11:59pm) can be counted toward the E/M visit time. Check-in and check-out time can't be used when determining the length of a visit as this may include ancillary staff time, wait time, etc.

**Documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.**

Examples of services that cannot be included in the time used to determine the level of E/M service, include but are not limited to:

- The performance of other services that are reported separately. See Separately Billable Services,
- Travel,
- Teaching that is general and not limited to discussion that is required for the management of a specific patient,
- Discussion of L&I claims process with the patient/family/caregiver.

**Note**: All questions, discussions, and/or concerns regarding the administrative process of L&I claims should be directed to the insurer.

### All other E/M visits

The 1995 Documentation Guidelines for Evaluation & Management Services or the 1997 Documentation Guidelines for Evaluation and Management Services guidelines are still applicable to all other E/M visits including but not limited to, **consultations** and emergency room visits.

The key components in determining the level of these types of E/M services are:

- The history,
- The examination, *and*
- Medical decision making.

Office visits that consist predominately (more than 50 percent of the visit) of counseling and/or coordination of care activities are the exception. For these visits, time is the key or controlling factor for selecting the level of evaluation and management service. If the level of service is reported based on counseling and/or coordination of care, the chart note must have the total length of the visit documented, as well as what portion of the time was spent performing covered counseling and/or coordinating care activities. The chart note must also describe the counseling and/or the activities to coordinate care. CPT® defines counseling as a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies,
- Prognosis,
- Risk and benefits of management (treatment) options,
- Instructions for management (treatment) and/or follow up,
- Importance with compliance with chosen management (treatment) options,
- Risk factor reduction,
- Patient and family education.

### Consultation reports

In addition to the above, **consultation** reports must include the elements listed in WAC 296-20-01002. These requirements are separate from those outlined in Chapter 2: Information for All Providers. Documentation of the referral must be present in either the attending physician notes or the **consultant's** report. The report must be received by the insurer within 15 days from the date of the **consultation**, per WAC 296-20-051.

**Links**: The following resources contain useful documentation guidelines and requirements:

- American Medical Association Guideline Changes
- The 1995 Documentation Guidelines for Evaluation & Management Services,
- The 1997 Documentation Guidelines for Evaluation and Management Services.

For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

For more information about chiropractic **consultation** services, see WAC 296-23-195.

## Separately billable services

Any procedure represented by their own CPT®, HCPCS, or local codes must be billed separately, and the time spent on these services cannot be included in the time used to determine the level of E/M service. This is applicable to all E/M services, regardless of which guideline the provider is required to follow.

This includes but is not limited to services, such as:

- Care coordination (e.g., telephone calls or online communications), *or*
- Completing forms such as a Report of Accident (ROA) or Activity Prescription Form (APF), *or*
- Independently interpreting results(when represented by its own CPT® code), *or*
- Injections, *or*
- Any treatment-based service.

When these services are performed in conjunction with an E/M service, you must append modifier **–25.**

### CPT® modifier –25

When billing with modifier -25, the insurer follows CPT® guidelines for the billing of an E/M service on the same day as performing a procedure or service identified by a CPT® code.

An E/M can only be billed if the patient's condition required a significant separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

**Note**: Evaluation and reporting is bundled into the payment of many services.

## Examples of billing with modifier –25 (time-based)

### Example 1 (new or established)

A worker goes to the physician's office for a follow-up of their work related elbow and shoulder injury. The physician evaluates and documents findings of the shoulder injury and suggests a steroid injection based on their findings. The physician also evaluates and documents findings related to the elbow injury and determines that physical therapy may provide benefit and provides a referral.

The physician performs the pre-service work (e.g., cursory history, palpatory examination, discusses side effects). The physician then performs the steroid injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the steroid injection (including pre-, intra- and post service work), totaling 25 minutes and an additional separately identifiable E/M service including record review, history, exam, counseling provided and charting time, totaling 30 minutes.

### How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the steroid injection, and
- CPT® code **99214**, with the **–25** modifier.

The physician can't include the time or activities spent performing the steroid injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service, including time spent on each service.

### Example 2 (new or established)

A worker goes to the physician's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the physician finds that they have questions regarding the current treatment plan. The physician documents a 10 minute telephone conversation with the neurologist on the day of the visit including all required documentation elements of that CPT® code. The physician evaluates and documents findings of the head injury as well as the treatment plan.

The physician documents 10 minutes for the telephone call as noted above. The physician also documents the separately identifiable E/M service including record review, history and exam, and charting, totaling 40 minutes.

### How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the telephone call, *and*
- CPT® code **99215**, with the –**25** modifier.

The physician can't include the time or activities spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately. The provider must clearly document each service, including time spent on each service.

## Examples of billing with modifier –25 (not time-based)

### Example 1 (new or established patient)

A worker goes to an osteopathic physician's office to be treated for back pain. The physician performs an E/M visit, including a multi-system examination, reviewing the patient's prior records and counseling the patient on the importance of appropriate lifting techniques for when they return to work. Based on their findings the physician then advises the worker that osteopathic manipulative treatment (OMT) is a therapeutic option for treatment of the condition.

The physician obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (e.g., cursory history, palpatory examination, discusses side effects). The physician then performs the manipulation, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the OMT, including the pre, intra and post service work, in their chart note along with the separately identifiable E/M service (e.g., multi- system examination above and beyond the palpatory exam completed for the OMT service, reviewing records and counseling the patient on return to work).

#### How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the OMT service, and
- **New** or **established patient** E/M code, with the –**25** modifier.

The physician can't include the activities or time spent performing OMT services (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

**Link**: More information on billing for OMT is available in Chapter 25: Physical Medicine Services.

### Example 2 (new or established patient)

The worker goes to the physician's office for a work related 2cm laceration of the worker's scalp. The physician evaluates the laceration and determines sutures are needed. The evaluation of the scalp laceration is considered inclusive of the pre-service work for the laceration repair and therefore is included in the payment of the surgical code.

The worker is also complaining of dizziness. The physician performs an exam to determine if the worker sustained a concussion. The physician places the patient off work and makes a phone call after the encounter to the worker's employer to notify them of the work restriction.

The physician documents the surgical procedure performed (including pre-, intra- and post service work), all required elements of the telephone call placed to the worker's employer, and the separately identifiable E/M service performed for the dizziness.

### How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the laceration repair procedure, and
- Level of telephone call based on the documented length of the call, and
- Level of **new** or **established patient** E/M code with the **–25** modifier.

The physician can't include any of the activities or time spent performing the laceration repair service (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The physician also can't include the time or activities spent performing or documenting the telephone call as this service is required to be billed separately. The provider must clearly document each service.

### Example 3 (multiple visits same day)

A worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury.

That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen. The provider sees the worker for a second office visit.

### How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed with the appropriate level of **established patient** E/M code for this visit alone, with no modifier appended, and
- The unscheduled visit would be billed with the appropriate level of **established patient** E/M code for this visit alone, with the **–25** modifier.

The activities or time spent performing each separate E/M service can't overlap between the two visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (e.g., review of records, referrals). You can only count these activities under the applicable visit.

### Example 4 (consultation)

The worker presents to the physician's office, at the request of their attending provider, as the patient has been experiencing changing chronic symptoms. The referral states the patient has a history of chronic low back pain since their work-related accident. Records were available in advance and are reviewed by the provider with the patient during the course of the visit. The physician obtains an additional history from the patient, completes a review of systems and performs a detailed examination. The physician determines an MRI has not been performed recently and one is necessary based on their findings, so they order an MRI. The physician also recommends a steroid injection today.

The physician obtains verbal consent and performs other pre-service work associated with the injection (e.g., preparation of equipment, prepping the patient, discusses side effects). The physician then performs the injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The physician documents the injection performed (including pre-, intra- and post service work), and the separately identifiable E/M service.

### How to bill for this scenario

For this office visit, the physician would bill the appropriate:

- CPT® code for the injection procedure, and
- Appropriate level **consultation** E/M code with the **–25** modifier.

The physician can't include the activities or time spent performing the injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

# Payment policy: Care plan oversight

## Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

## Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

## Requirements for billing

Payment for care plan oversight to a provider providing post-surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, and
- Modifier **–24** is used.

The medical record must document the medical necessity as well as the level of service performed.

## Payment limits

Payment is limited to one unit:

- Per attending provider,
- Per patient,
- Per 30 day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren't separately payable.

# Payment policy: Case management services – Online communications

## Requirements for online communications

**Online communications** must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association, *or*
- The Federation of State Medical Boards, *or*
- The eRisk Working Group for Healthcare.

## Who must perform these services to qualify for payment

**Online communications** are payable only to providers who have an existing relationship with the worker and personally provide and bill for the service.

## Services that can be billed

Payable **online communications** are billed using local code **9918M** and include:

- Follow up resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent services for an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications,
- Discussing care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claim manager.

Payable **online communications** must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The **online communications** must be with:

- The worker,
- L&I staff,
- Attending Provider,
- Vocational rehabilitation counselors,
- PT, OT, speech language pathologist,
- Nurse case managers,
- L&I medical **consultants**,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

## Services that aren't covered

CPT® codes **99421**-**99423** are not covered. The provider must bill local code **9918M**.

Services that aren't payable include:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine communications related to appointments (including, but not limited to requests and reminders),
- Ordering prescriptions, including requests for refills,
- Test results that are informational only, *or*
- Communications with office staff.

## Requirements for billing

**Online communication** documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The details of the **online communication** (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

A copy of the **online communication** must be sent to L&I.

Providers are not required to submit a separate document for **online communications** with an L&I claim manager made through the Claims and Account Center (CAC). CAC meets the documentation requirements for secure messaging.

## Payment limits

**9918M** is limited to once per day per claim per provider.

# Payment policy: Case management services – Team conferences

## Who must perform team conferences to qualify for payment

Team conferences may be payable when the current or former attending providers, **consultants**, or concurrent care providers meets with one or more of the following:

- An interdisciplinary team of health professionals, such as:
  - Vocational rehabilitation counselors, *or*
  - Nurse case managers, *or*
  - PTs, OTs, and speech language pathologists, *or*
  - Psychologists.
- L&I staff, *or*
- L&I medical **consultants**, *or*
- Employers, *or*
- SIEs/TPAs.

The Department doesn't follow CPT® by requiring all providers to have seen or treated the patient in the previous 60 days.

## Requirements for billing

Team conferences must be in-person or follow telehealth guidelines. See Payment Policy: Telehealth.

The following criteria must be met for team conferences:

- The need for a conference exceeds the day-to-day correspondence/communication among providers, and
- The worker isn't participating in a program in which payment for conference is already included in the program payment (For example, head injury program, or pain clinic), and
- 2 or more disciplines/specialties need to participate.

The insurer won't reimburse PT/OT and/or speech language pathologists for team conferences with members of the same clinic or care organization's physical medicine team.

Use correct CPT® billing codes. ARNPs, PAs, psychologists, speech-language pathologists, PTs, and OTs must bill using non-physician codes.

 

| If the **patient status** is… | And you are **physician**, then bill CPT® code: | And you are a **non-physician**, then bill CPT® code: |
|---|---|---|
| Patient present | Appropriate level E&M | **99366** |
| Patient not present | **99367** | **99368** |

For conferences **exceeding 30 minutes**, multiple units of **99366**, **99367**, and **99368** may be billed. For example, if the duration of the conference is:

- 1-30 minutes, then bill 1 unit, *or*
- 31-60 minutes, then bill 2 units.

## Documentation requirements

Each provider must submit their own team conference documentation; joint documentation isn't allowed for any provider. Each team conference participant's documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the visit, *and*
- The nature of the visit, *and*
- All medical, vocational or return to work decisions made.

In addition to the documentation requirements noted above, team conference documentation must also include a goal oriented, time limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, *or*
- Objective measures of function.

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function. For PTs and OTs, the team conference documentation must include an evaluation of the effectiveness of the previous therapy plan.

Additionally, if the patient is present, and you are a physician, you must comply with Evaluation and Management (E/M) coding guidelines, including the requirements to bill based off of time, medical decision-making, or key components (history, exam and medical decision making), depending on which guidelines the provider is required to follow for the E/M service. Please note, the department follows CPT® in covered counseling topics with the addition of the discussion of medical, surgical, vocational or return to work activities for Team Conferences **only** when billing for services that fall under the "1995 Documentation Guidelines for Evaluation and Management Services," or the "1997 Documentation Guidelines for Evaluation and Management Services."

Providers in a hospital setting may only be paid if the services are billed on a **CMS-1500** with an individual provider account number.

 

# Payment policy: Case management services – Telephone calls

## Who must perform these services to qualify for payment

Telephone calls are payable to the attending provider, **consultant**, psychologist, or other provider only when they personally participate in the call.

## Services that can be billed

Payable telephone calls include:

- Follow up resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent services for an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications,
- Discussing care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claims manager.

These services are payable when discussing or coordinating care or treatment with the following covered participants:

- The worker,
- L&I staff,
- Attending Provider
- Vocational rehabilitation counselors,
- Nurse case managers,
- Health services coordinators (COHE),
- L&I medical **consultants**,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

Telephone calls are payable regardless of when the previous or next office visit occurs. The insurer will pay for telephone calls if the provider leaves a detailed message for the recipient and meets all of the documentation requirements.

## Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine requests for appointments,
- Ordering prescriptions, including requests for refills,
- Test results that are informational only,
- Communications with the worker's attorney, or
- Communications with office staff.

The physician can't include the time spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately.

## Requirements for billing

Any provider who isn't a physician (e.g. ARNPs, PAs, psychologists, PTs, and OTs) must bill using non-physician codes.

| If the **duration** of the telephone call is… | And you are a **physician**, then bill CPT® code: | And you are a **non-physician,** then bill CPT® code: |
|---|---|---|
| 1-10 minutes | **99441** | **98966** |
| 11-20 minutes | **99442** | **98967** |
| 21+ minutes | **99443** | **98968** |

**Note**: Only 1 unit of **99443** or **98968** is payable for calls over 20 minutes. Billing a combination of these codes is not allowed.

## Documentation requirements

Each provider must submit comprehensive documentation for the telephone call that must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The details of the call (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

Mental health services must be authorized for psychiatrists and clinical psychologists to bill these services, per WAC 296-21-270. In addition, please see the Chapter 17: Mental Health Services for additional information on mental health services provided via audio only.

# Payment policy: End stage renal disease (ESRD)

## General information

L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

## Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes **99221**-**99223**),
- An initial inpatient **consultation** (CPT® codes **99251**-**99255**), *or*
- A hospital discharge service (CPT® code **99238** or **99239**).

## Payment limits

E/M services (CPT® codes **99231**-**99233** and **99307**-**99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are bundled in the dialysis service.

# Payment policy: Medical care in the home or nursing home

## General information

L&I allows attending providers to charge for E/M services in:

- Nursing facilities,
- Domiciliary, boarding home, or custodial care settings, *and*
- The home.

## Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

## Requirements for billing

The medical record must document the medical necessity, the level, type and extent of services billed and the location of the service.

# Payment policy: Prolonged E/M

## Requirements for billing

Refer to the table below for prolonged services billing requirements. Refer to CPT® for further details, including documentation requirements.

| If you are billing for this **CPT® code**… | Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service**: |
|---|---|
| **99417** | **99205** or **99215** |
| **99354** | **90837, 90847, 99241-99245, 99324-99337, 99341-99350** or **99483** |
| **99355** | **99354** and 1 of the CPT® codes required to bill **99354** |
| **99356** | **90837**, **90847**, **99218-99226**, **99231-99236**, **99251-99255**, or **99304-99310** |
| **99357** | **99356** and 1 of the CPT® codes required to bill **99356** |

### Prolonged Services Example

#### Prolonged service for an established patient (with or without direct patient contact).

For an 84-minute **established patient** E/M service bill **99215** and **99417** x 2.

To calculate this, the first 40 minutes are applied to the **99215**, which leaves a remaining 44 minutes of prolonged service. This equates to 2 units of **99417**. Do not report **99417** for any additional time increment of less than 15 minutes.

#### Prolonged service for a consultation.

For a 100-minute **consultation** E/M service bill **99244** and **99354** x 1.

To calculate this, the first 60 minutes are applied to **99244**, which leaves a remaining 40 minutes of prolonged service. This equates to 1 unit of **99354**.

Separately billable services and the time spent on those services can't be included in the calculation for the E/M service, including prolonged services. See also separately billable services section.

## Payment limits

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient.

Prolonged E/M service codes are payable only when another time-based E/M code or applicable psychotherapy code is billed on the same day.

The following prolonged services are not payable:

- Prolonged services without direct patient contact, except for **new** or **established patients**, (CPT® **99358**, **99359**), *or*
- Prolonged clinical staff services (CPT® **99415**, **99416**).

**Links**: For more information on prolonged E/M services, see the 1995 Documentation Guidelines for Evaluation and Management Services, the 1997 Documentation Guidelines for Evaluation and Management Services or the CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes.

# Payment policy: Split billing – Treating two separate conditions

## Requirements for billing

If the worker is treated for two unrelated conditions at the same visit, the charge for the service must be divided equally between the payers and/or claims.

If evaluation and treatment of the two injuries increases the complexity of the visit:

- A higher level E/M code might be billed, *and*
- If this is the case, the applicable guidelines must be followed and the documentation must support the level of service billed.

For State Fund claims, when submitting:

- Paper bills to L&I, list all workers' compensation claims treated in Box 11 of the **CMS-1500** form (F245-127-000) *or*
- Electronic claims, list all workers' compensation claims treated in the remarks section of the **CMS-1500** form.

L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition:

- Providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit.

## Payment limits

A physician would only be paid for more than one evaluation and management visit if there were two separate and distinct visits on the same day (see Example 3, below).

Scheduling back-to-back appointments doesn't meet the criteria for using the **–25** modifier. See more about Using billing code modifier **–25** in the All E/M services payment policy section of this chapter.

## Examples of split billing

### Example 1

A worker goes to a provider to be treated for a work related shoulder injury and a separate work related knee injury. The provider treats both work related injuries.

#### How to bill for this scenario

For State Fund claims, the provider bills for one visit listing both workers' compensation claims in Box 11 of the **CMS-1500** form (F245-127-000).

L&I will divide charges equally to the claims. For self-insured claims, contact the SIE or their TPA for billing instructions.

### Example 2

A worker goes to a provider's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident.

#### How to bill for this scenario

The provider would bill:

- 50% of their usual and customary fee to L&I or the SIE, and
- 50% to the insurance company paying for the motor vehicle accident.

L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

### Example 3

In the morning, a worker arrives at a physician's office for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit.

#### How to bill for this scenario

Since the two visits were completely separate, both E/M services may be billed as follows:

- The scheduled visit would be billed with the appropriate level of E/M code for this visit alone, with no modifier appended and
- The unscheduled visit would be billed with the appropriate level of E/M code for this visit alone, with the **–25** modifier.

# Payment policy: Standby services

## Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face patient contact, *and*
- The standby provider isn't concurrently providing care or service to other patients during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

## Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Round all fractions of a 30-minute period downward.

# Payment policy: Telehealth for evaluation and management services

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

## Services that must be performed in person

In-person evaluation is required for non-mental health services when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of attending provider, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- Consultations requested to determine if conservative care is appropriate.

An in-person evaluation is required in all cases when:

- A worker files a reopening application, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- Consultations in accordance with the restrictions noted below, *or*
- The worker does not want to participate via **telehealth**.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

## Teleconsultations

All consultations must be requested by the attending provider, department, self-insurer or authorized department representative.

The insurer covers teleconsultations when the following conditions have been met:

- The **telehealth** provider must be a(n): doctor as described in WAC 296-20-01002; ARNP; PhD clinical psychologist; or Consulting DC who is an approved consultant with L&I. This provider must note which provider referred the worker, *and*
- The referring provider must be one of the following: MD; DO; ND; DPM; OD; DMD; DDS; DC; ARNP; PA; or PhD clinical psychologist, *and*
- The patient must be present at the time of the consultation, *and*
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the **telehealth** provider, *and*
- The exam of the patient must be under the control of the **telehealth** provider, *and*
- The **telehealth** provider must submit a written report documenting this service to the referring provider, and must send a copy to the insurer.

**Links**: Learn more about coverage of these services in WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

## Services that are covered

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Store and Forward

**G2010** is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the patient provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

## Services that aren't covered

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Hands-on services,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report),

- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

**Note**: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs any service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services or expenses.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| Originating site is… | Worker's home | | |
|---|---|---|---|
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See the documentation requirements in this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same payment limits listed in this chapter apply regardless of how the service is rendered to the worker.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for E/M services | Washington Administrative Code (WAC) 296-20-045<br>WAC 296-20-051<br>WAC 296-20-01002<br>WAC 296-23-195<br>WAC 296-20-030 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **CMS 1500** form | F245-127-000 |
| The **1995 Documentation Guidelines for Evaluation & Management Services** | 1995 guidelines |
| The **1997 Documentation Guidelines for Evaluation and Management Services** | 1997 guidelines |
| The **2021 Documentation Guidelines for Evaluation and Management Services** | 2021 guidelines |
| **Fee schedules** for all healthcare professional services (including chiropractic) | Fee schedules on L&I's website |
| Payment policies **Chiropractic Services** | Chapter 7: Chiropractic Services |
| Payment Policies **Physical Medicine Services** | Chapter 25: Physical Medicine Services |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 11: Home Health Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Attendant care home health services**: Attendant services support personal care or assist with activities of daily living of a medically stable worker with physical or cognitive impairments. Attendant care home health is provided in the workers' home.

**By report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report, see WAC 296-20-01002.

**Chore services**: Housecleaning, laundry, shopping, meal planning and preparation, transportation of the injured worker, errands for the injured worker, recreational activities, yard work, and child care.

**Note**: Chore services aren't a covered benefit. See WAC 296-23-246.

**Home health services**: Multidisciplinary (RN, LPN, nursing aide, PT, OT, speech,) assessments and interventions for short-term rehabilitative therapy, home assessments for equipment and safety and long term nursing supervision for wound care, bowel and bladder management.

**Home infusion services**: Services to provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home, along with nursing services. Home infusion services can be authorized independently or in conjunction with home health services.

**Personal care**: May include, but isn't limited to administration of medication, bathing, personal hygiene and skin care, bowel and bladder incontinence, ostomy care, feeding assistance, mobility assistance, turning and positioning, range of motion exercises, transfers or walking, supervision due to cognitive impairment, behavior, or blindness.

 

# Payment policy: Home health services

## General information

When services become proper and necessary to treat a worker's accepted condition, the insurer will pay for aide, RN/LPN, physical therapy (PT), occupational therapy (OT), and speech therapy services provided by a licensed home health agency.

Most **home health services** are interventions to improve function and safety between hospital care and outpatient care and therapy. These services aren't intended for attendant care delivered in the home. The expectation of **home health services** is to enable the worker to receive outpatient, rehabilitative or medical services.

Home health therapies can be approved for the following types of needs:

- Post injury or post-surgical activity restrictions, restrictions on the ability to use 2 or more extremities, bilateral non-weight bearing restriction, or post-operative infection requiring IV antibiotics;
- Inability to ambulate or inability to maneuver a wheelchair;
- Inability to transfer in or out of a vehicle with or without assistance;
- Inability to safely negotiate ingress or egress of residence;
- Unable to sit (supported or unsupported) or alternate between sitting and standing for up to 2 hours;
- Inability to bathe or dress themselves if they live alone.
- No available transportation service exists due to rural setting; *or*
- No outpatient facilities are available to provide medically necessary care.

**Links**: For additional information on **home health services**, see WAC 296-20-03001(8) and WAC 296-23-246.

## Prior authorization

All **home health services** require prior authorization.

The insurer will determine maximum hours and type of authorized home health care based on a nursing assessment of the worker's **personal care** needs that are proper and necessary and related to the worker's industrial injury.

All **home health services** must be requested by a physician. The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

**Home health services** may be terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

## Home health agency requirements

Home health agencies provide skilled nursing and therapy related services. They must be licensed as a home health agency.

Services for which home health agencies may bill include:

- Nursing
- Home health aide
- Physical therapy
- Occupational therapy
- Speech therapy

## Home health care provider requirements

Aide, RN, LPN, physical therapy (PT), occupational therapy (OT), and speech therapy (ST).

 

## Services that can be billed

| HCPCS code | Description and notes | Max fee |
|---|---|---|
| G0151 | Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day | **$43.83** |
| G0152 | Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day | **$45.45** |
| G0153 | Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day | **$45.45** |
| G0159 | Plan of care established by Physical Therapist in the home, 15 min units | **$45.45** |
| G0160 | Plan of care established by Occupational Therapist in the home, 15 min units | **$45.45** |
| G0162 | Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units | **$45.45** |
| G0299 | Services of skilled nurse RN in the home. 15 min units | **$45.45** |
| G0300 | Services of skilled nurse LPN in the home. 15 min units | **$40.89** |
| 8970H | Home Health Aide Service up to 2 hours | **$65.33** |
| 8971H | Home Health Aide Services each additional 15 minutes | **$8.17** |

## Payment limits

Home Health Aide Service codes **8970H** and **8971H** can only be billed when there is RN oversight.

Base Rate Code **8970H** is billable once per day and covers up to 2 hours.

Add-on Code **8971H** is only billable with Base Rate Code **8970H**. Each unit of **8971H** equals 15 minutes. Up to 8 units per day are billable.

For **8970H** and **8971H** the insurer follows the timed code policies established by CMS in section 20.2 (reporting of service units with HCPCS), chapter 5 of the Medicare Claims Processing Manual (Internet-Only Manual 100-04).

 

## Documentation

The following documentation is required to be submitted by the home health care provider within 15 days of beginning the services:

- Attending provider's treatment plan and/or orders by the attending provider,
- An initial evaluation by the RN or PT/OT (bill using **G0159**, **G0160**, and **G0162** see table above), *and*
- A treatment plan.

Updated plans must be submitted every 30 days thereafter for authorization periods greater than 30 days.

Providers must submit documentation to the insurer to support each day billed that includes:

- Begin and end time of each caregiver's shift,
- Name, initials, and title of each caregiver, *and*
- Specific care provided and who provided the care.

Authorization for continued treatment requires:

- Documentation of the worker's needs and progress, *and*
- Renewed authorization at the end of an approved treatment period.

## Durable medical equipment (DME)

Durable medical equipment may require specific authorization prior to purchase or rental. Codes that require prior authorization are noted with a Y in the "PRIOR AUTH" column.

**Link**: To see which codes require prior authorization, see the HCPCS fee schedule.

## Worker responsibilities

The worker is expected to be present and ready for scheduled home health nurse or therapist treatment. The insurer may terminate services if the work is not present, refuses treatment or assessment.

 

# Payment policy: Attendant care home health services

Attendant services support **personal care** or assist with activities of daily living of a medically stable worker with physical or cognitive impairments. **Attendant care home health** is provided in the workers' home.

**Link**: See WAC 296-23-246 for details about Attendant Care.

## Prior authorization

All attendant care services require prior authorization.

The insurer will determine maximum hours and type of authorized attendant care based on a nursing assessment of the worker's **personal care** needs.

Services must be proper and necessary and related to the worker's industrial injury or covered under a department medical treatment order.

Attendant care services may be **terminated or not authorized if**:

- Behavior of worker or others at the place of residence is threatening or abusive,
- Worker is engaged in criminal or illegal activities,
- Worker doesn't have the cognitive ability to direct the care provided by the attendant and there isn't an adult family member or guardian available to supervise the attendant,
- Residence is unsafe or unsanitary and places the attendant or worker at risk, *or*
- Worker is left unattended during approved service hours by the approved provider.

The insurer will notify the provider in writing when current approved hours are modified or changed.

## Attendant care agency requirements

Attendant care services may be provided by a *home health licensed agency* or a *home care licensed agency*. The agency providing services must be able to provide the type of care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

Attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services.

The agency can bill workers for hours that aren't approved by the insurer if the worker is notified in advance that they are responsible for payment.

 

### Home Health Agencies

Home health agencies provide skilled nursing and therapy related services. Home health agencies must have registered nurse (RN) supervision of caregivers providing care to a worker.

Examples of services include nursing and home health aide.

### Home Care Agencies

Home care agencies provide non-medical services to people with functional limitations.

Examples of non-medical services include: Activities of daily living, such as assistance with ambulation, transferring, bathing, dressing, eating, toileting, and personal hygiene to facilitate self-care.

## Attendant care provider requirements

Caregivers and services provided are dependent on the type of agency license providing the services and the needs of the worker.

## Payment limits

Reimbursement for attendant care services includes supervision and training and is not billed separately(This does not include nurse delegation).

Attendant care providers can't bill for services the attendant performs in the home while the worker is away from the home.

The insurer won't pay services for more than 12 hours per day for any one caregiver, unless specifically authorized.

The insurer won't pay for care during the time the caregiver is sleeping.

## Services that can be billed

| HCPCS code | Description | Max fee |
|---|---|---|
| **S9122** | Attendant in the home provided by a home health aide certified or certified nurse assistant per hour | **$33.05** |
| **S9123** | Attendant in the home provided by a registered nurse per hour | **$66.46** |
| **S9124** | Attendant in the home provided by licensed practical nurse per hour | **$47.80** |

**Link**: To see which codes require prior authorization, see the HCPCS fee schedule.

## Documentation

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift,
- Printed name of caregiver, initials, signature and title of each caregiver, and
- Specific care provided and who provided the care.

## Chore services

**Chore services** and other services that are only needed to meet the worker's environmental needs aren't covered.

**Link**: Chore services aren't a covered benefit. See WAC 296-23-246.

## Attendant care services in hospitals or nursing facilities

Attendant care services won't be covered when a worker is in the hospital or a nursing facility unless:

- The worker's industrial injury causes a special need that the hospital or nursing facility can't provide, and
- Attendant care is authorized specifically to be provided in the hospital or nursing facility.

## Independent nurse evaluation reports

All RN evaluation reports must be submitted to the insurer:

- Within 15 days of the initial evaluation, *and then*
    - Annually, *or*
    - When requested, *or*
    - When the worker's condition changes and necessitates a new evaluation.

If a current nursing assessment is unavailable, a nursing evaluation will be conducted to determine the level of care and the maximum hours of **personal care** needs the worker requires.

An independent nurse evaluation requested by the insurer, may be billed under Nurse Case Manager or Home Health Agency RN codes, using their respective codes. (See more information about these reports under Requirements for billing, below.)

**Link**: See Chapter 20: Nurse Case Management for additional details.

## Wound care

When attendant care agencies are providing care to a worker with an infectious wound, prior authorization and prescription from the treating physician are required.

In addition to prior authorization, when caregivers are providing wound care a prescription from the treating provider is required to bill for infection control supplies (HCPCS code **S8301**).

An invoice for the supplies must be submitted with the bill.

## Worker travel

Workers who qualify for attendant care and are planning a long-distance trip must inform the insurer of their plans and request specific authorization for coverage during the trip.

The insurer won't cover travel expenses of the attendant or authorize additional care hours.

Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

The worker must coordinate the trip with the appropriate attendant care agencies.

## Temporary or respite care

If in-home attendant care can't be provided by an agency, the insurer can approve a temporary stay in a residential care facility or skilled nursing facility.

Temporary or respite care requires prior authorization. The agency providing respite care must meet L&I criteria as a provider of **home health services**.

The insurer can approve services for a spouse or family member who provides either paid or unpaid attendant care when respite (relief) is required.

**Note**: Spouses won't be paid for respite care.

## Spouse attendant care

Spouses may continue to bill for spouse attendant care if they:

- Aren't employed by an agency, *and*
- Provided insurer approved attendant services to the worker prior to October 1, 2001, *and*
- Met criteria in the year 2002.

**Link**: For more information on laws about spouse attendant care, see WAC 296-23-246.

Spouse attendants may bill up to 70 hours per week. Also:

- Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation, which must be performed yearly, *and*
- If the worker requires more than 70 hours per week of attendant care the insurer can approve a qualified agency to provide the additional hours of care, *and*
- The insurer will determine the maximum amount of additional care based on an RN evaluation.
- Spouse attendants won't be paid during sleeping time.

## Services that can be billed

| HCPCS code | Description | Max fee |
|---|---|---|
| **8901H** | Spouse attendant in the home per hour | **$15.00** |

## Documentation

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of caregiver's shift,
- Printed name of caregiver, initials, signature of caregiver, *and*
- Specific care provided.

# Payment policy: Home infusion services

**Home infusion services** provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home, along with nursing services. **Home infusion services** can be authorized independently or in conjunction with **home health services**.

## Prior authorization

Prior authorization is required for all **home infusion services** including nurse services, drugs, and supplies.

The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition.

## Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy, as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

## Services that can be billed

| CPT® code | Description and notes | Max fee |
|---|---|---|
| **99601** | Skilled RN visit for infusion therapy in the home. First 2 hours per visit | **$175.40** |
| **99602** | Skilled RN visit for each additional hour per visit | **$73.76** |

 

### Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

**Note**: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.

### Supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes.

# Payment policy: In-home hospice services

## Prior authorization

In-home hospice services must be preauthorized and may include **chore services**. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

## Services that can be billed

| HCPCS code | Description and notes | Max fee |
|---|---|---|
| **Q5001** | Hospice care, in the home, per diem. Applies to in-home hospice care. | **By report** |

**Note**: Social work and **chore services** aren't covered, except as part of home hospice care.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for home health services | Washington Administrative Code (WAC) 296-20-03001(8)<br>WAC 296-20-1102<br>WAC 296-23-246 |
| **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 professional services (including home health) | Fee schedules on L&I's website |
| Payment policies for **durable medical equipment (DME**) | Chapter 9: Durable Medical Equipment |
| Payment policies for **hospice services performed in a facility** | Chapter 36: Nursing Home and Other Residential Care Services |
| Payment policies for **physical therapy and occupational therapy** | Chapter 25: Physical Medicine Services |
| Payment policies for **supplies** | Chapter 28: Supplies, Materials, and Bundled Services |

## Need more help?

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Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 12: Impairment Rating Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Body areas**: For rating impairment, the following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Genitalia, groin, buttock,
- Back,
- Abdomen, *and*
- Each extremity.

Each extremity is counted **once per extremity examined** when determining standard or complex codes.

**Organ systems**: For rating impairment, the following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Respiratory,
- Genitourinary,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, *and*
- Hematologic/lymphatic/immunologic.

# Payment policy: Impairment ratings

## Prior authorization

Prior authorization is only required when:

- A psychiatric impairment rating is needed, *or*
- An IME is scheduled.

Only the claim manager may request and authorize local billing code **1198M**.

## When and how to perform an impairment rating

### When to rate impairment

When the worker has reached maximum medical improvement (MMI) or when requested by the insurer. Impairment rating should occur during the closing exam.

Rate impairment only for medical conditions accepted under the claim.

### Body areas and organ systems

The definitions of **body areas** and **organ systems** from Current Procedural Terminology (CPT®) book must be used to distinguish between standard and complex impairment rating.

### How to rate impairment

Use the appropriate rating system.

**Link**: For an overview of systems for rating impairment, see the Medical Examiners' Handbook.

Include the objective findings to support the impairment rating. The objective medical information is required if a worker requests the claim be reopened. **If there isn't an impairment, document that in the report.**

Impairment rating reports must include all of the following elements:

- **MMI**: Statement that the patient has reached maximum medical improvement (MMI) and that no further curative or rehabilitative treatment is recommended, *and*
- **Examination**: Pertinent details of the physical examination performed (both positive and negative findings). The report must include pertinent measurements (e.g. range of motion) even if they are within normal limits. This is important to document for comparison with potential reopening applications, *and*

- **Diagnostic tests**: Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam, *and*
- **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example:
    - The AMA Guidelines to the Evaluation of Permanent Impairment Fifth Edition, *or*
    - The Washington State Category Rating System.
- **Rationale**: The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

**Links**: Refer to WAC 296-20-19000 through WAC 296-20-19030 and WAC 296-20-200 through WAC 296-20-690, and for amputations refer to RCW 51.32.080.

## Who must perform these services to qualify for payment

Attending providers (APs) who are permitted to rate their own patients don't need an IME provider account number and may use their existing provider account number.

Qualified APs may rate impairment of their own patients.

Providers may only give ratings for areas of the body or conditions within their scopes of practice.

If the AP is unable or unwilling to perform the rating examination, the AP can ask a consultant to perform the rating examination.

Psychologists may not be an attending provider (except for Crime Victim's claims) and may not rate impairment for injured workers but may rate impairment for victims of crime.

 

Providers qualified to provide this service include the following:

| Provider type | Can you rate impairment as an AP or consultant? |
|---|---|
| Medicine and surgery | Yes |
| Osteopathic medicine and surgery | Yes |
| Podiatric medicine and surgery | Yes |
| Dentistry | Yes |
| Chiropractic | Yes, if L&I-approved IME examiner |
| Naturopathy | No |
| Optometry | No |
| Physicians' Assistant | No |
| Advanced Registered Nurse Practitioners (ARNP), including Psychiatric ARNPs | No |

**Links**: To see how these qualifications are set in state law, see WAC 296-20-2010.

For more details on the topic of impairment ratings, refer to the Medical Examiners' Handbook.

## Services that can be billed

The impairment rating exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the local billing code based on the number of **body areas** or **organ systems** that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related (see fee schedule, below).

Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

| Local billing code | Description | Maximum fee |
|---|---|---|
| **1190M** | **Comprehensive Hearing loss exam**<br>Use this code for comprehensive examination of the hearing system.<br>The hearing system is comprised of two **organ systems** that need to be thoroughly examined for evaluation of the contended or accepted condition(s). Included in this code are the following requirements:<br>• This specialty exam is directed only toward the affected body area or organ system.<br>• Familiarity with the history of the industrial injury, exposure or condition through patient interview and medical and work records if available.<br>• Diagnostic tests needed including audiograms are ordered and interpreted by the physician.<br>• The degree of impairment is based on the audiogram and is interpreted by a physician.<br>• The report must contain the required elements noted in the Medical Examiners' Handbook.<br>• The report conclusions address how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or conditions(s).<br>Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of **organ systems** and **body areas** can be found in the CPT® manual. | **$700.56** |

| Local billing code | Description | Maximum fee |
|---|---|---|
| **1191M** | **Impairment rating by attending physician, standard, 1-3 body areas or organ systems.**<br>Use this code if there are 1-3 **body areas** or **organ systems** that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:<br>• Familiarity with the history of the industrial injury or condition.<br>• Physical exam is directed only toward the affected body area or organ system.<br>• Diagnostic tests needed are ordered and interpreted.<br>• Impairment rating is performed.<br>• Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook.<br>• The report conclusions address how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or condition(s).<br>Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of **organ systems** and **body areas** can be found in the CPT® manual. | **$700.56** |

| Local billing code | Description | Maximum fee |
|---|---|---|
| **1192M** | **Impairment rating by attending physician, complex, 4 or more body areas, or organ systems.**<br>Use this code if there are 4 or more **body areas** or **organ systems** that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:<br>• Familiarity with the history of the industrial injury or condition.<br>• Physical exam is directed only toward the affected body area or organ system.<br>• Diagnostic tests needed are ordered and interpreted.<br>• Impairment rating is performed.<br>• Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook.<br>• The report conclusions address how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or condition(s).<br>Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of **organ systems** and **body areas** can be found in the CPT® manual. | **$875.69** |

| Local billing code | Description | Maximum fee |
|---|---|---|
| **1194M** | **Impairment rating by consultant, standard, 1-3 body areas or organ systems.**<br>Use this code if there are 1-3 **body areas** or **organ systems** that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:<br>• Records are reviewed.<br>• Physical exam is directed only toward the affected areas or **organ systems** of the body.<br>• Diagnostic tests needed are ordered and interpreted.<br>• Impairment rating is performed.<br>• Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook.<br>• The report conclusions address how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or condition(s).<br>Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of **organ systems** and **body areas** can be found in the CPT® manual. | **$700.56** |

| Local billing code | Description | Maximum fee |
|---|---|---|
| **1195M** | **Impairment rating by consultant, complex, 4 or more body areas or organ systems.**<br>Use this code if there are 4 or more **body areas** or **organ systems** that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:<br>• Records are reviewed.<br>• Physical exam is directed only toward the affected areas or **organ systems** of the body.<br>• Diagnostic tests needed are ordered and interpreted.<br>• Impairment rating is performed.<br>• Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook.<br>• The report conclusions address how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or condition(s).<br>Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of **organ systems** and **body areas** can be found in the CPT® manual. | **$875.69** |
| **1198M** | **Impairment rating, addendum report.**<br>Must be requested and authorized by the claim manager.<br>Addendum report for additional information which necessitates review of new records.<br>Payable to attending physician or consultant.<br>This code isn't billable when the impairment rating report didn't contain all the required elements. (See the Medical Examiners' Handbook for the required elements.) | **$133.21** |

### Rating hearing loss

When performing a comprehensive exam for hearing loss, the report must include a statement regarding eligibility for permanent partial impairment. Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within two years of last injurious exposure.

## Requirements for billing

APs use billing codes **1191M** and **1192M**.

Consultants use billing codes **1194M** and **1195M**.

Only the claim manager may request and authorize local billing code **1198M**.

## Additional information: How to find out if an impairment rating is scheduled

To see if an IME is scheduled, for a claim that is:

- **State Fund**, use our secure online Claim & Account Center.
- **Self-insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call 1-800-762-3716.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules and other Washington state laws** for impairment ratings | Washington Administrative Code (WAC) 296-20-19000<br>WAC 296-20-19030<br>WAC 296-20-200<br>WAC 296-20-2010<br>WAC 296-20-690<br>Revised Code of Washington (RCW) 51.32.080 |
| **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 services (including impairment ratings) | Fee schedules on L&I's website |
| **How to perform an impairment rating** | Medical Examiner's Handbook |
| **Laws** for Medical Aid | RCW 51.28.055 |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 13: Independent Medical Exams (IME)

**Effective July 1, 2022**

**Link**: Look for possible **updates and corrections** to these payment policies on L&I's website. The temporary telehealth policy for IMEs is in effect until December 31, 2022.

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Body areas**: For IMEs, the following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Abdomen,
- Genitalia, groin, buttock,
- Back, and
- Each extremity (each extremity is counted once per extremity examined when determining standard or complex codes)

**By Report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of **By Report (BR)**, see WAC 296-20-01002.

**Organ systems**: For IMEs, the following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Genitourinary,
- Respiratory,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, and
- Hematologic/ Lymphatic/ Immunologic.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers are utilized in this chapter:**

**–7N (X-rays and laboratory services in conjunction with an IME)**

When X-rays, laboratory, neuropsychological testing and other diagnostic tests are requested for the IME, identify the service(s) by adding the modifier – 7N to the usual procedure number.

**–26 (Professional component)**

Certain procedures are a combination of the professional (—26) and technical (—TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, the —26 modifier can't be used.

**Link**: Procedure codes are listed in the L&I Professional Services Fee Schedules, Radiology and Laboratory Sections.

# Payment policy: Independent Medical Exams (IMEs)

## General information

Independent medical exams (IMEs) are medical examinations requested by the department or self-insured employers to answer medical and legal questions about the claim. Performing IME or ratings requires considerable judgement and understanding of specialized terms and a mastery of skills that may not be part of a doctor's original training. IME providers must be familiar with and follow the Medical Examiners' Handbook.

Per RCW 51.36.070(2), the department or self-insurer shall provide the physician performing the exam all relevant medical records from the worker's claim file.

## Who must perform services to qualify for payment

Only **department approved** IME Providers with an IME provider account number can bill IME codes. Applications are available on our website.

For more information on **becoming an approved IME provider** or to perform impairment ratings, see the Medical Examiners' Handbook.

To receive email updates on IMEs, subscribe to the ListServ.

## Services that can be billed

### Interpretation services during IMEs

Interpreter services are covered during IMEs. All interpreter requests must be scheduled through the scheduling system. For additional information regarding interpreter services, see Chapter 14: Language Access Services. For Sign Language interpretation, see Chapter 22: Other Services.

## IME fee schedule

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1104M** | **IME, addendum report. Requested and authorized by claim manager**<br>Addendum report for information that isn't requested in original assignment, which necessitates review of records. Additional charges aren't payable. Not to be used in place of a new IME, if requested by the insurer.<br>Fee already includes additional reimbursement for file review.<br>May only be used for review of job analysis when records are re-reviewed and a report attesting to that re-review is submitted with the job analysis.<br>The review of diagnostic testing or study results ordered by the examiner isn't payable under this code.<br>Not payable with **1066M**. | **$162.46** |
| **1105M** | **IME Physical Capacities Estimate** (F242-387-000)<br>Must be requested by the insurer.<br>Bill under one examiner's provider account number for multi-examiner exams. (Bill once per exam.) | **$35.56** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1108M** | **IME, standard exam – 1-3 body areas or organ systems**<br>Use this code if there are only 1-3 **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s).<br>L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient.<br>Use of this code requires:<br>• Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook.<br>• Physical exam directed only toward the affected **body areas** or **organ systems**.<br>• Appropriate diagnostic tests ordered and interpreted.<br>• Impairment rating performed if requested.<br>• The IME report containing the required elements noted in the Medical Examiners' Handbook.<br>• Report conclusions addressing how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or condition(s).<br>• Review of up to 2 job analyses.<br>**Note**: Additional examiners use **1112M**. | **$700.56** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1109M** | **IME, complex exam – 4 or more body areas or organ systems**<br>Use this code if there are 4 or more **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s).<br>L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the worker.<br>Use of this code requires:<br>• Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook.<br>• Physical exam directed only toward the affected **body areas** or **organ systems**.<br>• Appropriate diagnostic tests ordered and interpreted.<br>• Impairment rating performed if requested.<br>• The IME report containing the required elements noted in the Medical Examiners' Handbook.<br>• Report conclusions addressing how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or condition(s).<br>• Review of up to 2 job analyses.<br>**Note**: Additional complex examiners use **1126M**. | **$875.69** |
| **1112M** | **IME, additional examiner for Standard IME**<br>Use where input from more than 1 examiner is combined into 1 report. Includes:<br>• Record review,<br>• Exam, *and*<br>• Contribution to combined report.<br>L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker.<br>**Note**: One examiner on IMEs with a combined report should bill a standard (**1108M**). | **$700.56** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1118M** | **IME by psychiatrist**<br>Psychiatric diagnostic interview with or without direct observation of a physical exam.<br>L&I expects these exams will typically involve at least 60 minutes of face-to-face time with the worker. Includes:<br>• Review of records, other specialist's exam results, if any.<br>• Consultation with other examiners and submission of a joint report if scheduled as part of a panel.<br>• Report with a detailed chronology of the injury or condition, as described in the Medical Examiners' Handbook.<br>• Review of up to 2 job analyses.<br>Also includes impairment rating, if applicable. | **$1,269.76** |
| **1123M** | **IME, communication issues**<br>Exam was unusually difficult due to expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report.<br>If an interpreter is needed, verify and record name of interpreter in report.<br>Bill once per examiner per exam.<br>Isn't payable with a no show fee (**1144M**). | **$233.14** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| 1124M | **IME, other, by report**<br>Requires preauthorization and prepay review:<br>For State Fund claims, contact the claims manager, or<br>For self-insured claims, contact the self-insured employer or third party administrator.<br>Billable services under this code are limited to:<br>• Research and review for chemically related illness claims to be billed only by contracted providers authorized to perform CRI IMEs,<br>• Security services for potentially violent workers, or<br>• Guard services for incarcerated workers. | **By Report** |
| 1125M | **Physician travel per mile**<br>Allowed when roundtrip exceeds 14 miles using Personally Owned Vehicles.<br>Code usage is limited to extremely rare circumstances, such as IMEs in correctional facilities.<br>Requires preauthorization and prepay review:<br>• For State Fund claims, call Provider Quality and Compliance at **800-468-7870**, or<br>• For self-insured claims, contact the self-insured employer or third party administrator. | **$5.70** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1126M** | **IME, additional examiner for Complex IME**<br>Use where input from more than 1 examiner is combined into 1 report. Includes:<br>• Record review,<br>• Exam, and<br>• Contribution to combined report.<br>L&I expects these exams will typically involve at least 45 minutes of face-to-face time with the worker.<br>**Note**: One examiner on an IME that has a combined report should bill a complex exam code. The IME report must meet the criteria required for a complex IME (**1109M**). | **$875.69** |
| **1128M** | **Occupational disease report** (Doctor's Assessment of Work Relatedness for Occupational Diseases)<br>Must be requested by insurer.<br>Examples of conditions which L&I considers occupational diseases are:<br>• Occupational carpal tunnel syndrome,<br>• Noise-induced hearing loss,<br>• Occupational dermatitis, and<br>• Occupational asthma.<br>The legal standard is different for occupational diseases from occupational injuries. Refer to RCW 51.080.140 on the definition for occupational disease.<br>This is a detailed assessment of work relatedness, with the exact content presented in the Medical Examiners' Handbook.<br>A doctor may bill this code **only once for each worker.** | **$215.60** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1129M** | **IME, extensive file review by examiner**<br>Units of service are based on the number of hardcopy pages reviewed by the IME examiner on microfiche, paper, Claim and Account Center, or other medium.<br>Review of the **first 400 hardcopy pages** is included in the base exam fee (**1108M**, **1109M**, **1112M**, **1118M**, **1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**).<br>Bill for each additional page reviewed beyond the first 400 hardcopy pages.<br>Isn't payable with IME late cancellations (**1143M**) or IME no show fee (**1144M**)**.**<br>Only the following document categories will be paid for **unless** the authorizing letter requests a review of **all** documents:<br>• Medical files,<br>• History,<br>• Report of Accident,<br>• Reopen Application, *and*<br>• Other documents specified by claim manager or requestor.<br>Bill per examiner.<br>Not payable for review of duplicate documents.<br><br>**Note**: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook. | **$1.17** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| **1130M** | **IME, terminated exam**<br>Bill for exam ended prior to completion.<br>Requires file review, partial exam by the examiner and report (including reasons for early termination of exam).<br>Bill per examiner.<br>Terminated exams don't include failure to obtain an interpreter. Terminated exams could be payable when the worker is uncooperative or becomes ill in the middle of the exam.<br>**Note**: A partial exam is face-to-face time between the examiner and the worker where, at a minimum, the worker's history is obtained. | **$413.00** |
| **1139M** | **No show fee for missed neuropsychological testing.**<br>Must be scheduled or approved by department or self-insurer as part of an independent medical examination. (For more information, see: WAC 296-20-010(5).)<br>This code is payable only once per independent medical examination assignment.<br>Must notify department or self-insurer of no-show as soon as possible.<br>Bill only if worker fails to show and appointment can't be filled. | **$1,036.71** |
| **1140M** | **No show fee for missed Functional Capacity Evaluation (FCE).**<br>Must be scheduled or approved by department or self-insurer as part of an independent medical examination. (For more information, see: WAC 296-20-010(5)<br>This code is payable only once per independent medical examination assignment.<br>Must notify department or self-insurer of no show as soon as possible.<br>Bill only if worker fails to show and appointment can't be filled. | **$331.63** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| 1141M | **IME, rare specialty exam – 1-4 or more body areas or organ systems**<br>Use this code in lieu of 1108M or 1109M when exam is performed by one of the following rare provider specialties:<br>• Allergy and Immunology<br>• Cardiology<br>• Dermatology<br>• Endocrinology<br>• Gastroenterology<br>• Hematology<br>• Obstetrics and Gynecology<br>• Oncology<br>• Ophthalmology<br>• Pain Medicine/Dolorology<br>• Pulmonology<br>• Urology<br>L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker.<br>**Note**: Follow the exam requirements for either 1108M or 1109M depending on number of body areas or organ systems involved. This specialty list may be updated depending on the number of examiners available. For additional rare specialty examiners use 1142M.<br>1108M or 1109M may be billed with an 1141M if one of the examiners is completing a standard or complex exam, and the other is completing a rare specialty exam. Only the rare specialty examiner may bill 1141M. | **$1,269.76** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| 1142M | **IME, additional examiner for Rare Specialty IME**<br>Use where input from more than 1 rare specialty examiner is combined into 1 report. Includes:<br>• Record review,<br>• Exam, *and*<br>• Contribution to combined report.<br>L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker.<br>**Note**: One rare specialty examiner on IMEs with a combined report should bill the rare specialty IME exam fee (1141M). | **$1,269.76** |
| 1143M | **IME late cancellation fee, per examiner**<br>Bill only if worker cancels the appointment within 5 business days prior to exam. Billable if appointment time can't be filled. (Business days are Monday through Friday.)<br>Isn't payable for no shows of IME related services (for example, neuropsychological evaluations). | **$382.42** |
| 1144M | **IME no show fee, per examiner**<br>Bill only if worker fails to show, and appointment time can't be filled.<br>Isn't payable for no shows of IME related services (for example, neuropsychological evaluations).<br>For more information, see WAC 296-20-010. | **$382.42** |

| Local code | Description and notes | Maximum fee |
|---|---|---|
| 1145M | **IME, one or more additional claims included in evaluation, up to five additional claims total**.<br>Bill by unit (1 unit = 1 additional claim).<br>Payable when medical examination includes one, two, three, four or five additional claims evaluated by the medical examiner. Bill this code by unit where each unit equals an additional claim included in the evaluation. Don't bill a unit for the first claim. The first claim must be billed using a base exam code (such as **1108M)**.<br>This code is used in addition to the primary IME exam code (**1108M, 1109M, 1112M, 1118M, 1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**) only.<br>This can't be reported as a stand-alone code<br>A maximum of five additional claims (units) are billable with this code. Anytime six or more additional claims are included, special review and authorization is required by the insurer.<br>Not payable when only one claim is examined.<br>Bill once per examiner.<br>**Note:** This code must be preauthorized by the insurer. | **$134.40 per unit** |
| 1146M | **Forensic IME**<br>Bill only if the worker is unavailable for the physical portion of the IME exam.<br>Isn't payable for no shows of IME related services (for example, neuropsychological evaluations).<br>**Note:** This code must be preauthorized by the insurer. | **$413.00** |
| 1147M | **Correctional facility IME**<br>Bill for IMEs conducted at a correctional facility, if the examiner travels to the facility. This code requires prior authorization. Examiners may also bill travel for IMEs conducted at a correctional facility; bill using **1125M**, which requires prior authorization. | **$2,627.07** |

| Modifier | Description | Fee |
|---|---|---|
| Modifier **-7N** | **X-rays and laboratory services in conjunction with an IME**<br>When X-rays, laboratory, neuropsychological testing and other diagnostic tests are provided with an exam, identify the service(s) by adding the modifier – 7N to the usual procedure number.<br>**Link**: Procedure codes are listed in the L&I Professional Services Fee Schedules, Radiology and Laboratory Sections, or the other payment policies available at: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/. | **N/A** |
| Modifier **-26** | **Radiology services in conjunction with an IME-Professional Component**<br>Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. Modifier **–26** must be used when only the professional component is performed. When a global service is performed, neither modifier can be used.<br>Payment will be made at the established professional component (modifier **–26**) rate for each specific radiology service. The professional interpretation or reinterpretation of all imaging studies reviewed must be documented within the IME report. Additionally, modifier **–7N** must be appended to all imaging study billings. When modifier **–26** is appended, it must appear prior to **–7N**.<br>**Link**: Fees are listed in the L&I Professional Services Fee Schedules, available at: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/.<br>Additional information on documentation requirements is listed under the Payment Policy “Radiology Reporting Requirements for IMEs” below. | **N/A** |

# Requirements for billing

## State Fund (L&I) provider account number requirements for IMEs

For IMEs, examiners need one IME provider account number for each payee they wish to designate.

An IME examiner who isn't working through any IME firms will need just one IME number, which will also serve as their payee number.

Bills for testing or other services performed in conjunction with an IME must be submitted by the provider who rendered the service (WAC 296-20-125(3)(o)). These services include:

- X-ray, diagnostic laboratory tests in conjunction with IME (append modifier **–26** and **–7N**).
- Neuropsychological evaluations and testing CPT® codes – **90791**, **96101**, **96102**, **96118**, **96119**. (For more detailed information on neuropsychological services, refer to Chapter 17: Mental Health Services.)
- Functional Capacity Evaluations (FCE) – **1045M.**

## Standard and complex coding

The exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the code based on the number of **body areas** or **organ systems** that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related.

Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of **body areas** and **organ systems** from the Current Procedural Terminology (CPT®) book must be used to distinguish between standard and complex IMEs.

 

# Payment limits

## Limit on total scheduled exams per day

L&I has placed a limit of 12 independent medical examinations scheduled per examiner per day. For psychiatrist examiners, the limit is 8 per day. A psychiatric examiner must spend at least 60 minutes of face-to-face time with the worker. This limit includes IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- **1108M IME**, standard exam – 1-3 **body areas** or **organ systems**,
- **1109M IME**, complex exam – 4 or more **body areas** or **organ systems**,
- **1112M IME**, additional examiner for Standard IME,
- **1118M IME** by psychiatrist,
- **1126M IME** additional examiner for Complex IME,
- **1130M IME**, terminated exam,
- **1141M IME,** rare specialty exam,
- **1142M IME,** additional examiner for Rare Specialty IME,
- **1143M IME,** late cancellation fee,
- **1144M IME,** no show fee,
- **1145M IME,** one or more additional claims included in exam,
- **1146M IME,** forensic exam,
- **1147M IME,** correctional facility exam

# Payment policy: Radiology reporting requirements for IMEs

## Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing.

Documentation includes:

- Charting of justification,
- Findings,
- Diagnoses, *and*
- Test result integration, including a comparison between repeat radiology studies where applicable.

When billing for the professional component of radiology services, bill using modifier **–26** and modifier **–7N**.

IME providers who read imaging studies they order in relation to an IME, or reinterpret imaging studies previously performed, are required to document their findings within the IME report. Each imaging study must be separately documented in its own section and include all of the following:

- Date the imaging study was performed, *and*
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- When ordering imaging studies, a brief sentence describing the reason for the study, such as:
    - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
    - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description of, or listing of, imaging findings:
    - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
    - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical

considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*

- Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*

- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the IME report. If the same imaging study was performed on multiple dates of service, the provider must document a comparison between the studies, in sequential order, noting any significant changes that occurred. For example:
  - For a neck comparison where there is a difference between the original imaging study and the most recent findings, the impression could be: “A comparison of this recent study from 7/1/2019 is made to the study of 5/1/2018. 5/1/2018 which noted narrowing of the disc space at C-5 with bony protuberance at right facet causing impingement. New image from 7/1/2019 shows bony protuberance has grown 5mm and is contributing to increased impingement of the nerve root. This appears to be a continuation of a natural growth process.”

In addition to the above information, when reinterpreting imaging studies, the IME provider must document whether they are or aren’t in agreement with original interpretation of the imaging study.

**Note**: Documentation such as "X-rays are negative" or "X-rays are normal" don’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances.

## Payment limits

### Reinterpretation of imaging studies

Reinterpretation of imaging studies may only be billed once per panel exam. The reinterpretation is only payable for studies related to the accepted or contended condition.

In addition, services must be billed with the correct CPT® code for the specific imaging study reinterpreted, along with modifier **-26** and modifier **-7N**.

### Example of how to bill for IME services including reinterpretation of imaging studies

The following example demonstrates how to bill when IME providers perform a reinterpretation of imaging studies. This example isn't reflective of the documentation requirements for an IME.

**Example**: A panel IME is performed on 7/1/21 meeting the documentation criteria for a complex IME. The IME providers review the following imaging studies, all related to the accepted conditions:

- 1 – 3 view knee x-ray performed 6/1/19
- 2 – 2 view shoulder x-rays performed 6/1/19 and 8/2/20
- 1 – Shoulder MRI without contrast

The correct billing for the services is:

#### Examiner 1

| Line item | Procedure code (and modifiers) | Number of Units |
|---|---|---|
| 1 | **1109M** | 1 |
| 2 | CPT® **73562-26-7N** | 1 |
| 3 | CPT® **73030-26-7N** | 2 |
| 4 | CPT® **73221-26-7N** | 1 |

#### Examiner 2

| Line item | Procedure code (and modifiers) | Number of Units |
|---|---|---|
| 1 | **1126M** | 1 |

**Note**: Reinterpretation is only payable once per panel exam.

# 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) |
| **Administrative rules** for IME no shows | WAC 296-20-010 |
| **Administrative rules and other Washington state laws** for impairment ratings | WAC 296-20-19000 through WAC 296-20-690 available in WAC 296-20<br>Revised Code of Washington (RCW) 51.32.080 |
| **Application to become an IME provider** | F245-046-000 |
| **Becoming an L&I IME provider** | Become an IME Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Fee schedules** for all healthcare professional services | Fee schedules on L&I's website |
| **Mental Health Services** | Chapter 17: Mental Health Services |
| Receiving **email updates on IMEs** | Subscribe to L&I's ListServ |
| Performing **impairment ratings** | Medical Examiner's Handbook |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 14: Language Access Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Authorized interpreter**: Interpreter who has passed a screening test from one or more of the organizations below. Since the scope of the screening test is not as comprehensive as a conventional certified test, those who meet the minimum proficiency requirements are issued an authorization letter in lieu of a certificate. Interpreters must hold an active, up-to-date credential in good standing (not revoked) from one or more of the following organizations:

| If the **agency or organization** is… | Then the **credential** is a: |
|---|---|
| Washington State Department of Social and Health Services (DSHS) | Letter of authorization as a qualified social and/or medical services interpreter |
| Federal Court Interpreter Certification Examination (FCICE) | Letter of designation or authorization |

**By Report (BR)**: When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report. For the full legal definition of **By Report (BR)**, see WAC 296-20-01002.

**Certified interpreter**: Interpreter who holds active, up-to-date credentials in good standing (not revoked) from one or more of the following organizations:

| If the **agency or organization** is… | Then the **credential** is a: |
|---|---|
| Washington State Department of Social and Health Services (DSHS) | Social or Medical Certificate |
| Washington State Administrative Office for the Courts (AOC) | Certificate |
| Registry of Interpreters for the Deaf (RID) | Certified Deaf Interpreter (CDI), or<br>National Interpreter Certification (NIC), or<br>Provisional Deaf Interpreter Certification (PDIC), up to the 12 months the certificate is allowed by RID. Interpreter must submit certification from the RID following the 12-months in order to continue providing services. |

| If the **agency or organization** is… | Then the **credential** is a: |
|---|---|
| National Board of Certification for Medical Interpreter | Certified Medical Interpreter (CMI) |
| Certification Commission for Healthcare Interpreters (CCHI) | Certified Healthcare Interpreter |
| Federal Court Interpreter Certification Test (FCICE) | Certificate |
| US State Department Office of Language Services | Verification letter or Certificate |

**Client**: A worker, an individual, or a group of people that uses the professional services of an interpreter. May also be known as a patient or worker.

**Encounter**: An interpreter encounter, initiated by the requestor (the medical or vocational provider), and scheduled by the insurer's contractor, InterpretingWorks.

**Individual interpreter**: An interpreter requested for on-demand appointments. Individual interpreters must use the ISAR and bill the insurer directly for on-demand appointments only.

**Independent medical examination (IME)**: An objective medical legal examination requested by the department or self-insurer to establish medical facts about a worker's physical condition. Only department-approved examiners may conduct these exams.

**Link**: For more information, see: WAC 296-23-302.

**Initial visit**: The first visit to a healthcare provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers' compensation.

**ISAR**: Interpretive Services Appointment Record. Only interpreters arranged outside of the scheduling system are required to submit an ISAR. A completed ISAR in the claim file is necessary at the time the bill is processed to justify and document the service provided.

**On-demand appointment**: Unscheduled appointments. This includes emergency, urgent care, and walk-in appointments.

**Sight translation**: Oral rendition of text written from one language into another language, usually done in the moment, by the interpreter.

**Sign language interpretation**: Sign language interpretation includes American Sign Language (ASL), tactile interpretation, and sign languages from countries other than the United States.

**Wait time**: The time between the scheduled start time and the actual start time of an appointment. No other covered services are performed during this time.

 

# Payment policy: All interpreter services

## General information

Workers or crime victims who have limited English proficiency or sensory impairments may need interpreter services to communicate effectively with healthcare or vocational providers.

## Prior authorization requirements

Prior to service delivery, providers and **individual interpreters** should check claim status with the insurer. Providers will check claim status with the insurer for scheduled appointments. Call **1-800-831-5227** for automated updates on claim status.

### Required

Document translation services require prior authorization and must be requested by the insurer.

Only translation agencies with a current Department of Enterprise contract may perform translation. See Payment Policy: Translation Services for more information.

### Not required

Interpreter services don't require prior authorization on open claims.

## Who must perform these services to qualify for payment

This policy applies to interpreter services provided:

- For healthcare, **independent medical examinations (IMEs)**, and vocational services,
- In all geographic locations,
- To workers and crime victims having limited English proficiency or sensory impairment, and receiving benefits from:
    - The State Fund, *or*
    - Self-insured employers, *or*
    - The Crime Victims Compensation Program.

**Healthcare and vocational providers may not select the same interpreter for every appointment scheduled by the worker, unless there are extenuating circumstances.** See Payment Policy: Scheduling System for more information.

### Credentials required for L&I provider account number

Interpreters must have an active L&I provider account, unless the interpreter is only providing services as part of the scheduling system. All interpreters are required to have a National Provider Identification (NPI) number. NPIs are unique 10-digit numbers used in identifying specific providers.

To obtain an L&I interpreter services provider account number for **on-demand appointments**, interpreters must submit credentials using the **Submission of Provider Credentials for Interpreter Services** form (F245-055-000). Also, note that:

- Credentials accepted include those listed under definitions for **certified interpreter** and **authorized interpreter** (see Definitions at the beginning of this chapter), *and*
- Provisional certification isn't accepted, except for **sign language interpreters**.

Interpreters located outside of Washington State must submit credentials from their:

- State Medicaid programs, *or*
- State or national court systems, *or*
- Other nationally recognized programs.

**Note**: Interpreters may only be paid for services in the languages for which they have provided credentials.

### Maintaining credentials

Interpreters are responsible for maintaining their credentials as required by the credentialing agency or organization.

If the interpreter's credentials expire or are revoked for any reason, the interpreter must immediately notify the insurer's vendor for scheduling appointments, InterpretingWorks. **Individual interpreters** must immediately notify L&I of the expiration or changes. Billings for services rendered after an interpreter's credentials expire or are revoked will be denied.

### Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers may provide services to **clients** if the provider determines it is most appropriate for their clinic to employ their own interpreter. The Department doesn't reimburse interpreters in this case. The provider is responsible for ensuring the interpreter is credentialed and provides meaningful access to the **client**.

## Services that are covered

These services are covered and are reimbursable:

- The **initial visit**, *and*
- Insurer requested IMEs, *and*
- A flat fee for an insurer requested IME appointment is payable when the worker doesn't attend, *and*
- Services related to the reopening application are payable. Only services to assist in completing the reopening application are payable unless or until a decision is made by the insurer on the status of the claim. If a claim is reopened, the insurer will determine which services are reimbursable, *and*
- Interpreter services which facilitate language communication between the worker and a healthcare or vocational provider, *and*
- Time spent waiting for an appointment that doesn't begin at time scheduled (when no other covered services are being delivered during the **wait time**), *and*
- Interpreters for family members or guardians of workers who are under 18 years old, *and*
- Assisting the worker to complete forms required by the insurer and/or healthcare or vocational provider using **sight translation**, *and*
- The insurer will reimburse interpreter services up to the date of a rejection order, if applicable.

### Rejected claims

Interpreter services for claims which are ultimately rejected will be paid up to (but not including) the date of the rejection order.

## Services that aren't covered

As a last resort, if the medical or vocational provider can't find an L&I approved interpreter, they may use non-certified or unapproved interpreters. L&I won't pay for these services and strongly discourages their use.

In addition, the following aren't covered:

- Interpreter services exceeding **480 minutes** (8 hours) per day per interpreter, *and*
- Interpretation for services that aren't covered by the insurer (see WAC 296-20-03002), *and*
- Interpreter services provided for a denied or closed claim (except services associated with the **initial visit**, or the visit for the worker's application to reopen a claim, or for a worker receiving a pension with a treatment order), *and*

- Bills for rejected claims for dates of service after the date of the rejection order are not reimbursable, except for the reopening application, *and*
- No show fee for any service other than an insurer requested IME *and*
- Personal assistance on behalf of the worker (for example, scheduling appointments, translating correspondence or making phone calls), *and*
- Interpreter services provided for communication not related to the worker's communications with healthcare or vocational providers, *and*
- Overhead costs (for example, phone calls, photocopying, and preparation of bills), *and*
- Document translation unless requested or authorized by the insurer, *and*
- Interpreters who have had their certification revoked by a certifying authority, *and*
- Mileage (mileage is bundled into interpreter services fees and is not separately reimbursable), *and*
- Family members, or friends or acquaintances, of the worker who provide interpretation, *and*
- Credentialed employees of providers who interpret for workers or crime victims, *and*
- Interpreter services for workers or crime victims for legal purposes, including but not limited to:
    - Attorney appointments, *or*
    - Legal conferences, *or*
    - Testimony at the Board of Industrial Insurance Appeals or any court, *or*
    - Depositions at any level.

**Note**: Payment for interpreter services for legal purposes is the responsibility of the attorney or other requesting party. Don't bill L&I or the self-insured employer for these services.

## Interpreter services fee schedule

| Code | Description | L&I limit and authorization information | 1 unit of service equals… | Maximum fee |
|---|---|---|---|---|
| 9973M | **interpretingWorks Encounter Fee** | Payable only to InterpretingWorks. | Encounter | **$7.50** per encounter |
| 9974M | **interpretingWorks interpreter Per Minute**<br>Direct service time between the **client** and healthcare or vocational provider. | Limited to 480 minutes (8 hours) per day per interpreter, for in-state or border zip codes only.<br>Doesn't require prior authorization.<br>InterpretingWorks is required to pay interpreters 15 days after receiving payment from the insurer. | 1 minute | **$1.03** per minute |
| 9975M | **On-Demand Interpreting**, per minute | Limited to 480 minutes (8 hours) per day.<br>**ISAR** required.<br>Payable only when:<br>• **Individual interpreters** provide interpretation for emergency/urgent care/walk in appointments;<br>• **Individual interpreters** provide services out of state;<br>• (For IMEs only) InterpretingWorks interpreter is documented as a no-show or unfulfilled.<br>Payable once per day. | 1 minute | **$1.03** per minute |

| Code | Description | L&I limit and authorization information | 1 unit of service equals… | Maximum fee |
|---|---|---|---|---|
| **9996M** | **Interpreter "IME no show"**<br>**Wait time** when worker doesn't attend the insurer requested IME, flat fee. | Only 1 no show per worker per day.<br>Payment requires prior authorization.<br>InterpretingWorks will request the authorization on behalf of the interpreter.<br>Contact the SIE/TPA after no show occurs. | 1 worker no show at IME | Flat fee<br>**$60.15** |
| **9997M** | **Document translation**, at insurer request | Over $500.00 per claim will be reviewed.<br>Authorization will be documented on translation request packet. Only payable to agencies with a Department of Enterprise Services contract. | 1 page | **By report** |

## Requirements for billing

The scheduling system will handle bills for interpreters. Interpreters must use the miscellaneous bill form and **ISAR** for **on-demand appointments**. See Payment Policy: On-Demand Appointments for more information.

## Payment limits

### Daily time limit

The combined total is limited to **480 minutes** (8 hours) per day per interpreter, for both on-demand and scheduled appointments.

On-demand interpretation is only for services rendered where the appointment occurred last minute, such as an emergency.

 

## L&I's Interpreter scheduling system

L&I has a contract with InterpretingWorks for the scheduling of most interpreter appointments. Providers must use this scheduling portal for their interpreter needs, except for some **on-demand appointments**.

**Link**: Interpreters who'd like to provide scheduled services should sign up with InterpretingWorks.

Interpreters are encouraged to join this scheduling system. A limited number of **on-demand appointments** will be available for interpreters who have provider accounts with L&I. See the Payment Policy: Scheduling System below for additional information.

## Standards and responsibilities for interpreter services provider conduct

L&I is responsible for ensuring workers and crime victims receive proper and necessary services. Interpreters are expected to adhere to the ethics requirements set forth by their certification, or the Department of Social and Health Services WAC 388-03-050, if the certification the interpreter holds doesn't have an ethics component.

The DSHS WAC is the insurer's reference for interpreter expectations. L&I adopts a modified version of this WAC and refers to this as the ethics expectation standard for interpreters.

**Healthcare and vocational providers may not select the same interpreter for every appointment scheduled by the worker, unless there are extenuating circumstances.** See Payment Policy: Scheduling System for more information.

**Link**: Modification of WAC 388-03-050 is referring to L&I instead of DSHS clients.

## Who chooses both the interpreter services provider and when the services are needed

Title VI of the Civil Rights Acts of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. This includes discrimination based on limited English proficiency (LEP) persons. As a result, recipients and sub recipients of Federal financial assistance are responsible for taking reasonable steps to ensure meaningful access by LEP persons to the recipients' and sub recipient's programs or activities, including the use of an interpreter. Failure to do so constitutes illegal discrimination and is a violation of an individual's civil rights.

The American with Disabilities Act (ADA) encourages healthcare or vocational providers serving L&I workers or crime victims to consult with the patient to identify appropriate aid or service necessary to treat them effectively. L&I covers the cost of interpretation services, however the healthcare or vocational provider is responsible for following the ADA guidance for interacting with individuals with communication challenges.

The healthcare or vocational provider will determine, with the worker, if the assistance of an interpreter is needed for effective communication to occur.

If **assistance is needed**, the healthcare or vocational provider will schedule an interpreter to provide medical interpretation during an appointment.

**Healthcare and vocational providers may not select the same interpreter for every appointment scheduled by the worker, unless there are extenuating circumstances.** See Payment Policy: Scheduling System for more information.

If an interpreter (whether paid or unpaid) accompanying the worker does not meet the communication needs, the healthcare or vocational provider determines **a different interpreter is needed** and:

- The worker may be consulted in the selection process, *and*
- Sensitivity to the worker's cultural background and gender is encouraged when selecting an interpreter, *and*
- The ultimate decision on who does the interpreting rests with the healthcare or vocational provider.

In all cases:

- A paid interpreter must meet L&I's credentialing standards (see Definitions at the start of this chapter) *and*
- Persons under age 18 may not interpret for workers or crime victims.

## Additional requirements of hospitals and other facilities

Hospitals, freestanding surgery and emergency centers, nursing homes, and other facilities may have additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider isn't a contractor or a facility employee.

The facility is responsible for notifying the interpreter services provider of their additional requirements and managing interpreter compliance with the facilities' requirements.

# Payment policy: Independent medical examination (IME) interpreter services

## Prior authorization

### IME interpretation services

When an IME is scheduled, the IME provider will arrange for the interpreter services through the scheduling system. Interpreters who accompany the worker won't be paid or allowed to interpret at the IME. The IME provider will arrange interpreter services through the scheduling system, interpretingWorks.

If a request for interpreter is not filled by interpretingWorks and 24 or fewer hours remain before the scheduled appointment time, IME providers may utilize an on-demand interpreter. This rule only applies to IME providers.

**Link**: Arrange for an interpreter through interpretingWorks.

## Who can't perform these services

Interpreters for IMEs must be arranged through the scheduling system. In addition, persons (including interpreters through interpretingWorks) who can't provide interpretation or translation services at IMEs for workers or crime victims are:

- Those related to the worker or crime victim, *or*
- Those with an existing personal relationship with the worker or crime victim, *or*
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative, *or*
- The employer's legal or lay representative or employees of the legal or lay representative, *or*
- Any person who couldn't be an impartial and independent witness, *or*
- Persons under age 18.

**Link**: Also see WAC 296-23-362(3), which states, "The worker may not bring an interpreter to the examination. If interpreter services are needed, the insurer will provide an interpreter."

# Services that can be billed

## IME no shows

Authorization is required prior to payment for an IME no show. For questions, call the Provider Hotline at **1-800-848-0811** or email PHL@Lni.wa.gov. Only services related to no shows for insurer-requested IMEs will be paid.

The insurer will pay a flat fee for an IME no show. After occurrence of IME no show for Self-insured claims, contact the SIE/TPA.

**Link**: For more information, see: WAC 296-20-010(5) which states, “L&I or self-insurers will not pay for a missed appointment unless the appointment is for an examination arranged by the department or self-insurer.”

# Payment limits

Only one no-show fee per day is payable. Prior authorization is required.

For IME panel appointments only, provider may request the same interpreter for the duration of the appointment time. Breaks in the schedule aren’t covered by the insurer.

## Examples

If the IME the panel exam takes place from 10:00 am until 12:00 pm, the provider should request the same interpreter for both hours.

If the IME panel exam occurs between 10:00 am until 2:00 pm, with the hour of 12:00 pm until 1:00 pm used for lunch, the provider should request two separate appointments; one for 10:00 am until 12:00 pm, and one from 1:00 pm until 2:00 pm. The provider may request the same interpreter for both appointments, but L&I will not reimburse the interpreter for break time when no interpreter services are provided.

 

# Payment policy: On-demand appointments

## General information

For services arranged for **on-demand appointments**, interpreters must have an L&I provider account number, use the **ISAR**, and bill the insurer using the miscellaneous billing form. The healthcare or vocational provider arranges **on-demand appointments** by contacting the interpreter directly using the insurer's interpreter lookup tool.

InterpretingWorks and interpreters working for interpretingWorks are not required to submit an **ISAR** form or a miscellaneous billing form when billing the insurer.

## Billing information

### How to Identify State Fund, Self-Insurer, or Crime Victim Claims

**State Fund** claims begin with the letters A, B, C, F, G, H, J, K, L, M, N, P, X, Y, or Z followed by six digits, or double alpha letters (example AA) followed by five digits.

**Self-insured** claims begin with an S, T, or W followed by six digits, or double alpha letters (example SA) followed by five digits. Department of Energy (DOE) claims are now self-insured.

**Crime Victims** claims begin with a V followed by six digits, or double alpha letters (example VA) followed by five digits.

For **on-demand appointments**, the healthcare or vocational provider or their staff must verify services on the Interpreter Services Appointment Record (**ISAR**) (F245-056-000).

**Links**: The **ISAR** form (F245-056-000) can be ordered from the warehouse. Also, see Common Errors on the Interpreter Services Appointment Record (ISAR) for assistance in completing the form.

### How to submit bills for State Fund and Crime Victim claims

Interpreter service appointment record must be submitted to the insurer when services are billed (at the same time). Fax State Fund documentation to **360-902-4567**.

Don't staple documentation to bill forms.

Send documentation separately from bills for State Fund or Crime Victims Compensation Program claims, and:

**Send State Fund bills to:**

Department of Labor & Industries
PO Box 44269
Olympia, WA 98504-4269

Or call **360-902-6500** or **1-800-848-0811**

Interpreters can also set up electronic billing for State Fund claims, or

Contact the Electronic Billing Unit at:

Phone: **360-902-6511**
Fax: **360-902-6192**
Email: ebulni@Lni.wa.gov

Fax documentation (**ISAR**) to **360-902-4567** when billing electronically. **ISARs** may not be submitted electronically.

**Send Crime Victims Compensation Program bills to:**

Department of Labor & Industries
PO Box 44520
Olympia, WA 98504-4520

Or call **360-902-5377** or **1-800-762-3716**

## How to correct an ISAR

If corrections to the **ISAR** form are necessary, see "Changes to medical records" in Chapter 2: Information for All Providers for information on how to make corrections appropriately. (See definition of **Medical records** in Definitions at the beginning of Chapter 2.)

## How to bill multiple claims

If the appointment involves multiple claims, a separate **ISAR** must be submitted for each claim and the healthcare or vocational providers or their staff must verify services on each **ISAR**.

All services provided to a worker on the same date for the same claim must be billed together.

When multiple claims are involved, the billable minutes must be prorated between the claims. The "Total Billable Minutes" on each **ISAR** submitted must match the amounts billed for that claim.

If the appointment is a group of clients, include on the form:

- The total number of clients (not healthcare or vocational providers) participating in the appointment, and
- Verification of appointment by healthcare or vocational provider (printed name and signature of person verifying services), and
- Date signed.

## How to bill self-insured claims

To determine the insurer, see the SIE/TPA list or call 360-902-6901.

### Required items for bill payment

All Interpreter Services Appointment Record (**ISAR**) forms must be signed by the healthcare or vocational provider or the provider's staff to verify services, *and*

All **ISAR** forms must be in the claim file. All **ISAR** forms must be in the file without crossed out information, comments, or notes in margins, *and*

If the appointment involves multiple claims, a separate **ISAR** must be submitted for each claim and the healthcare or vocational providers or their staff must verify services on each **ISAR**, *and*

All services provided to a worker on the same date for the same claim must be billed together.

**Links**: Additional information on interpreter billing is available online.

For more information about billing, see the General Provider Billing Manual.

Additional information on adjustments is available online.

### When billing for interpretation services:

Only the time actually spent delivering those services may be billed, *and*

To avoid bill denial, you must bill all services for the same worker, for the same date of service, on one bill form, *and*

Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end, *and*

**Exception**: If the appointment starts early, time is counted from when the appointment actually begins. For example, the appointment is scheduled to start at 8:30 a.m. but interpreter arrives at 8:00 a.m. and appointment starts early at 8:15 a.m. Time is counted from 8:15 a.m. when the appointment actually started, *and*

Time spent providing **sight translation** isn't counted separately.

# Payment policy: Out-of-State Language Access Services

## Who must perform interpreter services to qualify for payment

This policy applies to services rendered outside of Washington State. Interpreter services are covered regardless of the location of the worker; however, the healthcare or vocational provider must arrange an interpreter depending on the location where services occur.

The rules outlined in the All interpreter services section also apply to out-of-state interpreters.

## Services that are covered

| If treatment or services occur… | Then… | And reference… |
|---|---|---|
| In a border zip code. A border zip code are zip codes that start with: 970, 971, 972, 978 for Oregon, or 835 or 838 for Idaho. | Healthcare or vocational provider must use the scheduling system. Interpreters don't need a unique provider ID. | Scheduling System |
| Outside of a border zip code and outside of Washington State. | Healthcare or vocational provider must arrange services with a local, **individual interpreter**. Interpreters must have a unique provider ID and fill out an **ISAR**. | On-Demand Appointments |
| Outside of a border zip code and outside of Washington State and there are no interpreters available. | Healthcare or vocational provider may use CTS Language Link. | Telephone interpreter services |

# Payment policy: Scheduling System

## L&I's Interpreter scheduling system

L&I has a contract with InterpretingWorks for the scheduling of most face-to-face interpreter appointments in and near Washington State. Providers must use this scheduling portal for their interpreter needs, except for some **on-demand appointments**.

**Link**: Arrange for an interpreter through InterpretingWorks.

Interpreters are encouraged to join this scheduling system. A limited number of **on-demand appointments** outside of the scheduling system will be available for interpreters who have provider accounts with L&I. These are arranged by the healthcare or vocational provider.

Healthcare and vocational providers may not select the same interpreter for every appointment scheduled by the worker, unless there are extenuating circumstances.

Situations in which the same interpreter may be used for each appointment are limited to the following:

### Crime victims

When it is necessary for continuity of care and case familiarity for a **crime victim.**

### Mental health treatment by a mental health provider

If the worker has authorized coverage for **mental health** (mental health must be an L&I authorized condition on the claim). The ability to request the same interpreter is ONLY for the mental health provider furnishing mental health treatment and/or a diagnosis to a worker, and not every provider involved in the care. See the MARFS Mental Health Services Chapter 17 for information regarding who must perform mental health services to qualify for payment.

### Pain management or brain injury program

A **pain management program** or a **brain injury rehabilitation program** where having the same interpreter is beneficial to the outcome of the program, and the provider is providing services as part of an approved structured intensive pain management program (SIMP) or brain injury rehabilitation program. **L&I must have provided specific approval as a pain management or brain rehab program while offering services to a worker as part of that program.**

On a case-by-case basis, requests for the same interpreter for languages of lesser diffusion may be allowed. Decision rests with the scheduling system and is dependent on availability of the interpreter.

Providers need to provide access to their QR codes for the interpreter check in and check out process to ensure interpreter time is accurately captured. Interpreters should check in at the start time of the appointment, unless arriving after the start time in which case check in at the time of arrival. Interpreters should promptly check out when the appointment ends.

**Link**: More information about the InterpretingWorks process is available online.

If InterpretingWorks is unable to secure an interpreter for the provider, the provider must use CTS Language Link. Read more about this in the Payment Policy: Telephone interpreter services. InterpretingWorks is required to remit payment to interpreters within 15 days of receiving payment from the insurer.

**Note**: If the appointment request is for a panel IME, the same interpreter may be requested. See Payment Policy: Independent Medical Examination Interpreter Services for more information.

# Payment policy: Telephone and video remote interpreter services

## Prior authorization

Over the phone (OPI) interpreter services and video remote interpreter (VRI) services don't require prior authorization on open claims, or closed claims that have a treatment order.

**Providers should check claim status with the insurer prior to requesting interpreter services.** Call **1-800-831-5227** for updated claim status.

## Who must perform these services to qualify for payment

Healthcare, vocational, and activity coach providers, both in and out of state, who use OPI or VRI services must use the preapproved DES contracted vendor(s).

**Link**: Information about how providers arrange interpreter services is available on the L&I website.

## Services that are covered

Providers may only use the DES contracted vendor(s).

OPI services for healthcare and vocational providers are covered when:

- The healthcare or vocational provider requests the services, *and*

  The healthcare or vocational provider is administering a covered, billable treatment or service to the worker.

VRI services for healthcare and vocational providers are covered when:

- There is a live video and audio connection between the healthcare or vocational provider and the worker, *and*
- The healthcare or vocational provider requests the services, *and*
- The healthcare or vocational provider is administering a covered, billable treatment or service to the worker.

## Services that aren't covered

OPI and VRI services for healthcare and vocational providers aren't covered when the provider or their staff call the patient for administrative purposes, such as scheduling or rescheduling an appointment.

OPI and VRI services rendered by interpreters who are not part of L&I's contract with the vendor are not covered. Self-insured employers are also required to obtain services using L&I's contracted vendor(s).

# Payment policy: Translation services

## Prior authorization

Document translation services are only paid when performed at the insurer's request. Services will be authorized before the request packet is sent to the translators.

## Who must perform translation services to qualify for payment

Only Department of Enterprise Services (DES) contracted translators may complete document translation requests.

**Sight translation** is provided by interpreters during an appointment with a **client** and a healthcare or vocational provider. Document translation services are for written materials and are only payable when requested by the insurer.

## Services that are covered

Document translation is an insurer-requested service only. Payment for document translation will be made only if the service was requested by the insurer, and the translation provider is part of the DES contract.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for interpreter services | Washington Administrative Code (WAC) 296-20-010(5)<br>WAC 296-23-362(3)<br>WAC 296-23-302 |
| **Administrative rules** for missed appointments | WAC 296-20-010(5) |
| **Becoming an L&I interpreter provider** | Become an Interpreter on L&I's website |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** adjustments | Billing adjustments on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Common Errors** on the Interpreter Services Appointment Record (ISAR) | F245-436-000 |
| **DES** Telephone and Video Interpreter Services contract | Washington State Government DES website |
| **Ethics for Interpreters** | WAC 388-03-050 |
| **Federal laws** relevant to interpreter services | Civil Rights Act of 1964 |
| **Fee schedules** for all healthcare professional services (including interpreter services) | Fee schedules on L&I's website |
| How providers **arrange interpreter services** | How to arrange for interpreter services on L&I's website |
| **Interpreter Lookup Service** | Interpreter lookup service on L&I's website |
| **Interpreter Services Website** | Interpreter services |
| **Interpreter Services Appointment Record** (ISAR) form | F245-056-000 |

| If you're looking for more information about… | Then see… |
|---|---|
| **InterpretingWorks** (L&I's contracted scheduling system) | InterpretingWorks website |
| L&I's **General Provider Billing Manual** | F245-432-000 |
| **Language Link** (DES contracted vendor) | Language Link website |
| **National Provider Identification number** | Centers for Medicare and Medicaid Services website |
| Sign up for **L&I provider news and updates through GovDelivery** | Sign up for GovDelivery |
| **Statement for Miscellaneous Services** form | F245-072-000 |
| **Statement for Crime Victim Miscellaneous Services** form | F800-076-000 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 15: Medical Testimony

**Effective July 1, 2022**

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

## Table of Contents

# Payment policy: Medical testimony and depositions

## Who arranges testimonies and depositions

The Office of the Attorney General or the self-insured employer SIE makes arrangements with expert witnesses to provide testimony or deposition.

## Responsibilities of providers

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.

**Link**: For more information, see RCW 51.04.050.

## Reasonable availability

The Office of the Attorney General or the self-insurer and the provider must 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 Appeals.

## Cancellation fees

| If the **cancellation notice** for the testimony or deposition is… | Then the Attorney General/SIE: |
|---|---|
| 3 working days or less than 3 working days before a hearing or deposition | **Will pay a cancellation fee** for the amount of time you were scheduled to testify, at the allowable rate. |
| More than 3 working days before a hearing or deposition | **Won't pay** a cancellation fee. |

## Services that can be billed

The Office of the Attorney General provides a medical provider testimony fee schedule when testimony is scheduled. The medical witness fee schedule (see below) is set by the Attorney General's Office and not by the Department.

In the fee schedule below, 1 unit equals 15 minutes of actual time spent.

 

## Fee schedule for testimony and related fees

| If the service provided by a **doctor**, **attending ARNP or psychologist** is… | Then the **maximum fee** is: |
|---|---|
| Medical testimony (live or by deposition) | **$100.00**/unit*<br>(maximum of 17 units) |
| Record review | **$100.00**/unit*<br>(maximum of 25 units) |
| Conferences (live or by telephone) | **$100.00**/unit*<br>(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*<br>(maximum of 17 units) |

| If the service provided by **all other healthcare providers** is… | Then the **maximum fee** is: |
|---|---|
| Medical testimony (live or by deposition) | **$23.00**/unit*<br>(maximum of 17 units) |
| Record review | **$23.00**/unit*<br>(maximum of 25 units) |
| Conferences (live or by telephone) | **$23.00**/unit*<br>(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) | **$23.00**/unit*<br>(maximum of 17 units) |

 

| If the service provided by a **vocational provider** is… | Then the **maximum fee** is: |
|---|---|
| Medical testimony (live or by deposition), regular vocational services<br>Medical testimony (live or by deposition), forensic vocational services | **$23.00**/unit*<br>**$27.50**/unit*<br>(maximum of 17 units) |
| Record review, regular vocational services<br>Record review, regular vocational services, forensic vocational services | **$23.00**/unit*<br>**$27.50**/unit*<br>(maximum of 25 units) |
| Conferences (live or by telephone), regular vocational services<br>Conferences (live or by telephone), forensic vocational services | **$23.00**/unit*<br>**$27.50**/unit*<br>(maximum of 9 units) |
| Travel, regular vocational services<br>Travel, forensic vocational services<br>(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) | **$23.00**/unit*<br>**$27.50**/unit*<br>(maximum of 17 units) |

| If the service provided by an **out of state doctor** is… | Then the **maximum fee** is: |
|---|---|
| Medical testimony (live or by deposition) | **$125.00**/unit*<br>(maximum of 17 units) |
| Record review | **$125.00**/unit*<br>(maximum of 25 units) |
| Conferences (live or by telephone) | **$125.00**/unit*<br>(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*<br>(maximum of 17 units) |

 

**Link**: For legal definitions of Doctor or attending doctor, see WAC 296-20-01002.

## Services that aren't covered

Requests for a nonrefundable amount will be denied.

## Requirements for billing

For **State Fund claims**:

- Providers shouldn't use the CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the Office of the Attorney General. State Fund uses a separate voucher **A19 form**, which will be provided to you by the Office of the Attorney General.

For **self-insured employer claims:**

- SIEs must allow providers to use CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the SIE/TPA.

## Payment limits

### Pre-payment

L&I can't provide pre-payment for any of these services.

### Calculating timed fees

Travel fees are calculated:

- On a portal to portal time basis (from the time you leave your office until you return), *and*
- Don't include side trips.

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

### Interpretive services

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

### Out of state testimony

Payment for medical testimony for an independent medical examination at the out of state rate will only be made if the examination was conducted out of state. Payment isn't based on the physical address of the examiner.

 

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for definitions | Washington Administrative Code (WAC) 296-20-01002 |
| **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 services | Fee schedules on L&I's website |
| Legal statute (Washington State law) for physician or licensed advanced registered nurse practitioner's **testimony not privileged** | Revised Code of Washington (RCW) 51.04.050 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 16: Medication Administration and Injections

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Bundled codes**: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.

**Dry Needling**: Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations, as opposed to the distant points or meridians used in acupuncture.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**–LT (Left side)**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

**–RT (Right side)**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

# Payment policy: Botulinum toxin (BTX)

## Prior authorization

Botulinum toxins are payable when authorized.

Coverage of Onabotulinumtoxin A for treatment of chronic migraine is exempt from the two course limit based on an HTCC coverage determination. A maximum of five courses may be authorized.

**Link**: Prior authorization criteria and coverage decision information is available online.

## Requirements for billing

### Billing codes

Refer to the fee schedule for current fees.

| If the **injection** is… | Then the appropriate **HCPCS billing code** is: |
|---|---|
| Onabotulinumtoxin A, 1 unit (Botox® or Botox Cosmetic®) | **J0585** |
| If the **injection** is… | Then the appropriate **HCPCS billing code** is: |
| Abobotulinumtoxin A, 5 units (Dysport®) | **J0586** |
| Rimabotulinumtoxin B, 100 units (Myobloc®) | **J0587** |
| Incobotulinumtoxin A, 1 unit (Xeomin®) | **J0588** |

## Services that aren't covered

The insurer won't authorize payment for BTX injections for off label indications.

Onabotulinumtoxin A for the treatment of chronic tension-type headache isn't a covered benefit.

# Payment policy: Compound drugs

## Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk nonpayment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

**Link**: For more information, see the department's coverage policy on compound drugs.

## Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA approved alternatives, on the Outpatient Drug Formulary such as:

- Oral generic nonsteroidal anti-inflammatory drugs,
- Muscle relaxants,
- Tricyclic antidepressants,
- Gabapentin, *and*
- Topical salicylate and capsaicin creams.

## Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient.

## Payment limits

No separate payment will be made for **99070** (Supplies and materials).

# Payment policy: Hyaluronic acid for osteoarthritis of the knee

## Prior authorization

Hyaluronic acid injections for osteoarthritis of the knee are payable when authorized. For authorization, the correct side of body HCPCS billing code modifier (**–RT** or **–LT**) is required. If bilateral procedures are required, both modifiers must be authorized.

**Link**: Prior authorization criteria and coverage decision information is available online.

## Requirements for billing

CPT® code **20610** must be billed for hyaluronic acid injections along with and the appropriate HCPCS code:

| If the **injection** is… | Then the appropriate **HCPCS billing code** is: |
|---|---|
| Hymovis | **C9471** |
| Durolane | **J7318** |
| GenVisc 850 | **J7320** |
| Hyalgan or Supartz | **J7321** |
| Visco-3 | **J7321** |
| Euflexxa | **J7323** |
| Orthovisc | **J7324** |
| Synvisc or Synvisc-1 | **J7325** |
| Gel-One | **J7326** |
| Monovisc | **J7327** |
| Gel-Syn | **J7328** |
| TriVisc | **J7329** |

The correct side of body HCPCS code billing modifier (**–RT** or **–LT**) is required for billing. If bilateral procedures are authorized, both modifiers must be billed as a separate line item. Refer to the fee schedule for current fees.

**Link**: For more information about treatments that aren't authorized, see WAC 296-20-03002(6).

# Payment policy: Immunizations

## Prior authorization

Immunization materials are payable when authorized.

## Services that can be billed

CPT® codes **90471** and **90472** are payable, in addition to the immunization materials code(s).

For each additional immunization given, add on CPT® code **90472** may be billed.

## Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a **–25** modifier.

### Additional information: Bloodborne pathogens and infectious diseases

Information on bloodborne pathogens is available online. For more information about work related exposure to an infectious disease, see WAC 296-20-03005.

# Payment policy: Immunotherapy

## Services that aren't covered

Complete service codes aren’t paid.

## Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- One of the injection codes, *and*
- One of the antigen/antigen preparation codes.

# Payment policy: Infusion therapy services and supplies for RBRVS providers

## Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

An exception is **outpatient services**, which are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. (See Services that can be billed, below.)

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, baclofen).

## Services that can be billed

### Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

### Supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782-E0783**, *and*
- **E0785-E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

## Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered with the following exceptions for accepted conditions:

- To treat pain caused by cancer or other end-stage diseases, *or*
- To administer anti-spasticity drugs when spinal cord injury is an accepted condition.

**Link**: For more information, see WAC 296-20-03002.

## Requirements for billing

### Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for Home infusion services in Chapter 11: Home Health Services for more information.

**Link**: For information on home infusion therapy in general, see the Home infusion services section of Chapter 11: Home Health Services.

### Drugs

Drugs for outpatient use must be billed by pharmacy providers, either electronically through the point of service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

**Note**: Total parenteral and enteral nutrition products are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

# Payment limits

## E/M office visits

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the code definitions.

## Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren't covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term postoperative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

**Link**: For more information, see WAC 296-20-03014.

## Equipment and supplies

Infusion therapy supplies and related DME, such as infusion pumps, aren't separately payable for RBRVS providers. Payment for these items is **bundled** into the fee for the professional service).

## Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373** and **96374**, won't be paid separately in conjunction with the IV infusion codes.

# Payment policy: Injectable medications

## Requirements for billing

Providers must use the HCPCS J codes for injectable drugs that are administered during an E/M office visit or other procedure. The HCPCS J codes aren't intended for self-administered medications.

When billing for a nonspecific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, **providers must bill their acquisition cost for the drugs**. To get the total billable units, divide the:

- Total strength of the injected drug, *by*
- The strength listed in the manual.

For example:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

## Payment limits

Payment is made according to the published fee schedule amount, or the acquisition cost for the covered drug(s), whichever is less.

# Payment policy: Medical foods and co-packs

## Services that aren't covered

Medical food products and their convenience packs or "co-packs" aren't covered.

Examples of medical food products include:

- Deplin® (L-methylfolate), *and*
- Theramine® (arginine, glutamine, 5-hydroxytryptophan, and choline).

Examples of "co-packs" include:

- Theraproxen® (Theramine and naproxen), *and*
- Gaboxetine® (Gabadone and fluoxetine).

**Link**: For more information, see the department's coverage policy on Medical foods and co-packs.

## Payment limits

Medical foods and co-packs administered or dispensed during office procedures are considered **Bundled** in the office visit.

No separate payment will be made for **99070** (Supplies and materials), which is a **bundled** code.

# Payment policy: Non-injectable medications

## Services that can be billed

Providers may use distinct HCPCS J codes that describe specific non-injectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The HCPCS J codes aren't intended for self-administered medications.

## Services that aren't covered

No payment will be made for pharmaceutical samples or repackaged drugs.

## Requirements for billing

**Providers must bill their acquisition cost for these drugs.**

The name, NDC, strength, dosage, and quantity of the drug administered must be documented in the medical record and noted on the bill.

**Link**: For more information, see the payment policy for Acquisition cost in Chapter 28: Supplies, Materials, and Bundled Services.

## Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Noninhalation drug for DME), *or*
- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*
- **J8499** (Oral prescription drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

 

# Payment policy: Spinal injections

## Payment methods

### Physician or CRNA/ARNP

The payment methods for physician or CRNA/ARNP are:

- Injection procedure: **–26** component of Professional Services Fee Schedule, *and*
- Radiology procedure: **–26** component of Professional Services Fee Schedule

A separate payment for the injection **won't be made** when computed tomography is used for imaging unless documentation demonstrating medical necessity is provided.

### Radiology facility payment methods

The payment methods for radiology facilities are:

- Injection procedure: No facility payment, *and*
- Radiology procedure: **–TC** component of Professional Services Fee Schedule.

### Hospital payment methods

The payment methods for hospitals are:

- Injection procedure: APC or POAC (payment method depends on the payer and/or the hospital's classification), *and*
- Radiology procedure: APC, POAC or **–TC** component of Professional Services Fee Schedule. Radiology codes may be packaged with the injection procedure.

# Payment policy: Therapeutic or diagnostic injections

## Prior authorization

### Required

These services require prior authorization:

- Trigger point injections and **dry needling** (refer to guideline for limits), and
- Sympathetic nerve blocks (refer to the CRPS guideline).

**Links**: Guidelines on trigger point and dry needling injections are available online.

CRPS guidelines are available online.

### Required along with utilization review

These services require both prior authorization and utilization review:

- Therapeutic epidural and spinal injections for chronic pain,
- Therapeutic sacroiliac joint injections for chronic pain,
- Diagnostic facet and medial branch block injections (refer to neurotomy guideline).

**Links**: Review L&I's website for the coverage decision and guidelines on spinal injections, neurotomy guidelines, and our coverage decision on discography.

## Services that can be billed

These services can be billed without prior authorization:

- E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable,
- Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS J code for the drug,
- Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360**, **96361**, **96365**-**96368**), and
- Spinal injections that don't require fluoroscopy or CT guidance:
    - CPT® code **62270** – diagnostic lumbar puncture,
    - CPT® code **62272** – therapeutic spinal puncture for drainage of CSF, and
    - CPT® code **62273** – epidural injection of blood or clot patch.

## Services that aren't covered

CPT® code **99211** won't be paid separately.

If billed with the injection code, providers will be paid only the E/M service and the appropriate HCPCS J code for the drug.

Perineural Injection Therapy (PIT), also known as sclerotherapy, neurofascial, subcutaneous or neural prolotherapy, are considered forms of prolotherapy. L&I does not cover any form of prolotherapy per WAC 296-20-03002. Providers may not bill or be paid for PIT. These procedures should not be confused with peripheral nerve blocks (CPT code **64450**), which are allowed for regional anesthesia and acute pain management.

**Link**: The coverage decision on perineural injection therapy is available online.

The insurer doesn't cover:

- Therapeutic medial branch nerve block injections, *or*
- Therapeutic or diagnostic intradiscal injections, *or*
- Therapeutic facet injections, *or*
- Diagnostic sacroiliac joint injections, *or*
- Therapeutic genicular nerve blocks for chronic knee pain, *or*
- Perineural injection therapy.

 

**Links**: More information about these injections and the coverage decision on therapeutic genicular blocks for chronic knee pain is available online.

## Requirements for billing

### Dry needling

**Dry needling** of trigger points must be billed using CPT® codes **20552** and **20553**.

### Spinal injections that require fluoroscopy

For spinal injection procedures that require fluoroscopy:

- One fluoroscopy code must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied, and
- Only one fluoroscopy code may be billed for each injection (see table below).

| Only one of these **CPT® fluoroscopy codes** may be billed for each injection … | … and it must be billed along with this underlying **CPT® code**: |
|---|---|
| **77002**, **77012**, **76942** | **62268** |
| **77002**, **77012**, **76942** | **62269** |
| **77003**, **72275** | **62281** |
| **77003**, **72275** | **62282** |
| **77003**, **77012**, **76942**, **72240**, **72255**, **72265**, **72270** | **62284** |
| **72295** | **62290** |
| **72285** | **62291** |
| **72295** | **62292** |
| **77002**, **77003**, **77012**, **75705** | **62294** |
| **77003**, **72275** | **62320** |
| **77003**, **72275** | **62322** |
| **77003**, **72275** | **62324** |
| **77003, 72275** | **62326** |

### Spinal injection procedures that include fluoroscopy, ultrasound, or CT in the code description

Paravertebral facet joint injections now include fluoroscopic, ultrasound, or CT guidance as part of the description. This includes these CPT® codes:

- **64479-64480**, *and*
- **64483-64484**, *and*
- **64490-64495**, *and*
- **0213T-0218T**, *and*
- **0228T-0231T**.

Fluoroscopic, ultrasound, or CT guidance can't be billed separately.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for drug limitations (such as opiates) | Washington Administrative Code (WAC) 296-20-03014 |
| **Administrative rules** for treatment authorization (including prolotherapy) | WAC 296-20-03002 |
| **Administrative rules** for work related exposure to an infectious disease | WAC 296-20-03005 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Bloodborne pathogens** | Bloodborne pathogens guidelines |
| **Botulinum toxin** (BTX) injections | Botulinum toxin coverage decision |
| **Complex Regional Pain Syndrome (CRPS)** guidelines | Complex Regional Pain Syndrome guidelines |
| **Compound drugs** coverage decision | Compound drugs coverage decision |
| **Discography** guidelines | Discography guidelines |
| **Dry needling and trigger point injections** guidelines | Dry needling and trigger point injections guidelines |
| **Fee schedules** for all healthcare professional services (including medication administration) | Fee schedules on L&I's website |
| **Hyaluronic acid injections** | Hyaluronic acid injections coverage decision |

| If you're looking for more information about… | Then see… |
|---|---|
| Medical coverage decision for **acupuncture** | WAC 296-20-03002(2)<br>Acupuncture guidelines on L&I's website |
| **Medical foods and co-packs** coverage decision | Medical foods and co-packs coverage decision |
| **Neurotomy** guidelines | Neurotomy guidelines |
| Payment policies for **acquisition cost policy** | Chapter 28: Supplies, Materials, and Bundled Services |
| Payment policies for **home infusion therapy** | Chapter 11: Home Health Services |
| **Spinal injections** coverage decision and guidelines | Spinal injections coverage decision |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 17: Mental Health Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Bundled codes**: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Residential facility for mental health:** These facilities provide high level care to workers with long-term or severe mental disorders, or workers with substance-related disorders, with 24-hour medical and nursing services. **Residential facilities for mental health** typically provide less intensive medical monitoring than subacute hospitalization care. Treatment includes a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. **Residential facilities for mental health** include training in the basic skills of living as determined necessary for each worker. Treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care. Adult family homes, skilled nursing facilities, or boarding homes aren't included in this definition.

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**-93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)**

Used to indicate an audio only service occurred between a physician or other qualified health care professional and a patient who is located away from the physician or other qualified health care professional. The totality of the exchange between the health care professional and patient must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

 

# Payment policy: All mental health services

## 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 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 can be an attending provider

### Can be attending provider: Psychiatrists and psychiatric ARNPs

A psychiatrist or psychiatric ARNP can be a worker's attending provider only when:

- The insurer has accepted a psychiatric condition, *and*
- It is the only condition being treated.

A psychiatrist or psychiatric ARNP may certify a worker's time loss from work if:

- A psychiatric condition has been allowed, *and*
- The psychiatric condition is the only condition still being treated.

A psychiatrist may also rate mental health permanent partial disability.

A psychiatric ARNP can't rate permanent partial disability.

### Can't be attending provider: Psychologists

Psychologists can't be attending providers and can't certify time loss from work or rate permanent partial disability. Psychologists may document worker's return to work issues related to accepted mental health conditions.

**Link**: For more information on who can be an attending provider, see WAC 296-20-01002.

## Social workers and other master's level counselors

Mental health evaluation and treatment services aren't covered when provided by social workers and other master's level counselors, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

**Link**: The Department is currently conducting a Master's Level Therapist (MLT) Pilot. MLTs participating in the pilot may provide limited services.

## Payment rates for specific provider types

### Licensed clinical psychologists and psychiatrists

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

### Psychiatric ARNPs

Psychiatric ARNPs are paid at 100% of the values listed in L&I's Professional Services Fee Schedule.

## Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

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

### Psychological testing

Staff supervised by a psychiatrist, psychiatric ARNPs, or licensed clinical psychologist may administer psychological testing; however, the psychiatrist, or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports.
- Bill for the services performed by their staff

 

## Services that aren't covered

These services (CPT® billing codes) aren't covered:

- **90845**,
- **90846**,
- **90849**,
- **90863**.

Psychologists can't bill the E/M codes for office visits.

**Link**: The coverage decision for Chronic Migraine or Chronic Tension-type Headache is available online.

## Payment limits

These services (CPT® billing codes) are **bundled** and aren't payable separately:

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

Psychiatrists and psychiatric ARNPs may only bill the E/M codes for office visits on the same day psychotherapy is provided if it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized.

The provider must submit documentation of the event and request a review before payment can be made.

**Link**: For additional information see Authorization and Reporting Requirements for Mental Health Specialists. This document provides guidance for mental health specialists on the following:

A. Coverage of Mental Health Conditions
   - Conditions caused or aggravated by an industrial injury or occupational disease
   - Pre-existing or unrelated conditions delaying recovery
   - Services that mental health specialists provide

B. Authorization Requirements
   - Initial evaluation and treatment
   - Ongoing treatment

C. Reporting Requirements
   - Diagnosis of a mental health condition
   - Return to work considerations
   - Identification of barriers to recovery from an industrial injury
   - Documenting a treatment plan with special emphasis on functional recovery
   - Assessment of functional status during treatment

D. Billing Codes

# Payment policy: Audio only mental health services

## General information

The insurer covers audio only mental health services when prior authorization for mental health has been obtained, and only in specific circumstances. See Chapter 10: Evaluation and Management Services for additional requirements regarding phone calls.

## Services that must be performed in person

An in-person evaluation is required once every 6 months. In-person evaluations are always required when:

- Consultations requested to determine if conservative care is appropriate, *or*
- The provider has determined the worker is not a candidate for audio only either generally or for a specific service, *or*
- The worker does not want to participate via audio only.

## Prior authorization

The same prior authorization requirements listed in Chapter 17: Mental Health Services apply to this policy update.

## Services that are covered

When mental health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore the insurer has adopted a modified list of services that may occur via audio only. The requirements for prior authorization, documentation, and payment limits listed in Chapter 17: Mental Health Services apply to the following services covered under this update:

- **90791**
- **90832**
- **90834**
- **90837**
- **90839**
- **90840**
- **90847**
- **90853**

In addition, **90785** may be billed if it is appropriate for the audio visit. **90785** is only payable with **90791**, **90832**, **90834**, **90837**, or **90853** when the visit is audio only. See CPT® for additional requirements when billing **90785**.

Case management services may also be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

## Services that aren't covered

The same services that aren't covered in Chapter 17: Mental Health Services apply to this policy.

Aside from **90791**, mental health codes with an evaluation component aren't covered when performed telephonically (audio only). These services may only be billed if the service is rendered via **telehealth** or in-person.

### Audio only procedures

Audio only procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of audio only equipment or systems,
- Neuropsychological testing, *and*
- Home health monitoring.

**Q3014** and **T1014** aren't covered under this policy.

## Requirements for billing

Bill using modifier **-93** to indicate services rendered via audio only.

### Documentation requirements

Providers must document all medical, vocational, or return to work decisions made. For the purposes of this policy, the following must be included in the provider's documentation:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in audio only services.

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

# Payment policy: Case management services

## Payment limits

Psychiatrists, psychiatric ARNPs, and clinical psychologists may only bill for case management services (telephone calls, team conferences, and secure e-mail) when mental health services are authorized.

**Links**: For more information about payment criteria and documentation requirements for these services, see the payment policy for case management services in Chapter 10: Evaluation and Management.

# Payment policy: Individual and group goal oriented psychotherapy

## Prior authorization

### Group psychotherapy

Group psychotherapy treatment is authorized on a case by case basis only.

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

## Requirements for billing

### Individual psychotherapy services

To report individual psychotherapy:

- Don't bill more than one unit per day, *and*
- Use the following timeframes for billing the psychotherapy codes:
  - 16-37 minutes for **90832** and **90833**.
  - 38-52 minutes for **90834** and **90836**.
  - 53 or more minutes for **90837** and **90838**.

**Note**: Chart notes must document time spent performing psychotherapy. Coverage of these services is different for psychiatrists and psychiatric ARNPs than it is for clinical psychologists (see below).

### 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.

Psychiatrists and psychiatric ARNPs may bill the following individual goal oriented psychotherapy CPT® billing codes without an E/M service:

- **90832**,
- **90834**,
- **90837**.

Psychiatrists and psychiatric ARNPs may bill the following CPT® billing codes when performing an evaluation and management service on the same day:

- **90833**,
- **90836**,
- **90838**.

Psychiatrists and psychiatric ARNPs bill these CPT® billing codes in addition to the code for evaluation and management services.

### Clinical psychologists

Clinical psychologists may bill only the individual goal oriented psychotherapy codes without an E/M component **90832**, **90834**, and **90837**. They can't bill psychotherapy codes **90833**, **90836**, or **90838** in conjunction with an E/M component 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.

### Prolonged Services

Use the appropriate prolonged services code (**99354**, **99355**, **99356**, **99357**) with **90837** for psychotherapy services of 90 minutes or longer, face to face with the patient, not performed with E/M service.

### 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.

The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.

# Payment policy: Narcosynthesis and electroconvulsive therapy

## Prior authorization

Narcosynthesis and electroconvulsive therapy require 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**: More information about electroconvulsive therapy is available online.

# Payment policy: Neuropsychological testing

## What's included in neuropsychological testing

Test data must be sent to L&I by the treating psychologist. Test data includes:

- The injured worker's test results,
- Raw test data,
- Records,
- Written/computer-generated reports,
- Global scores or individual's scale scores, *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.

The term **test data** also refers to:

- Raw and scaled scores,
- Patient responses to test questions or stimuli, *and*
- Psychologists' notes and recordings concerning patient statements and behavior during an examination.

**Note**: The psychologist is responsible for releasing test data to the insurer.

## Services that can be billed

The following billing codes may be used when performing neuropsychological evaluation:

| If the CPT® code is… | Then it may be billed: |
|---|---|
| **90791** or **90792** | Once every 6 months per patient per provider. |
| **96130**, **96131**, **96136** or **96137** | Up to a combined 4 hour maximum.<br>In addition to CPT® codes **96138** and **96139**. |
| **96138** or **96139** | Per hour, up to a combined 12 hour maximum. |

**Note**: Reviewing records and/or writing/submitting a report is included in these codes and can't be billed separately.

# Payment policy: Pharmacological evaluation and management

## Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs with pre-authorization.

## 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 **90833**, **90836**, or **90838** *and*
- Can bill a separate code for E/M services (CPT® codes **99202-99215**) at the same time.

### 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.

# Payment policy: Mental health consultations and evaluations

## Prior authorization

Prior authorization is required for all mental health care referrals. This requirement includes referrals for mental health consultations and evaluations.

**Links**: For more information on consultations and consultation requirements, see WAC 296-20-045 and WAC 296-20-051.

## Services that can be billed

When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the:

- Psychiatric diagnostic evaluation code **90791**, *or*
- Psychiatric diagnostic evaluation with medical services code **90792**.

When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code **90791** (Psychiatric diagnostic evaluation).

Telehealth psychology services are covered. For more information see link below.

**Links**: For more information, see the payment policy for teleconsultation and other telehealth services in Chapter 10 Evaluation and Management (E/M) Services.

## Payment limits

CPT® codes **90791** or **90792** are limited to one occurrence every six months, per patient, per provider.

# Payment policy: Repetitive Transcranial Magnetic Stimulation (rTMS) for treatment-resistant depression

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 decisions for TMS therapy. The coverage details are available online.

## Prior authorization

Prior authorization is required prior to initiating rTMS treatment.

## Who must perform these services to qualify for payment

Authorized services must be performed by a:

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

## Requirements for billing

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan established by the visit billed using **90867.**

Billing of rTMS codes must be in accordance with CPT® code definitions.

Documentation of the treatment must support billing one of the three codes listed below for each date of service.

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

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

E/M activities related to cortical mapping, motor threshold determination, and/or delivery and management of rTMS aren't separately payable.

Don't bill more than one unit per day to report TMS.

 

## Services that can be billed

Repetitive transcranial magnetic stimulation (rTMS) is covered for workers with unipolar or bipolar diagnosis. This coverage is dependent upon the criteria outlined in the coverage decision.

Only therapies reflected in the CPT® code descriptions for the following codes may be authorized:

- **90867**
- **90868**
- **90869**

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

## Payment limits

| When billing this code… | The max billable units per day is… | And the max billable units per the life of the claim is… |
|---|---|---|
| **90867** | 1 | 3 |
| **90868** | 1 | As proper and necessary |
| **90869** | 1 | 6 |

**These three codes may not be billed together on the same date of service.**

Multiple claims for the same claimant are subject to split billing.

## Services not covered

TMS protocol that isn't FDA approved is not covered.

Services that aren't pre-authorized may be denied.

# Payment policy: Residential facility offering treatment for mental health

## General information

This policy applies to workers who require admission to a **residential facility for mental health** services. Workers covered under this policy update are either filing the initial claim, or have an open and allowed claim. This includes those who:

- Have an accepted mental health condition, such as occupational posttraumatic stress disorder (PTSD), *or*
- Have mental health treatment authorized, which may include the need for treatment of substance use disorder.

For information on which insurer to bill, see Chapter 2: Information for All Providers.

For additional inpatient or outpatient facility information, see Chapter 35: Hospitals.

For mental health services and authorization requirements, see Chapter 17: Mental Health Services. Supplemental information is defined in WAC 296-21-270.

Requirements for PTSD is defined in RCW 51.08.165. For occupational disease requirements, see RCW 51.08.142 and RCW 51.32.185 (presumptive coverage).

### Claim filing

The filing of the initial L&I Report of Accident (ROA) or Provider's Initial Report (PIR) does not require prior authorization. The insurer covers the initial visit and evaluation so long as the L&I ROA or PIR and documentation of the initial evaluation conducted by the facility is submitted within one year from date of service. See Chapter 2: Information for All Providers for additional details on initial visits.

For workers where the facility is filing the L&I Report of Accident (ROA) or Provider's Initial Report (PIR) **and the worker requires treatment**, the following must be submitted to the insurer:

- The ROA or PIR, *and*
- Initial evaluation of the worker, including DSM-5 diagnosis with supporting documentation to support the diagnosis and pre-screening intake, if conducted, *and*
- Request for authorization for ongoing treatment.

The recommended treatment plan and all treatment records must be submitted to the insurer for authorization of ongoing treatment.

**Note**: Each facility may require their own release of record form, however, the insurer's ROA/PIR requires a signature by the worker to release relevant medical records. The ROA/PIR may be used in lieu of the facility's release of records form.

### Claim status

The following are example claim statuses of workers who seek treatment at a **residential facility for mental health**:

1. Initial claim filing, evaluation **without** treatment. In this case, the worker may seek initial evaluation from a facility without prior authorization, but may not receive a mental health diagnosis per DSM-5 or require ongoing treatment. The insurer covers the initial visit and evaluation so long as the L&I ROA or PIR and documentation of the initial evaluation conducted by the facility is submitted within one year from date of service. See Chapter 2: Information for All Providers for additional details on initial visits.
2. Initial claim filing, evaluation **with** treatment. In this case, the worker may seek treatment from a facility and may require ongoing treatment per a DSM-5 diagnosis. The insurer covers the initial visit and evaluation so long as the L&I ROA or PIR and documentation of the initial evaluation conducted by the facility is submitted within one year from date of service. Additionally, prior authorization is required for ongoing treatment. See Mental Health Services, Chapter 17: Mental Health Services, and the prior authorization requirements for additional details.
3. Established claim. In these cases, an L&I worker's compensation claim is open and allowed and requires prior authorization for treatment. See prior authorization requirements for additional details.

In order to assist the worker and their providers, the insurer requires timely documentation. See documentation requirements below for additional details.

Treatment beyond the first visit and evaluation won't be paid when a claim is rejected.

### Treatment

A referral from either the attending provider (AP) or a mental health provider (psychiatrist, psychiatric ARNP) is required prior to admission for open and allowed claims.

## Prior authorization

Mental health prior authorization treatment requirements apply to claims filed through a **residential treatment facility**. Contact the insurer for prior authorization.

For workers with an open and allowed claim for accepted mental health conditions or treatment has been authorized, the following is required:

Inpatient:

- An evaluation by the facility, including a treatment plan, must be sent to the insurer for authorization **prior** to initiating treatment. The start date for treatment must be submitted as part of the evaluation.
- For treatment lasting longer than 6 weeks additional authorization is required. Contact the insurer for prior authorization. An updated treatment plan is required for additional authorization.

Ongoing treatment:

- Once discharged from inpatient treatment, an AP must be identified by the worker, or alternatively if the worker has identified an AP prior to admission at a facility, then care must be transferred back to the provider upon the worker's discharge. The AP is responsible for managing the overall care of the patient after discharge from a **residential facility for mental health**. The worker has the right to choose their AP.
- Once an AP is obtained or the worker returns to their provider's care, an updated treatment plan is required for additional treatment authorization as part of the worker's ongoing medical management. Facilities aren't required to develop an ongoing treatment plan once the worker has transferred care to an AP.

## Payment methods

Bill the insurer usual and customary fees.

In state facilities will be paid POAC, DRG, or APC rate. See Chapter 35: Hospitals for details.

Out of state facilities will be paid at POAC rate. See Chapter 35: Hospitals for details.

## Who must perform these services to qualify for payment

Washington State **residential facilities for mental health** must be certified and licensed by the Department of Health.

Out of state **residential facilities for mental health** must be licensed by the state the facility is located in, and accredited by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or any other state-approved accrediting organization.

See Chapter 17: Mental Health Services for additional details on who can provide mental health services.

 

## Services that can be billed

The insurer covers the following codes with prior authorization:

- **H0035**
- **H0047-H0050**
- **H2035**
- **H2036**
- **S9480**

This is in addition the codes found on the fee schedule.

## Services that aren't covered

In addition to the codes not covered on the fee schedule, the following services aren't covered:

- **H0031-H0032**
- **H0036-H0040**
- **H0046**
- **H2001**
- **H2010-H2034**
- **H2037-H2038**

## Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a 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 a patient admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via POAC rate.

 

### Documentation requirements

Chart notes and any treatment plan updates, per Chapter 2: Information for All Providers, and Chapter 17: Mental Health Services must be submitted to the insurer.

In addition to the requirements noted in Chapter 2: Information for All Providers, Chapter 17: Mental Health Services, and mental health services, all facilities must provide the insurer with the following documentation:

- Causality statement for the industrial injury or occupational disease (DSM-5 diagnosis) for initial claim filing, *and*
- The initial evaluation from a provider at the facility when the worker is admitted, *and*
- A recommended course of action for the worker, *and*
- Progress reports on a bi-weekly basis, *and*
- Discharge summary, including the proposed ongoing treatment plan for the worker when they return to their AP or mental health provider.

Make sure all documentation includes:

- The worker's full name,
- L&I claim number,
- Time as required per CPT® or HCPC coding,
- Treatment that was provided,
- Treating provider name, address and telephone number.

Don't fax the treatment plans or chart notes with bills. See Chapter 2: Information for All Providers for details on submitting chart notes and treatment plans to the insurer.

## Payment limits

Providers may not charge workers for copayments or deductibles. The worker may not be balance billed for any services that are claim related. See RCW 51.04.030(2) and WAC 296-20-020.

# Payment policy: Telehealth for mental health services

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services.

## Services that must be performed in person

An in-person evaluation is required once every 6 months. In-person evaluations are always required when:

- Consultations requested to determine if conservative care is appropriate, *or*
- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific services, *or*
- The worker does not want to participate via **telehealth.**

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

 

## Prior authorization

The prior authorization requirements listed in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

## Services that are covered

The same services that can be billed in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Mental health examinations to complete a ROA or PIR filing and/or Activity Prescription Forms (even when restrictions or changes are anticipated) are covered when performed via **telehealth**.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

 

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

**Note**: See the Audio Only Mental Health Services payment policy for additional details regarding mental health services provided via audio only.

## Services that aren't covered

The same services that aren't covered in Chapter 17: Mental Health Services apply to this policy.

Telephonic (audio only) mental health services may be payable in certain circumstances, see the Audio Only Mental Health Services for additional details. Case management services may also be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

**G2010** and **G2250** aren't covered services.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Neuropsychological testing,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs any service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| | | | |
|---|---|---|---|
| Originating site is… | Worker's home | | |
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth.**

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

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

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same limits noted in Chapter 17: Mental Health Services apply regardless of how the service is rendered to the worker.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for attending providers | Washington Administrative Code (WAC) 296-20-01002 |
| **Administrative rules** for consultations and consultation requirements | WAC 296-20-045<br>WAC 296-20-051 |
| **Administrative rules** for mental health services | WAC 296-21-270<br>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 website** | Mental health services on L&I's website |
| Payment policies for **case management services** | Chapter 10: Evaluation and Management (E/M) Services |
| Payment policies for **teleconsultations and other telehealth services** | Chapter 10: Evaluation and Management (E/M) Services |
| Mental health services payment policies for **crime victims** | Crime Victims program on L&I's website<br>WAC 296-31 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 18: Modifications to Home and Vehicle

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**By Report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report, see WAC 296-20-01002.

**Residence (home) modification**: A residence or home modification is a permanent change to an existing residence or a repair of a modification previously approved and paid for by the department or self-insured employer, or a modification made when constructing a new residence.

**Links**: For more information, see WAC 296-14-6200. For Job Modifications and Pre-Job Modifications, see Chapter 30: Vocational Services.

 

# Payment policy: Home modifications

## Prior authorization

To request prior authorization for a **consultation**, contact:

- The claim manager for State Fund claims.
- The employer or their claims representative for self-insured claims.

For **construction and design work**, pre-authorization:

- Must be done by the Assistant Director (AD) for Insurance Services for State Fund claims.
- Can't be denied without the AD's approval for self-insured claims.

## Who must perform these services to qualify for payment

The **home modification** consultant must:

- Be a licensed nurse, occupational therapist, or physical therapist, *and*
- Have training or experience in both rehabilitation of catastrophic injuries and modifying homes.

# Services that can be billed

## Home modifications fee schedule

| For this **HCPCS or local billing code**… | The **provider that can bill** is a: | And the **insurer pays for**: | With a **maximum fee** of: |
|---|---|---|---|
| **8914H**<br>Home modification **construction and design**. | Contractor,<br>Architect,<br>Construction material supplier, *and*<br>Worker. | • Construction materials,<br>• Labor & tax,<br>• Permits and inspections, and<br>• Architect plans.<br>If the worker pays for inspections, predesign, or planning services, the worker may be reimbursed if the modification request is approved. | Each bill pays **By Report** (as billed) up to the maximum amount authorized for the home modification. |
| **8916H**<br>Home modification **consultation**. | Home modification consultant. | **Time spent** doing:<br>• Onsite home evaluation,<br>• Consultation, or<br>• Required reports. | **By Report.** |

| For this **HCPCS or local billing code**… | The **provider that can bill** is a: | And the **insurer pays for**: | With a **maximum fee** of: |
|---|---|---|---|
| **8917H**<br>Home modification **mileage, lodging, bridge and ferry tolls, airfare, and car rental.** | Home modification consultant. | **Mileage**<br><br>**Lodging** for 1 person when the onsite visit requires:<br>• Two or more consecutive days, *and*<br>• Is greater than 125 miles one way.<br>**Airfare** (economy) for 1 person when travel is greater than 180 miles one way.<br><br>**Car rental** (economy) when air travel is involved. | **State rates.** |
| **0391R**<br>**Travel**. | Home modification consultant. | **Travel time or wait time** | **$5.56** per unit (1 unit = 6 minutes) |

## Requirements for billing

To get reimbursed, you must submit a copy of receipts for:

- Materials,
- Lodging,
- Airfare, *and*
- Car rental.

## Payment limits

The insurer will pay for **home modification** construction and design for only one residence for each catastrophically injured worker. The maximum amount payable is the current Washington State average annual wage.

 

# Payment policy: Vehicle modifications

## Prior authorization

Vehicle modifications require prior authorization based on approval by the Assistant Director of L&I's Insurance Services Program.

**Link**: More information about vehicle modifications is available in RCW 51.36.020(8).

## Who must perform these services to qualify for payment

### Consultations

The vehicle modification consultant must:

- Be a licensed occupational or physical therapist, or licensed medical professional, *and*
- Have training or experience in both rehabilitation and vehicle modification.

## Services that can be billed

| If the **HCPCS and local billing code** is… | Then the **provider who can bill** is: | And **the insurer pays** for: | And the **maximum fee** is: |
|---|---|---|---|
| **8915H**<br>Vehicle modification | Contractor | **Vehicle modification** | Maximum payable for all work is ½ **the current Washington State average wage.**<br>The amount paid may be increased by no more than $4,000.00 by written order of the Supervisor of Industrial Insurance (see Link below table). |

| If the **HCPCS and local billing code** is… | Then the **provider who can bill** is: | And **the insurer pays** for: | And the **maximum fee** is: |
|---|---|---|---|
| **8917H**<br>Vehicle modification mileage, lodging, bridge and ferry tolls, airfare, and car rental | Vehicle modification consultants | **Mileage**<br>**Lodging** for 1 person when the onsite visit requires:<br>• Two or more consecutive days, and<br>• Is greater than 125 miles one way.<br>**Airfare** (economy) for 1 person when travel is greater than 180 miles one way.<br>**Car rental** (economy) when air travel is involved. | **State rates** |
| **8918H**<br>Vehicle modification consultation or driving evaluation | Vehicle modification consultants | **Time spent** doing:<br>• Onsite – vehicle and/or driving evaluation,<br>• Consultation, or<br>• Required reports. | **By report** |
| **0391R**<br>Travel | Vehicle modification consultants | **Travel time or wait time** | **$5.56** per unit<br>(1 unit = 6 minutes) |

## Requirements for billing

To get reimbursed, you must submit copies of receipts for:

- Lodging,
- Airfare, *and*
- Car rental.

## Payment limits

For local billing code **8915H**, the maximum payable for all vehicle modification is 50% of the current Washington State average wage. The amount paid may be increased by no more than **$4,000.00** by written order of the Supervisor of Industrial Insurance.

**Link**: For more information about vehicle modification payment increases, see RCW 51.36.020(8)(b).

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for home modifications | Washington Administrative Code (WAC) 296-14-6200 through WAC 296-14-6238 available in WAC 296-14 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Contractors' questions and answers** about home modifications for workers with catastrophic injuries | F252-061-000 |
| **Fact sheet** on home modifications for workers with catastrophic injuries | F252-060-000 |
| **Fee schedules** for all healthcare and vocational services | Fee schedules on L&I's website |
| **Home Modification Acknowledgement of Responsibilities** form | F247-003-000 |
| **Laws** for definitions | Revised Code of Washington (RCW) 50.04.355 |
| **Laws** for modification to residences or motor vehicles | RCW 51.36.020(7) and (8) |
| **Laws** for residence modification services | RCW 51.36.022 |
| **Laws** for right to and amount | RCW 51.32.095(4)<br>RCW 51.32.250 |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 19: Naturopathic Physicians and Acupuncture Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Comprehensive office visit** (from WAC 296-23-215): "A level of service pertaining to an in-depth evaluation of a patient with a new or existing problem, requiring development or complete reevaluation of treatment data; includes recording of chief complaints and present illness, family history, past treatment history, personal history, system review; and a complete exam to evaluate and determine appropriate therapeutic treatment management and progress."

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Established patient**: One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

**Extended office visit** i.e. expanded or detailed (from WAC 296-23-215): "A level of service pertaining to an evaluation of patient with a new or existing problem requiring a detailed history, review of records, exam, and a formal conference with patient or family to evaluate and/or adjust therapeutic treatment management and progress."

**New patient**: One who hasn't received any professional services from the physician nor another physician of the same specialty who belongs to the same group practice within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Routine office visit** i.e. problem-focused (from WAC 296-23-215): "A level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and exam."

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

# Payment policy: Acupuncture services

## General information

The insurer covers acupuncture only for allowed claims with an accepted diagnosis of a low back condition. Acupuncture requires a referral from the attending physician (AP).

## Who must perform these services to qualify for payment

Only Acupuncture and Eastern Medicine Practitioners (AEMP) and other providers who are licensed by the Department of Health to perform acupuncture may perform these services to qualify for payment.

## Services that can be billed

Treatment must be billed with local code **1582M**. No other acupuncture codes will be reimbursed.

- **1582M** (Acupuncture treatment with one or more needles, with or without electrical stimulation)

This code is billable a maximum of **10 times** during the life of a claim.

A provider performing acupuncture and billing the department for this service must perform an initial evaluation and submit a report that includes a treatment plan. This evaluation must be billed using the appropriate level evaluation and management (E/M) code. In addition to the initial visit, the acupuncture provider may schedule an E/M visit for a progress report as well as for a final visit.

At the baseline visit, middle or fifth visit, and on the final visit a 2-item GCPS (Graded Chronic Pain Scale) and an Oswestry Disability Index (ODI) form must be completed with the worker and sent to the insurer.

On the final visit, the reason for discharge of the worker must be documented.

**Link**: For details about payment criteria and documentation requirements for E/M services, see the payment policies in Chapter 10: Evaluation and Management.

# Payment policy: Naturopathic office visits

## Who must perform these services to qualify for payment

Naturopathic physicians must perform these services to qualify for payment.

## Services that can be billed

For initial office visits (i.e. **new patient**), these local codes can be billed:

- **2130A** (**Routine** face-to-face **office visit** and submission of a report),
- **2131A** (**Extended** face-to-face **office visit** and submission of a report), and
- **2132A** (**Comprehensive** face-to-face **office visit** and submission of a report [in addition to the report of accident]).

For follow up office visits (i.e. **established patient**), these local codes can be billed:

- **2133A** (**Routine** face-to-face **office visit** and submission of a report), *and*
- **2134A** (**Extended** face-to-face **office visit** and submission of a report).

## Services that aren't covered

Treatment of chronic migraine or chronic tension-type headache with manipulation/manual therapy is not a covered benefit.

The insurer won't pay naturopathic physicians for services that aren't specifically allowed, including consultations.

**Link**: For additional information, see WAC 296-23-205 and WAC 296-23-215.

## Requirements for billing

When billing for services, naturopathic physicians should use:

- The local codes listed in this payment policy (under Services that can be billed) to bill for office visit services,
- CPT® codes **99367** and **99441**-**99443** to bill case management services,
- Local code **9918M** to bill for secure online communication with L&I staff, vocational rehabilitation counselors, TPAs, or employers, and
- The appropriate HCPCS codes to bill for miscellaneous materials and supplies.

**Link**: For details about payment criteria and documentation requirements for case management services or secure online communication, see the payment policies in Chapter 10: Evaluation and Management.

## Payment limits

Only one naturopathic care visit per day per worker is payable.

**Note:** For details about splitting bills between multiple claims, see Chapter 10: Evaluation and Management.

# Payment policy: Telehealth for naturopathic physicians

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

## Services that must be performed in person

In-person evaluation is required when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- Consultations requested to determine if conservative care is appropriate, *or*
- A worker files a reopening application, *or*
- A worker requests a transfer of attending provider, *or*

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Services that are covered

When the treatment of the day doesn't require a hands-on component, naturopaths may bill local codes (**2133A-2134A**) when performed via **telehealth**.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Services that aren't covered

Any service that includes a hands-on component isn't covered under this policy, including acupuncture.

The same services that aren't covered in Chapter 19: Naturopathic Physicians and Acupuncture Services apply to this policy.

**G2010** and **G2250** aren't covered.

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- Initial office visits (**2130A**-**2132A**) aren't covered when performed via **telehealth**. These services require an in-person visit.
- The services listed under "Services that must be performed in-person",
- Hands-on services, including acupuncture,
- Completion and filing of any form that requires a hands-on physical examination (e.g. Report of Accident, Provider's Initial Report),
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
    - Telehealth transmission, per minute (HCPCS code **T1014**).

**Note**: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, such as an E/M, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| | | | |
|---|---|---|---|
| Originating site is… | Worker's home | | |
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See Chapter 19: Naturopathic Physicians and Acupuncture Services and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same limits noted in Chapter 19: Naturopathic Physicians and Acupuncture Services apply regardless of how the service is rendered to the worker.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for naturopathic physicians | Washington Administrative Code (WAC) 296-23-205<br>WAC 296-23-215 |
| **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 services | Fee schedules on L&I's website |
| Payment Policies for **Evaluation and Management** | Chapter 10: Evaluation and Management |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

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# Chapter 20: Nurse Case Management

**Effective July 1, 2022**

## *Note for MARFS 2022*

**L&I is in the process of revising this payment policy. Sign up for GovDelivery to stay informed of changes. We will notify providers via GovDelivery if this policy is revised prior to July 2023.**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**By Report (BR)**: A code listed in the fee schedule as "BR" doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must supply a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report (BR), see WAC 296-20-01002.

**Nurse case management (NCM)**: A collaborative process used to meet a worker's healthcare and rehabilitation needs. The nurse case manager:

- Works with the attending provider, worker, allied health personnel, and insurer's staff to assist in locating a provider (primarily for out-of-state claims) and/or with coordination of the prescribed treatment plan, and
- Organizes and facilitates timely receipt of medical and healthcare resources and identifies potential barriers to medical and/or functional recovery of the worker, and
- Communicates this information to the attending provider, claim manager, and ONC to develop a plan for resolving or addressing the barriers.

 

# Payment policy: Case management records and reports

## Requirements for reports

Nurse case management reports must be completed **monthly**.

Optional reporting templates available are **Nurse Case Management Initial Care Management Plan** (F245-442-000) and **Nurse Case Management Progress Report** (F245-439-000).

Initial assessment, monthly, progress, and closure reports must include all of the following information:

- Type of report (initial, progress, or closing), *and*
- Worker name and claim number, *and*
- Report date and reporting period, *and*
- Worker date of birth and date of injury, *and*
- Contact information, *and*
- Diagnoses, *and*
- Reason for referral, *and*
- Current medical status, *and*
- Recommendations for future actions, *and*
- Actions taken and dates, *and*
- Ability to positively impact a claim, *and*
- Health care provider(s) name(s) and contact information, *and*
- Psychosocial/economic issues, *and*
- Vocational profile, *and*
- Hours incurred to date on the referral, *and*
- Amount of time spent completing the report.

## Requirements for records

Case management records must:

- Be created and maintained on each claim, *and*
- Present a chronological history of the worker's progress in NCM services, *and*
- Be submitted within 30 days of the date of service, *and*
- Include **index to: NCM** in the lower right footer of the report.

## Requirements for case notes and reports

Case management notes and reports must be created when a service is rendered and must specify:

- When the service was provided, *and*
- What type of service was provided using local billing codes, *and*
- Description of the service provided including subjective and objective data, *and*
- How much time was spent providing each service.

## Payment limits

Payment is restricted to:

- Up to 2 hours (20 units) for **initial reports**, and
- Up to 1 hour (10 units) for **progress and closure reports**.

 

# Payment policy: Nurse case management (NCM)

## Prior authorization

### NCM services

Prior authorization by the worker's claim manager and L&I's ONC is required for NCM services. Contact the insurer to make a referral for NCM services.

Workers must meet one or more of these criteria to be selected to receive NCM services:

- Catastrophic work-related injuries not managed under the Catastrophic Project, *and/or*
- Moved out of state and need assistance locating a provider, *and/or*
- Medically complex conditions, *and/or*
- Barriers to successful claim resolution.

### Expenses

The claim manager must give prior authorization to reimburse for expenses for:

- Parking,
- Ferry,
- Toll fees,
- Cab,
- Lodging, *and/or*
- Airfare

These expenses correspond to local billing code **1225M** and have a payment limit of **$725.00**.

## Who must perform these services to qualify for payment

To qualify for payment, NCM services must be performed by a registered nurse:

- With case management certification, *and*
- Who is aware of resources in the worker's location.

Examples of case management certification include but are not limited to:

- Certification of Disability Management Specialists (CDMS)
- Commission for Case Manager Certification (CCMC or CMC)
- Certified Rehabilitation Registered Nurse (CRRN)
- Certified Occupational Health Nurse (COHN)
- Certified Occupational Health Nurse-Specialist (COHN-S)

### NPIs for NCMs

Effective January 1, 2022, NCMs are required to submit a National Provider Identifier (NPI) through the ProviderOne portal. NPIs are unique 10-digit numbers used for identifying specific providers. NPIs are used by medical providers nationwide.

If you do not have an NPI number, go to the National Provider Identifier Standard section of the Centers for Medicare and Medicaid Services (CMS) website. Registering for an NPI number is free and does not require an SSN. Assistance with submitting the NPI is available on L&I's ProviderOne website.

## Services that aren't covered

Expenses that aren't covered include:

- Nurse case manager training,
- Supervisory visits,
- Postage, printing and photocopying (except medical records requested by L&I),
- Telephone/fax equipment,
- Clerical activity (for example, faxing documents, preparing documents to be mailed, organizing documents, email, etc.),
- Travel time to post office or fax machine,
- Wait time exceeding 16 hours per referral,
- Email communications with department staff,
- Fees related to legal work, such as deposition and testimony, *and*
- Any other administrative costs not specifically mentioned above.

 

**Note**: Legal fees may be charged to the requesting party, but not the claim.

## Requirements for billing

### Local billing codes

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

- **1220M** (Phone calls, per 6 minute unit),
- **1221M** (Visits, per 6 minute unit),
- **1222M** (Case planning, per 6 minute unit),
- **1223M** (Travel/Wait, per 6 minute unit – 16 hour limit per referral.)
- **1224M** (Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager), which pays at the **state rate**, and
- **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), which pays **By Report**.
- **9918M** (Online communications) view Chapter 10 for details about using this code.

### Billing units

When billing the local codes for NCM services (listed above), units are whole numbers only (don't use tenths of units), and 1 unit of service equals:

- Each traveled mile, *or*
- Each 6 minutes of phone calls, visits, case planning, or travel/wait time (see table below), *or*
- Each related travel expense (see **1225M**).

| If the time is… | Then bill: |
|---|---|
| 6 minutes-11 minutes | 1 unit |
| 12 minutes-17 minutes | 2 units |
| 18 minutes-23 minutes | 3 units |
| 24 minutes-29 minutes | 4 units |
| 30 minutes-35 minutes | 5 units |
| 36 minutes-41 minutes | 6 units |
| 42 minutes-47 minutes | 7 units |
| 48 minutes-53 minutes | 8 units |
| 54 minutes-59 minutes | 9 units |
| 60 minutes | 10 units |

## Payment limits

### NCM services

NCM services are capped at 75 hours of service per referral, including professional and travel/wait time.

Pre-authorization is required for continued NCM work beyond the initial authorization. An additional 25-hour extension may be granted after staffing with the insurer. For State Fund claims, please contact the ONC. Further extensions may be granted in exceptional cases, contingent upon review by the insurer, and will also require prior authorization.

### Expenses

Local billing code **1225M** has a payment limit of **$725.00**.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **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 services | Fee schedules on L&I's website |
| **General Provider Billing Manual** | F245-432-000 |
| **Nurse Case Management Initial Care Management Plan** | F245-442-000 |
| **Nurse Case Management Progress Report** | F245-439-000 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 21: Obesity Treatment

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Body Mass Index (BMI)**: BMI is a number calculated from a person's weight and height and is used as an indicator of body fatness (the higher the number, the more body fat). A BMI calculator is available on the National Institute of Health website.

**Severe obesity**: For the purposes of providing obesity treatment services, L&I defines severe obesity as a BMI of 35 or greater (see definition of **BMI**, above).

# Payment policy: Obesity treatment

## Prior authorization

### Parameters for coverage

All obesity treatment services require prior authorization.

Obesity doesn't meet the definition of an industrial injury or occupational disease. **Temporary treatment** may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

To be eligible for obesity treatment services, the worker must have **severe obesity** (a **BMI** of 35 or greater).

### Requesting weight reduction services

The attending provider should contact the insurer to request a weight reduction program if the worker meets *all* of the following criteria:

- Is severely obese (**BMI**>35), *and*
- Obesity is the primary condition retarding recovery from the accepted condition, *and*
- Weight reduction is necessary to undergo required surgery, participate in physical rehabilitation, or return to work.

The attending provider who believes that the worker may qualify for weight reduction services:

- Must advise the insurer of the worker's weight and level of function prior to the injury and how it has impacted rehab and recovery, *and*
- Must submit medical justification for obesity treatment, including tests, consultations, or diagnostic studies that support the request, *and*
- May request nutrition counseling with a Certified Dietician (CD) or Certified Registered Dietician Nutritionist (RDN) when it has been determined that weight reduction nutrition counseling is appropriate for the worker.

### Required: Treatment plan

Prior to receiving authorization for weight reduction services, the attending provider and worker are required to develop a **treatment plan**, which must include:

- The amount of weight the worker must lose to undergo surgery, *and*
- The estimated length of time needed for the worker to lose the weight, *and*
- A diet and exercise plan, including a weight loss goal, approved by the attending provider as safe for the worker, *and*
- Specific program or other weight loss method requested, *and*
- Attending provider's plan for monitoring weight loss, *and*
- Documented weekly weigh-ins, *and*
- Counseling and education provided by trained staff *and*
- For State Fund claims, the attending provider must sign an authorization letter generated by the Claim Manager, which serves as a memorandum of understanding between the insurer, the worker, and the attending provider.

### Restrictions

A weight reduction treatment plan may include participation in a group weight loss program, but this isn't a requirement.

Weight reduction services won't include requirements to buy supplements or special foods.

### Authorization

The insurer authorizes obesity treatment for **up to 90 days at a time** as long as the worker does all of the following to ensure continued compliance with the obesity treatment plan:

- Loses at least 5 pounds over the course of 6 weeks of treatment *and*
- Regularly attends weekly treatment sessions *and*
- Complies with the approved weight reduction plan, *and*
- Is evaluated by the attending provider at least every 30 days, *and*
- Sends the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

 

The insurer will no longer authorize obesity treatment when any one of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan (if the worker chooses to continue the weight loss program for general health, it will be at his or her own expense), *or*
- Obesity no longer interferes with recovery from the accepted condition (see Link below), *or*
- The worker isn't losing the 5 pound minimum requirement over 6 weeks of treatment *or*
- The worker isn't cooperating with the approved weight reduction services plan of care.

**Link**: To see more information about why it is prohibited to treat an unrelated condition once it no longer retards recovery from the accepted condition, see WAC 296-20-055.

## Attending provider's responsibilities

Upon approval of the obesity treatment plan, the attending provider's role is to:

- Examine the worker every 30 days to monitor and document weight loss, *and*
- Notify the insurer when:
  - The worker reaches the weight loss goal, *or*
  - Obesity no longer interferes with recovery from the accepted condition, *or*
  - The worker is no longer losing the weight needed to meet the weight loss expectations and plan of care.

## Who must perform these services to qualify for payment

### Nutrition counseling

Only Certified Dieticians or Certified Registered Dietician Nutritionists will be paid for nutrition counseling services.

Providers practicing in a state other than Washington that are similarly certified or licensed may apply to be considered for payment.

# Services that can be billed

## Nutrition counseling

Certified Dieticians and Certified Registered Dietician Nutritionists may bill for authorized services using these CPT® billing codes:

- **97802** at initial visit, with a maximum of four units, *and if necessary*
- **97803** for re-assessment with a maximum of four units per visit and a maximum of five visits. An additional six visits may be authorized if the minimum weight loss is met.

One unit of either CPT® **97802** or **97803** equals 15 minutes.

## Expenses for an attending provider-recommended group support setting

The **worker** will be reimbursed for attending provider-recommended group support meetings when billing using the following local codes:

- **0440A** (Weight loss program, joining fee, worker reimbursement), and
- **0441A** (Weight loss program, weekly fee, worker reimbursement).

  The worker may participate in these meetings remotely (via telehealth).

# Services that aren't covered

The insurer doesn't pay the group support weight loss provider directly.

The insurer doesn't pay for:

- Surgical treatments of obesity (for example, gastric stapling, or jaw wiring),
- Drugs or medications used primarily to assist in weight loss,
- Special foods (including liquid diets),
- Supplements or vitamins,
- Educational materials (such as food content guides and cookbooks),
- Food scales or bath scales,
- Nutrition counseling via telehealth, or
- Exercise programs or exercise equipment.

 

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for treating conditions unrelated to the accepted condition | Washington Administrative Code (WAC) 296-20-055 |
| **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 obesity treatment services) | Fee schedules on L&I's website |
| How to **calculate BMI** | National Institute of Health's website |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 22: Other Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Sign language interpretation**: Sign language interpretation includes American Sign Language (ASL), tactile interpretation, and sign languages from countries other than the United States.

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren’t appropriate without a video connection.

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**-8S (Health services coordination)**

Used to indicate health services coordinators bill completed a second billable case note on the same day for the same claimant on the same claim. Payment for the second case note is made at 50% of the fee schedule level or billed charge, whichever is less.

**-93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)**

Used to indicate an audio only service occurred between a physician or other qualified health care professional and a patient who is located away from the physician or other qualified health care professional. The totality of the exchange between the health care professional and patient must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

 

# Payment policy: Activity coaching (PGAP®)

## Definition of activity coaching

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<br>(1 unit = 15 min) | **$44.81** |
| **1401W** | Activity Coaching Reassessment | 5 units per day<br>10 units maximum<br>(1 unit = 15 min) | **$43.42** |
| **1402W** | Activity Coaching Intervention | 4 units per day<br>40 units maximum<br>(1 unit = 15 min) | **$41.32** |
| **1160M** | PGAP® Workbook/EBook/Video | 1 maximum | **$109.25** |

 

# Payment policy: Activity coaching (PGAP®) telehealth

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Services can be offered in person, telephonically, or via **telehealth**. There is reimbursement parity regardless of the mode of service.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Services that are covered

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** visit with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

 

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Services that aren't covered

**G2010** isn't a covered service.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- The services listed under "Services that must be performed in-person",
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| Originating site is… | Worker's home | | |
|---|---|---|---|
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

Chart notes must contain documentation that justifies the level, type and extent of service billed. See Activity Coaching (PGAP®) and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same limits noted in Activity Coaching (PGAP®) apply regardless of how the service is rendered to the worker.

# Payment policy: Activity coaching telephone calls to worker legal representatives

## Who must perform these services to qualify for payment

Telephone calls are payable to approved PGAP® Activity Coaches only when they personally participate in the call.

## Services that can be billed

These services are payable when providing outreach, education, and facilitating services with the worker's legal representative identified in the claim file.

The insurer will pay for telephone calls if the coach leaves a detailed message for the recipient and meets all of the documentation requirements. Telephone calls are payable regardless of when the previous or next office visit occurs.

## Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues, *or*
- Routine requests for appointments.

## Requirements for billing

Use the correct local billing codes and provide documentation as described below.

| If the duration of the telephone call is… | And you are a PGAP activity coach, then bill local code… |
|---|---|
| 1-10 minutes | **1725M** |
| 11-20 minutes | **1726M** |
| 21-30 minutes | **1727M** |

## Documentation requirements

Each provider must submit documentation for the telephone call that includes:

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

This may be documented in a report and/or a session note.

**Note**: See Chapter 10: Evaluation and Management Services for telephonic communication with persons other than legal representatives.

# Payment policy: After-hours services

## Services that can be billed

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

- When the provider's office isn't regularly open during the time the service is provided, *or*
- When emergency services are provided out of the office, and these services interrupt both normal office operations and other scheduled office visits.

## Documentation requirements

Medical necessity and urgency of the service must be documented in the medical records and be made available to the insurer upon request.

## Payment limits

Only one code for after-hours services will be paid per worker per day. A second day can't be billed for a single episode of care that carries over from one calendar day to the next.

CPT® codes **99050**-**99060** aren't payable when billed by:

- Emergency room physicians,
- Anesthesiologists/anesthetics,
- Radiologists, *or*
- Laboratory clinical staff.

# Payment policy: Behavioral health interventions (BHI)

## Definition of behavioral health intervention

Behavioral health interventions (BHIs) 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.

Intervention can take many forms. Cognitive behavioral therapy and motivational interviewing are two popular methods. An overview of other common modalities is available from the University of Washington.

Behavioral health interventions are appropriate if the provider has reason to believe that psychosocial factors may be affecting the worker's medical treatment or medical management of an injury.

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

## Who must perform these services to qualify for payment

Attending providers, psychologists, and Masters Level Therapists (MLTs) may provide these services. Coverage and billing requirements differ—see the table in Requirements for billing later in this section.

## Services that can be billed

Prior authorization isn't required for behavioral health interventions.

MLTs may bill up to a maximum of 16 during the life of a claim. See the Behavioral Health Services policy for details.

## Services that aren't covered

If a mental health condition has been accepted or denied on a claim, BHIs aren't appropriate and can't be billed. Don't perform or bill for BHIs on claims with accepted or denied mental health conditions. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions.

## Requirements for billing

BHIs are billed using the physical diagnosis or diagnoses on the claim.

| If you are… | Then bill… |
|---|---|
| A psychologist | CPT® **96156**, **96158**, and/or **96159**, as appropriate |
| An attending provider | BHI as part of your Evaluation & Management service, per CPT® manual |
| A Masters Level Therapist (MLT) such as an LMFT, LICSW, or LMHC participating in L&I's pilot project | Using the billing procedures and guidelines in L&I's MLT Pilot Behavioral Health Services policy |

**Link**: See Chapter 10: Evaluation and Management Services for additional information.

# Payment policy: Behavioral health interventions (BHI) audio only

## General information

The insurer covers audio only behavioral health interventions (BHIs). Refer to the Master Level Therapists pilot policy for information on BHIs provided by Master Level Therapists (MLTs).

## Services that are covered

When behavioral health interventions are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created a local code for behavioral health intervention services that may occur via audio only. See requirements for billing. The requirements for prior authorization, documentation, and payment limits listed in Behavioral Health Interventions apply to the following services covered under this update.

Bill using code **9959M** when BHI occurs over audio only. This code is only payable to psychologists.

**Note**: Refer to Chapter 10: Evaluation and Management Services and CPT® coding for telephone calls for behavioral health counseling services that are included as part of E/M.

## Services that aren't covered

If a mental health condition has been accepted or denied on a claim, BHIs aren't appropriate and can't be billed. Don't perform or bill BHIs on claims with accepted or denied mental health conditions. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions.

## Requirements for billing

Bill using modifier **-93** to indicate services rendered via audio only.

### Documentation requirements

Psychologists must document all medical, vocational, or return to work decisions made.

For the purposes of this policy, the following must be included in the provider's documentation:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in audio only services.

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

# Payment policy: Health Services Coordination (HSC)

## General information

Health services coordinators assist the providers, workers, and employers by:

- Assisting the worker in setting and accomplishing reactivation goals,
- Coordinating and tracking clinical referrals,
- Identifying barriers by conducting the Functional Recovery Questionnaire (FRQ),
- Tracking outcomes by capturing Pain and Function Scales,
- Referring workers to community services,
- Communicating medication issues to providers,
- Supporting return-to-work when medically possible,
- Facilitating the transition between providers, *and*
- Providing ongoing monitoring of the claim and worker's progress.

## Who must perform these services to qualify for payment

Approved health services coordinators collaborate with providers, employers, workers, and vocational counselors within L&I's provider Best Practice programs to improve communication and reduce disability.

Coordinators are identified in one of the three Best Practice programs and have their own L&I provider number for each program they participate in.

The Department approves new health services coordinators, who must meet a set of minimum qualifications. A provider or others meeting the minimum qualifications may become health services coordinators when their HSC application and attestations are approved by L&I.

L&I Claim Managers maintain adjudicative authority. L&I will have the sole responsibility for approving health services coordinator's provider number applications, establishing minimum qualifications, and setting and reporting performance measures.

**Links**: Health services coordinators should visit our Health Services Coordination homepage for additional details.

L&I's ProviderOne website has details on how to obtain a provider ID.

Information about occupational health and surgical best practices incentive programs is available online.

## Prior authorization

The attending provider must be enrolled in an L&I provider Best Practice program in order for the health services coordinator to bill for these services.

## Services that can be billed

The following activities are billable per 6-minute unit:

- Care coordination planning,
- Communicating with any parties to the claim or treatment plan, including, but not limited to, workers, providers, and employers,
- Community and clinical resource identification,
- Pain/function scales completion,
- Transfer of care documentation,
- Case conferences planning, participation, and documentation, *and*
- FRQ completion.

The following activities are bundled into the payment for health services coordination:

- Any claim file review, *and*
- Preparing documentation (ex: case notes).

### Health services coordination fee schedule

| Code | Description | Program | Fee |
|---|---|---|---|
| **1083M** | **Surgical health services coordination (initial surgical intake)**<br>Can be billed as a stand-alone service.<br>Max 1 per claim every 3 years. | Surgical Quality Care Program (SQCP) | **$157.28** |
| **1085M** | **Provider Recognition Program complex care coordination**<br>Can be billed as a stand-alone service.<br>Max 1 per claim.<br>*Note: Enrollment for this program begins July 1. Payment begins September 1, 2022. | Provider Recognition Program (PRP) | **$250** |

| Code | Description | Program | Fee |
|---|---|---|---|
| **1087M** | **COHE health services coordination**<br>Can be billed as a stand-alone service. Can be billed with the **-8S** modifier.<br>Max 16 hours per claim per incentive program, using six-minute increments. | COHE | **$9.68** |
| **1088M** | **Surgical Quality Care Program health services coordination**<br>Can be billed as a stand-alone service. Can be billed with the **-8S** modifier.<br>Max 16 hours per claim per incentive program, using six-minute increments. | Surgical Quality Care Program (SQCP) | **$9.68** |
| **1089M** | **Provider Recognition Program health services coordination**<br>Can be billed as a stand-alone service. Can be billed with the **-8S** modifier.<br>Max 16 hours per claim per incentive program, using six-minute increments. | Provider Recognition Program (PRP) | **$9.68** |

## Services that aren't covered

Time spent documenting the case note and reviewing of the claim file isn't covered.

In addition, the following activities aren't payable:

- Traveling to/from a work site,
- Conducting provider orientation/education,
- General administrative meeting time,
- Responding to provider questions about best practice reporting, *and*
- Discussing best practice reporting with the Medical or Program Directors.

## Requirements for billing

When completing a second billable case note on the same day for the same claimant, bill using the **-8S** modifier.

Perform L&I health services coordinator standard work as defined on the care coordination webpage.

 

## Documentation and recordkeeping requirements

Document sharing agreement must be on file with the insurer.

Approved application/attestations are required by each incentive program.

Health services coordinator must utilize MAVEN's standard case note and submit required fields, including care coordination plan. Provider Recognition Program pilot health services coordinators are exempt from utilizing MAVEN for the duration of the pilot.

**Note**: Failure to comply with these requirements will result in denial or recoupment of payment by the insurer.

## Payment limits

Each incentive program is limited to 16 hours of HSC billing per claim.

# Payment policy: Locum tenens

## Who must perform these services to qualify for payment

A locum tenens physician must provide these services.

**Link**: For information about requirements for who may treat, see WAC 296-20-015.

## Services that aren't covered

Modifier **–Q6** isn't covered, and the insurer won't pay for services billed under another provider's account number.

## Requirements for billing

The department requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered.

# Payment policy: Provider mileage

## Prior authorization

Prior authorization is required for a provider to bill for mileage.

The round trip mileage must exceed 14 miles.

**Note**: Reimbursement for provider mileage is limited to extremely rare circumstances.

## Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **$5.70** per mile.

# Payment policy: Sign language interpretation

## General information

**Sign language** interpreters must follow all required standards for certification and interpreter behavior outlined in *Payment policy: All interpreter services* in Chapter 14: Language Access Services.

## Prior authorization

**Sign language interpretation** doesn't require prior authorization on open claims.

## Requirements for billing

**Sign language** interpreters must have an active L&I Provider ID.

Each submitted bill must be supported by an Interpretive Services Appointment Record (ISAR). Bills submitted without an ISAR may be denied. Please submit a completed ISAR (F245-056-000) with each bill. In addition to the ISAR, please attach an invoice with the following details:

- The interpreter's usual and customary fee amount, *and*
- Calculations used to determine the interpreter's usual and customary fee, including whether the fee includes an appearance fee and/or blocks of time (such as a 2-hour minimum).

## Services that can be billed

| Code | Description | L&I limit and authorization information | 1 unit of service equals… | Maximum fee |
|---|---|---|---|---|
| **9976M** | In-person **sign language interpretation** provided to facilitate communication between a worker or crime victim and a healthcare or vocational provider.<br><br>Interpretation time, wait time, and form completion time should be documented and shown as part of the calculation of the interpreter's usual and customary fee. | Doesn't require prior authorization. | 1 visit.<br><br>Each separate appointment for an individual worker/crime victim is considered one visit. | **By Report** |

## Services that aren't covered

Spoken language interpretation is covered under separate policies and is not billable using code **9976M**.

**Sign language** interpreters may not bill for mileage or travel time. However, if a **sign language** interpreter's usual and customary fee includes a block of time (such as a 2-hour minimum), that block can include time spent traveling to or from an appointment.

All other rules outlined in *Services that aren't covered* in *Payment policy: All interpreter services* in Chapter 14: Language Access Services also apply to **sign language** interpreters.

## Additional information

### Team interpretation

If a visit is scheduled for more than two hours, L&I recommends that two or more **sign language** interpreters be present in order to reduce fatigue and facilitate clear communication. All interpreters will be paid **By Report** for the visit when billing **9976M**. Group billing is not allowed; all interpreters must have valid L&I Provider IDs and should submit their own bills.

**Note**: For additional information on credentials, services that are covered, and other details regarding interpretation service, see Chapter 14: Language Access Services.

# 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 "Who may treat" | Washington Administrative Code (WAC) 296-20-015 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Health Services Coordination** | General information<br>Minimum requirements<br>Best practice incentive programs<br>Standard work |
| **Fee schedules** for all healthcare facility services | Fee schedules on L&I's website |
| **Masters Level Therapist** Behavioral Health Services policy | Masters Level Therapist policy on L&I's website |
| **Vendor services lookup** tool | Vendor services lookup tool on L&I's website |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 23: Pathology and Laboratory Services

**Effective July 1, 2022**

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

## Table of Contents

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–91 (Repeat clinical diagnostic laboratory test)**

Performed on the same day to obtain subsequent report test value(s). Modifier –91 must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use modifier –91 with the appropriate procedure code.

# Payment policy: Bloodborne pathogens

## Prior authorization

The insurer may pay for post exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease.

Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later.

The exposed worker must submit an accident report form before the insurer can pay for testing and treatment.

## Services that can be billed

### Diagnostic test or procedure

For diagnostic tests and procedures, the following CPT® codes can be billed:

- **47100**,
- **81370**-**81383**
- **86689**,
- **86701**,
- **86704**,
- **86706**,
- **86803**-**86804**,
- **87340**,
- **87390**,
- **87521**-**87522**,
- **87901**,
- **87903**-**87904**.

### Testing related procedure

For testing related procedures, the following CPT® codes can be billed:

- **78725**,
- **86360**,
- **87536**,
- **80076**,
- **90371**,
- **90746** (adult),
- **99202**-**99215**,
- **99217**-**99220**.

**Link**: The department's coverage decision about bloodborne pathogens is available online.

### Treating a reaction to testing or treatment of an exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to covered treatment for a probable exposure.

## Covered test protocols

### Testing schedule

Testing for hepatitis B, hepatitis C, and HIV should be done:

- At the time of exposure, *and*
- At 3, 6, and 12 months post exposure.

### Hepatitis B

For hepatitis B (HBV), the following test protocols are covered:

- HbsAg (hepatitis B surface antigen),
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen),
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate for post exposure prophylaxis.

 

### Hepatitis C

For hepatitis C (HCV), the following test protocols are covered:

- Enzyme Immunoassay (EIA),
- Recombinant Immunoblot Assay (RIBA),
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services only if HCV is an accepted condition on the claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR),
- Branched chain DNA (bDNA),
- Genotyping,
- Liver biopsy.

### HIV

For HIV, two blood tests are needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, *and*
- Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test,
- EIA test,
- Western Blot test,
- Immunofluorescent antibody.

The following tests are covered services only if HIV is an accepted condition on the claim:

- HIV antiretroviral drug resistance testing,
- Blood count, kidney, and liver function tests,
- CD4 count,
- Viral load testing.

 

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. Prior authorization isn't required.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count,
- Renal and hepatic chemical function tests.

## Covered bloodborne pathogen treatment regimens

### Chronic hepatitis B

For chronic hepatitis B (HBV):

- Interferon alfa-2b,
- Lamivudine.

### Hepatitis C

For hepatitis C (HCV) – acute:

- Mono therapy,
- Combination therapy.

### HIV/AIDS

For HIV/AIDS, covered services are limited to those within the most recent guidelines issued by the US Department of Health and Human Services AIDSinfo.

**Link**: The US Department of Health and Human Services AIDSinfo guidelines are available online.

# Payment policy: COVID-19 testing and vaccinations

## Prior Authorization

Prior authorization is required for COVID-19 tests and vaccinations.

## Requirements for billing

**U0002**-**U0004** are only payable to laboratories as outlined by Centers for Medicare and Medicaid Services (CMS).

High-throughput testing may only be performed and billed by pathologists.

## Services that can be billed

### Vaccinations and boosters

The insurer will pay for COVID-19 vaccinations and booster vaccinations when:

- The worker is immunocompromised, *and*
- The worker is residing in a nursing home, group home, skilled nursing facility, or receiving home health at home.

### Lab testing

Lab testing is covered when:

- The worker is receiving treatment or preparing for an invasive procedure that has been approved under the claim, *and*
- The provider requires the test, *and*
- The insurer authorizes the test.

Examples of procedures that may require testing in advance include:

- Approved surgeries, *or*
- Approved dental treatments.

Workers who reside in a nursing home, group home, skilled nursing facility, or are receiving home health at home may have lab testing for COVID-19 provided prior authorization is obtained.

**Link**: For new coverage decisions, see the MARFS updates and corrections online.

## Services that aren’t covered

Lab testing isn’t covered when:

- The provider doesn’t require the test, *or*
- The treatment or procedure hasn’t been approved under the claim, *or*
- The claim manager hasn’t authorized the test, *or*
- The employer has requested testing as a requirement for returning to work.

At-home testing kits aren’t covered for any reason.

# Payment policy: Drug screens

## Services that can be billed

The insurer will pay for:

- Drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver, *and*
- Confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

The department will pay for drug screening using the following billing codes:

- For presumptive testing billing codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

## Payment limits

Billing codes **80305**, **80306**, and **80307** are payable to laboratories with a CLIA certificate of waiver.

HCPCS billing codes **G0480**, **G0481**, **G0482** and **G0483** are limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.

 

# Payment policy: Non-CLIA Waived Testing

## Requirements for billing

Complex or moderately complex clinical pathology procedures that aren't waived under the Clinical Laboratory Improvement Act (CLIA) must be performed in laboratories that are accredited or have a categorized status under the State Department of Health or equivalent accrediting body.

## Payment limits

Payment for complex and moderately complex clinical pathology procedures won't be paid to any provider that only has a CLIA certificate of waiver or the Provider Performed Microscopic Procedure certificate.

# Payment policy: Panel tests

## Services that can be billed

### Automated multichannel tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both. Please refer to our fee schedule for code coverage and fees.

The following tests (CPT® codes) are automated multichannel tests or panels comprised solely of automated multichannel tests:

- **80047**,
- **80048**,
- **80050,**
- **80051**,
- **80053**,
- **80061**,
- **80069**,
- **80076**,
- **82040**,
- **82247**,
- **82248**,
- **82310**,
- **82374**,
- **82435**,
- **82465**,
- **82550**,
- **82565**,
- **82947**,
- **82977**,
- **83615**,
- **84075**,
- **84100**,
- **84132**,
- **84155**,
- **84295**,
- **84450**,
- **84460**,
- **84478**,
- **84520**,
- **84550**.

# Additional information: How to calculate payments

## Automated tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient.

Calculate the payment using the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined, *then*
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day, *then*
- Any duplicated tests are denied, *then*
- The total number of remaining unduplicated automated tests is counted.

To determine the payable fee based on the total number of unduplicated automated tests performed, see the following table:

| If the number of unduplicated automated tests performed is… | Then the fee is: |
|---|---|
| 1 test | Lesser of the single test or **$10.94** |
| 2 tests | **$10.94** |
| 3-12 tests | **$13.39** |
| 13-16 tests | **$17.89** |
| 17-18 tests | **$20.04** |
| 19 tests | **$23.21** |
| 20 tests | **$23.95** |
| 21 tests | **$24.71** |
| 22-23 tests | **$25.45** |

 

### Panels with automated and non-automated tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they are priced based on the:

- Automated multichannel test fee based on the number of tests, added to
- Sum of the fee(s) for the individual non-automated test(s).

**For example**, CPT® code **80061** is comprised of 2 automated multichannel tests and 1 non-automated test. As shown in the table below, the fee for **80061** is **$30.78**.

| If the CPT® 80061 component tests is: | And the number of automated tests is… | Then the maximum fee is: |
|---|---|---|
| Automated:<br>CPT® **82465** and CPT® **84478** | 2 | Automated:<br>**$10.94** |
| Non-automated:<br>CPT® **83718** | n/a | Non-automated:<br>**$11.63** |
| Maximum payment for CPT® code **80061**: | | **$30.78** |

### Multiple panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be **limited to the total fee allowed for the unduplicated component tests.**

The table below shows how to calculate the maximum payment when:

- **Panel codes 80050**, **80061**, and **80076** are billed with
- **Individual test codes 82977**, **83615**, **84439**, and **85025**.

| Test type | CPT® panel codes | | | | Individual tests | Test count | Max fee |
|---|---|---|---|---|---|---|---|
| | **80050** | **80061** | **80076** | | | | |
| Automated tests | **82040**, **82247**, **82310**, **82374**, **82435**, **82565**, **82947**, **84075**, **84132**, **84155**, **84295**, **84450**, **84460**, and **84520** | **82465** and **84478** | **82248** + these duplicated tests: **82040**, **82247**, **84075**, **84155**, **84450**, and **84460** | | **82977** **83615** | = 19 unduplicated automated tests (Note the fee in previous table on fees for automated tests) | **$23.21** |
| | **84443** | | — | — | — | — | **$24.02** |
| | **85025** or **85027** and **85004** or **85027** and **85007** or **85027** and **85009** | | — | — | — | — | **$11.11** |
| | **83718** | | — | — | — | — | **$11.63** |
| | — | | — | — | **84439** | — | **$12.90** |

| Test type | CPT® panel codes | | | | Individual tests | Test count | Max fee |
|---|---|---|---|---|---|---|---|
| | **80050** | **80061** | **80076** | | | | |
| Non-automated tests | — | | — | — | **85025** or<br>**85027** and **85004** or<br>**85027** and **85007** or<br>**85027** and duplicated test **85009** | — | **$11.11** |
| | | | | | | Maximum payment: | **$93.98** |

# Payment policy: Repeat tests

## Requirements for billing

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) **must be taken** from separate encounters. Also, the medical necessity for repeating the test(s) **must be documented** in the patient's record.

When billing, modifier **–91** must be used to identify the repeated test(s).

Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests payment policy section of this chapter (above).

## Payment limits

Tests normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

# Payment policy: Specimen collection and handling

## Who must perform these services to qualify for payment

The fee for billed specimen collection services is payable only to the provider who actually draws the specimen.

Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.

## Services that can be billed

### Specimen collection

Complex vascular injection procedures, such as arterial punctures and venisections, aren't subject to this policy and will be paid with the appropriate CPT® or HCPCS billing codes.

### Travel

Travel will be paid in addition to the specimen collection fee when all of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility, or homebound patient, *and*
- The provider personally draws the specimen, *and*
- The trip is solely for collecting the specimen.

## Services that aren't covered

### Specimen collection

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

### Travel

HCPCS code **P9604** (Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient, prorated trip charge) isn't covered.

# Requirements for billing

## Specimen collection

Use HCPCS billing codes:

- **P9612**, which is for "Catheterization for collection of specimen, single patient, all places of service," *and*
- **P9615**, which is for "Catheterization for collection of specimen(s) multiple patient(s)."

For venipuncture, use CPT® billing code **36415**.

## Travel

To bill for actual mileage, use HCPCS code **P9603** (1 unit equals 1 mile).

# Payment limits

## Specimen collection

Costs for media, labor, and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection. Payment for performing the test is separate from the specimen collection fee.

A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:

- A throat culture, *or*
- Pap smear, *or*
- A routine capillary puncture for clotting or bleeding time.

## Handling

Handling and conveyance won't be paid (for example, shipping, messenger, or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are integral to the process and are bundled into the total fee for testing service.

## Travel

Travel won't be paid to nursing home or skilled nursing facility staff that performs specimen collection.

If the specimen draw is incidental to other services, no travel is payable.

 

# Payment policy: STAT lab fees

## Services that can be billed

Usual laboratory services are covered under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS codes **S3600** or **S3601**.

## Requirements for billing

Tests ordered STAT should be limited only to those needed to manage the patient in a true emergency situation. Also:

- The medical record must reflect the medical necessity and urgency of the service, *and*
- The laboratory report should contain the name of the provider who ordered the STAT test(s).

Payment is limited to one (1) STAT charge per episode (not once per test).

## Payment limits

The STAT charge will only be paid with these tests:

- HCPCS code **G0306** (Complete CBC, auto w/diff), *or*
- HCPCS code **G0307** (Complete CBC, auto), *or*
- For presumptive testing CPT® codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

| …with these CPT® billing codes: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **80047** | **80184** | **81003** | **82435** | **83874** | **84520** | **85049** | **86880** | **87210** |
| **80048** | **80185** | **81005** | **82550** | **83880** | **84550** | **85378** | **86900** | **87281** |
| **80051** | **80188** | **82009** | **82565** | **84100** | **84702** | **85380** | **86901** | **87327** |
| **80069** | **80192** | **82040** | **82803** | **84132** | **84704** | **85384** | **86902** | **87400** |
| **80076** | **80194** | **82150** | **82945** | **84155** | **85004** | **85396** | **86920** | **89051** |
| **80156** | **80197** | **82247** | **82947** | **84157** | **85007** | **85610** | **86921** | |
| **80162** | **80198** | **82248** | **83615** | **84295** | **85025** | **85730** | **86922** | |

 

| …with these CPT® billing codes: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **80164** | **81000** | **82310** | **83663** | **84450** | **85027** | **86308** | **86923** | |
| **80170** | **81001** | **82330** | **83664** | **84484** | **85032** | **86367** | **86971** | |
| **80178** | **81002** | **82374** | **83735** | **84512** | **85046** | **86403** | **87205** | |

## 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 |
| **US Department of Health and Human Services AIDSinfo** guidelines | National Institute of Health (NIH) 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 services (including pathology and laboratory services) | Fee schedules on L&I's website |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 24: Pharmacy Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

## General

**Average wholesale price (AWP)**: A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

**Initial prescription drug or "first fill"**: Any drug prescribed for an alleged industrial injury or occupational disease during the initial visit.

**Initial visit**: The first visit to a healthcare provider during which the Report of Industrial Injury or Occupational Disease is completed for a claim for workers compensation.

## Preferred drug list

**Endorsing practitioner**: A practitioner who has reviewed the preferred drug list and has notified the health care authority that he or she has agreed to allow therapeutic interchange of a preferred drug for any non-preferred drug in a given therapeutic class,

**Preferred drug list (PDL)**: The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased healthcare programs,

**Refill (protection)**: The continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral or immunosuppressive drug, or for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least 24 weeks but no more than 48 weeks,

**Therapeutic alternative**: Drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses,

**Therapeutic interchange**: To dispense with the endorsing practitioner's authorization, a therapeutic alternative to the prescribed drug,

**Wrap around formulary**: The formulary the department uses for the drug classes that aren't part of the PDL but are part of the department's allowed drug benefit.

**Note**: Also see WAC 296-20-01002 for the above definitions.

# Payment policy: All pharmacy services

## Services that can be billed

The Outpatient Drug Formulary is a list of therapeutic classes and drugs that are covered under L&I's drug benefit. L&I uses a subset of the Washington State PDL and a wrap-around formulary for the remaining drug classes. Drugs or therapeutic classes listed on the formulary do not guarantee coverage and may be subject to specific L&I policy and determination of appropriateness for the accepted conditions.

**Links**: The Drug Lookup tool gives current coverage status for all non-injectable drugs, as well as a list of formulary alternatives and links to coverage policies, when applicable.

The outpatient formulary can be found online.

L&I's website has a list of policies relating to drug coverage, including limitations, criteria for coverage and treatment guidelines.

## Prior authorization

If a drug requires prior authorization but approval isn't obtained before filling the prescription, the drug won't be covered by the insurer.

### Non-preferred drugs

To obtain authorization for non-preferred drugs:

| If the **non-preferred drug** is part of the… | And you are a **PDL endorsing provider**, then: | Or you are a **non-endorsing provider**, then: |
|---|---|---|
| Preferred drug list | Change to the preferred drug<br>*or*<br>Write DAW for non-preferred drug. | Change to the preferred drug<br>*or*<br>For State Fund claims, contact the PDL Hotline.<br>For self-insured claims, contact the self-insured employer. |

| If the **non-preferred drug** is part of the… | And you are a **PDL endorsing provider**, then: | Or you are a **non-endorsing provider**, then: |
|---|---|---|
| Wrap-around classes | Change to the preferred drug<br>*or*<br>For State Fund claims, contact the PDL Hotline.<br>For self-insured claims, contact the self-insured employer. | Change to the preferred drug<br>*or*<br>For State Fund claims, contact the PDL Hotline.<br>For self-insured claims, contact the self-insured employer. |

**Note**: The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm (Pacific Time), and the toll free contact number is 1-888-443-6798.

**Links**: A list of SIE/TPAs is available online.

### Filling prescriptions after hours

If a pharmacy receives a prescription for a non-preferred drug when authorization can't be obtained, the pharmacist may dispense an **emergency supply** of the drug by entering a value of 6 in the DAW field. An emergency supply is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

The insurer must authorize additional coverage for the non-preferred drug.

## Who must perform pharmacy services to qualify for payment

The pharmacy services fee schedule applies to pharmacy providers only. It doesn't apply to medical providers administering drugs in the office. Please see Chapter 16: Medication Administration.

## Requirements for writing prescriptions

### Prescription forms

Orders for over the counter drugs or non-drug items must be dispensed pursuant to a prescription from an authorized prescriber for coverage consideration.

### Recordkeeping for prescriptions

Records must be maintained for audit purposes for a minimum of five years.

**Link**: For more information on recordkeeping requirements, see WAC 296-20-02005.

# Requirements for billing

## NCPDP payer sheet, version D.0 and 5.1

For State Fund claims, L&I currently accepts versions D.0 and 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system.

POS hours:

- 6 a.m. to midnight Sunday through Friday.
- 6 a.m. to 10 p.m. on Saturday.

**Link**: The current version of the NCPDP payer sheet is available online.

# Payment methods

Payment for drugs and medications, including all oral over the counter drugs, will be based on these pricing methods:

| If the **drug type** is… | Then the **payment method** is: |
|---|---|
| Generic | AWP less 50%<br>(+)<br>**$4.50** professional fee |
| Single or multisource brand | AWP less 10%<br>(+)<br>**$4.50** professional fee |
| Brand with generic equivalent<br>(dispense as written only) | AWP less 10%<br>(+)<br>**$4.50** professional fee |
| Compounded prescriptions | Allowed cost of ingredients<br>(+)<br>**$4.50** professional fee<br>(+)<br>**$4.00** compounding time fee (per 15 minutes) |

### Pricing details

Orders for over the counter non-oral drugs or nondrug items are priced on a 40% margin.

Prescription drugs and oral or topical over the counter medications are nontaxable.

No payment will be made for repackaged drugs.

**Links**: For more information on tax exemptions for sales of prescription drugs, see RCW 82.08.0281. For a definition of Average Wholesale Price (AWP), see WAC 296-20-01002.

# Payment policy: Compound drugs

## Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk non-payment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, and
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

**Link**: For more information, see the department's coverage policy on compound drugs.

## Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA-approved alternatives, such as oral generic non-steroidal anti-inflammatory drugs, muscle relaxants, tricyclic antidepressants, gabapentin and topical salicylate and capsaicin creams on the Outpatient Drug Formulary.

## Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient. No separate payment will be made for this service:

- **99070** (Supplies and materials)

# Payment policy: Emergency contraceptives and pharmacist counseling

## Coverage policy

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, *and*
- The ECP and/or counseling service is sought by the worker, *and*
- The claim manager authorizes payment for the ECP and/or the counseling, *and*
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

## Requirements for billing

Once the Coverage policy conditions listed above have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code **S9445**.

# Payment policy: Opioids

## Coverage policy

When treating an acute injury, generic short-acting opioids will be covered without authorization for up to 6 weeks from the date of injury.

## Prior authorization

Providers must seek authorization from the insurer for opioid coverage beyond the acute phase of the injury (>6 weeks). Coverage will depend on documented use of specific best practices.

For post-surgical pain medication, contact the insurer so that post-surgical opioids can be authorized.

**Link**: For more information, see the department's opioid policy.

## Services that aren't covered

Long-acting opioids (e.g. OxyContin, MS ER, MS Contin, methadone, Opana ER) aren't covered for acute post-injury or post-surgical pain.

## Requirements for billing

The number of days' supply of opioids prescribed for acute and subacute pain are subject to Department of Health rules.

Prescriptions for opioids from dental providers are limited to a maximum of a 3-day supply.

Prescriptions for chronic opioids are limited to a maximum of a 28-day supply.

# Payment policy: Endorsing Practitioner and Therapeutic Interchange Program

## Requirements for writing prescriptions

Endorsing practitioners may indicate Dispense as Written (DAW) on a prescription for a non-preferred drug on the PDL, and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates “substitution permitted” on a prescription for a non-preferred drug on the PDL:

- The pharmacist will interchange a preferred drug for the non-preferred drug, *and*
- A notification will be sent to the prescriber.

## Additional information: When therapeutic interchange won’t occur

Therapeutic interchange won’t occur if the endorsing practitioner indicates “dispense as written” on the non-preferred prescription; if the prescription is a refill of:

- An antipsychotic,
- antidepressant,
- antiepileptic,
- chemotherapy,
- antiretroviral,
- immunosuppressive drug,
- immunomodulator/antiviral treatment for hepatitis,
- if the pharmacy and therapeutics committee has determined therapeutic interchange isn’t clinically appropriate for a specific drug or drug class on the Washington preferred drug list,or
- if the prescription is for a schedule II controlled substance.

**Link**: For exception criteria, see L&I’s website.

# Payment policy: Infusion therapy

## Prior authorization

Regardless of who is providing services, prior authorization is required for:

- Home infusion nurse services, *and*
- Drugs, *and*
- Any infusion supplies.

The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Home infusion services can be authorized independently or in conjunction with home health services.

Home infusion skilled nurse services will only be authorized when infusion therapy is, approved as treatment for the worker's allowed industrial condition.

## Who must perform these services to qualify for payment

### Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

### Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

**Note**: Total parenteral and enteral nutrition products are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

### Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for “Home infusion services” in Chapter 11: Home Health Services for more information.

**Links**: For information on home infusion therapy in general, see the Home infusion services section of Chapter 11: Home Health Services.

Billing instructions for non-pharmacy providers are detailed in the Payment policy for Injectable medications in Chapter 16: Medication Administration and Injections.

# Payment policy: Initial prescription drugs or "first fills" for State Fund claims

## Payment methods

L&I will pay pharmacies or reimburse workers for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance.

Payment for "first fills" will be based on L&I's fee schedule including but not limited to:

- Drug utilization review (DUR) criteria, *and*
- Preferred drug list (PDL) provisions, *and*
- Supply limit, *and*
- Formulary status.

**Links**: For definitions of "initial prescription drug" and "initial visit," see WAC 296-20-01002.

For billing and payment for initial prescription drugs information, see WAC 296-20-17004.

## Requirements for billing

Your bill must be received by L&I within one year of the date of service.

For non-state fund claims, pharmacies should bill the appropriate federal or self-insured employer. If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

**Link**: For additional information and billing instructions, visit the Pharmacy Services website, or see the Pharmacy Prescription Billing Instructions manual.

A list of SIE/TPAs is available online.

## Payment limits

L&I won't pay:

- For refills of the initial prescription before the claim is accepted, *or*
- For a new prescription written after the initial visit but before the claim is accepted, *or*
- If it is a federal or self-insured claim.

 

# Payment policy: Third party billing for pharmacy services

## Requirements for billing

Pharmacy services billed through a third party pharmacy biller will be paid using the pharmacy fee schedule **only when**:

- A valid L&I claim exists, *and*
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I, *and*
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

Pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement, *and*
- Allow third party pharmacy billers to route bills on their behalf, *and*
- Agree to follow L&I rules, regulations and policies, *and*
- Ensure that third party pharmacy billers use L&I's online POS system, *and*
- Review and resolve all online POS system edits using a licensed pharmacist during the dispensing episode.

## Payment limits

Third party pharmacy billers **can't resolve** POS edits.

## Additional information: Third Party Pharmacy Supplemental Agreements

Third Party Pharmacy Supplemental Agreements can be obtained either:

- Through the third party pharmacy biller, *or*
- By contacting L&I's Provider Credentialing (see contact info, below).

The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I.

**Links**: To contact L&I's Provider Credentialing, email PACMail@Lni.Wa.gov.

For more information about these agreements, refer to the Pharmacy Services website.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for pharmacy services | Washington Administrative Code (WAC) 296-20-01002<br>WAC 296-20-17004<br>WAC 296-20-03014(6)<br>WAC 296-20-1102<br>WAC 296-20-02005 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Drug coverage policies** | Drug coverage policies on L&I's website |
| **PDL** | Drug Formulary |
| **Endorsing the PDL** | Online registration through the Health Care Authority<br>WA State Endorsing Practitioner Customer Service:<br>1-877-255-4637 |
| **Fee schedules** for all healthcare facility services (including ASCs) | Fee schedules on L&I's website |
| **NCPDP payer** sheet current version | NCPDP payer sheet |
| **Opioid Policy** | L&I's opioid policy |
| **Outpatient formulary** | Outpatient formulary |
| **PDL Hotline** | Open Monday through Friday, 8:00 am to 5:00 pm (Pacific Time):<br>1-888-443-6798 |
| **Therapeutic Interchange Program** exception criteria | Therapeutic interchange program |

 

| If you're looking for more information about… | Then see… |
|---|---|
| **Third Party Pharmacy Supplemental Agreements** | Third party pharmacy supplemental agreement form |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 25: Physical Medicine Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Body regions**: For osteopathic manipulation treatment (OMT) services, body regions are defined as:

- Head,
- Cervical,
- Thoracic,
- Lumbar,
- Sacral,
- Pelvic,
- Rib cage,
- Abdomen and viscera regions,
- Lower and upper extremities.

**Bundled codes**: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Student**: As part of their clinical training, a student is a person who is enrolled and participating in an accredited educational program to become a physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, or speech language pathologist. Interim permitted students who have already completed their training but aren't yet licensed can also act as students for the purposes of this chapter.

**Supervising therapist**: a licensed physical or occupational therapist with an active L&I provider number who has entered into a private agreement with a student and their educational institution to provide hands on training, instruction and supervision during the clinical phase of the student's course work. A supervising therapist can only supervise a student within their discipline. They are responsible for all services provided to injured workers by their students. Physical therapist assistants and occupational therapy assistants must not act as supervising therapists.

 

**Student supervision**: The supervising therapist can only supervise one student at a time and won't treat another patient while supervising the student. The supervising therapist must maintain line-of-sight and be physically present for the entire session during treatment to provide direct instruction to the student, oversee the work, and adjust the treatment or change other patient-centered tasks while the service is being provided. Services may be single patient (student therapist to patient) or group services (student therapist to a group of patients).

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

**Work conditioning**: An intensive, work related, goal oriented conditioning program designed specifically to restore function for work.

**Work hardening**: An interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular, and psychosocial functioning of the worker.

**Link**: More information about L&I's work hardening program (including a list of approved work hardening providers, criteria for admission into a work hardening program, and other work hardening program standards) is available on L&I's website.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–1S (Surgical dressings for home use)**

Bill the appropriate HCPCS code for each dressing item using this modifier –1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

**–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**–52 (Reduced services)**

Payment is made at the fee schedule level or billed charge, whichever is less.

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

# Payment policy: Electrical stimulators (including TENS)

## Prior authorization

These HCPCS codes for **electrical stimulator devices for home use or surgical implantation** require prior authorization:

| HCPCS code | Brief description | Additional coverage information |
|---|---|---|
| **E0745** | Neuromuscular stimulator for shock | This code is covered for **muscle denervation only**. |
| **E0747** | Electrical osteogenesis stimulator, not spine | — |
| **E0748** | Electrical osteogenesis stimulator, spinal | — |
| **E0749** | Electrical osteogenesis stimulator, implanted | Authorization for this code is subject to **utilization review**. |
| **E0760** | Osteogenesis ultrasound, stimulator | This code is covered for appendicular skeleton only (**not the spine**). |
| **E0764** | Functional neuromuscular stimulator | — |

## Services that can be billed

For electrical stimulator devices **used in the office setting**:

- When it is within the provider's scope of practice, a provider may bill professional services for application of stimulators with the CPT® physical medicine codes.
- Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code **1044M**, which is limited to six units per claim. See Payment Limits in the Physical Therapy and Occupational Therapy payment policy for more information, below.

For electrical stimulator devices and supplies for **home use or surgical implantation**, HCPCS code **E0761** (Nonthermal electromagnetic device) is covered.

## Services that aren't covered

For **use outside of medically supervised facility settings** (including home use and purchase or rental of durable medical equipment and supplies), the insurer doesn't cover:

- Transcutaneous Electrical Nerve Stimulators (TENS) units and supplies, or
- Interferential current therapy (IFC) devices, or
- Percutaneous neuromodulation therapy (PNT) devices.

Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

For **home use or surgical implantation devices and supplies**, these HCPCS codes aren't covered:

- **E0731** (Conductive garment for TENS),
- **E0740** (Incontinence treatment system),
- **E0744** (Neuromuscular stimulator for scoliosis),
- **E0755** (Electronic salivary reflex stimulator),
- **E0762** (Transcutaneous electrical joint stimulation device system),
- **E0765** (Nerve stimulator for treatment of nausea and vomiting),
- **E0769** (Electric wound treatment device, not otherwise classified),
- **L8680** (Implantable neurostimulator electrode),
- **S8130** (Interferential current stimulator, 2 channel),
- **S8131** (Interferential current stimulator, 4 channel).

For home use or in medically supervised facility settings, CPT® code 64555 (Peripheral nerve neurostimulator) isn't covered.

Treatment of chronic migraine or chronic tension-type headache with trigger point injections or massage therapy isn't a covered benefit.

**Link**: The coverage decision for Chronic Migraine or Chronic Tension-type Headache is available online.

## Payment limits

These supplies are **bundled and not payable separately for office use**:

- **A4365** (Adhesive remover wipes),
- **A4455** (Adhesive remover per ounce),
- **A4556** (Electrodes, pair),
- **A4557** (Lead wires, pair),
- **A4558** (Conductive paste or gel),
- **A5120** (Skin barrier wipes box per 50),
- **A6250** (Skin seal protect moisturizer).

## Additional information: Why the insurer doesn't cover TENS

Based on extensive review of the evidence for use of Electrical Nerve Stimulation (ENS), including TENS, interferential current therapy (IFC), and percutaneous neuromodulation therapy (PNT) as treatment for acute and chronic pain, the State Health Technology Clinical Committee (HTCC) determined that ENS is not covered for use outside of medically-supervised facilities. Purchase or rental of TENS, IFC, or PNT equipment is also not covered. For more details, see the HTCC decision paper.

# Payment policy: Massage therapy

## Who must perform these services to qualify for payment

To qualify for payment, massage therapy services must be performed by:

- A licensed massage therapist, *or*
- Other covered provider whose scope of practice includes massage techniques.

## Prior authorization

Services provided by massage therapists require prior authorization after the 6th visit.

**Link**: For more information, see WAC 296-23-250.

## Services that can be billed

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. The insurer won't pay massage therapists for additional codes.

## Requirements for billing

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. Massage therapists must also use CPT® code **97124** for evaluations and reevaluations.

Massage therapists must bill their usual and customary fee and document the duration of the massage therapy treatment. Bill the appropriate units based on the length of time the service is rendered, per CPT® code description.

Documentation must support the units of service billed. Document the amount of time spent performing evaluations and reevaluations as well as the treatment.

 

### Progress Reports

Massage therapists are required to submit progress reports following every six treatment visits or after each month, whichever comes first. Documentation must include:

- an outline of the proposed treatment program, *and*
- the expected restoration goals, *and*
- the expected length of treatment, *and*
- substantiation of improvement during the most recent treatment period, such as:
    - signs of treatment progress (e.g. range of motion, sitting and standing tolerance, reduction in medication), *and/or*
    - self-reported functional outcome measures from L&I's recommended scales (such as the patient-specific functional scale).

Failure to submit a progress report after each set of six visits or one month of treatment, whichever comes first, may result in denial of bills and/or revocation of authorization for treatment.

**Link**: See pages 16-20 in Options for Documenting Functional Improvement in Conservative Care for more examples of appropriate functional scales.

## Payment limits

Massage therapy is paid at **75%** of the maximum daily rate for PT and OT services.

The daily maximum allowable amount is **$105.63**.

**Link**: For more information, see WAC 296-23-250.

## Services that aren't covered

These items are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices,
- Lubricants (for example, oils, lotions, emollients).

Massage therapy isn't a covered benefit for the treatment of chronic migraine or chronic tension-type headaches.

**Link**: The coverage decision for Chronic Migraine or Chronic Tension-type Headache is available online.

# Payment policy: Osteopathic manipulative treatment (OMT)

## Who must perform these services to qualify for payment

Only osteopathic physicians may bill for OMT services.

## Requirements for billing

OMT includes pre and post service work (for example, cursory history and palpatory examination). The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of an E/M service in addition to OMT services on the same day.

An E/M office visit service may be billed in conjunction with OMT **only when all** of the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included with OMT, *and*
- The worker's record contains documentation supporting the level of E/M service billed, *and*
- The E/M service is billed using modifier **–25**. Without modifier **–25**, the insurer won't pay for E/M codes billed on the same day as OMT.

## Payment limits

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level, type and extent of service billed. The CPT® book describes the requirements that must be present for each level of service.

For OMT services, only one CPT® code is payable per treatment. This is because CPT® codes for body regions ascend in value to accommodate the additional body regions involved.

**Example**: If three body regions were manipulated, one unit of the correct CPT® code would be payable.

(See definition of **Body regions** in Definitions at the beginning of this chapter.)

## Services that aren't covered

CPT® code **97140** isn't covered for osteopathic physicians.

# Payment policy: Functional capacity evaluation

## Prior authorization

Requires prior authorization by the claim manager.

## Who must perform these services to qualify for payment

To qualify for payment, a functional capacity evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

## Services that can be billed

### Standard Functional Capacity Evaluation

**1045M** is used to bill the Standard Functional Capacity Evaluation. When billing for this service:

- Units of service must be billed. 1 hour of direct time = 1 unit of service.
- The fee for 3-6 units of service is **$829.05**.
- A maximum of six units may be billed.
- Each provider must bill independently for their time.
- Time accumulates regardless of the number of days. Evaluations will involve at least 3 hours of face-to-face time. The fee for 1 unit of service is **$276.35** and the fee for 2 units of service is **$552.70**.

### Supplemental Functional Capacity Evaluation

**1098M** is used to bill the Supplemental Functional Capacity Evaluation. Use this code when billing more than 6 hours of time beyond a Standard Functional Capacity Evaluation or for follow up testing. When billing for this service:

- Units of service must be billed. 1 hour of direct time = 1 unit of service.
- The fee for each 1 unit of service is **$138.68**.
- A maximum of six units may be billed.
- Each provider must bill independently for their time.
- Time accumulates regardless of the number of days.

 

## Requirements for billing

Eligible providers must bill their usual and customary fee for Standard Functional Capacity Evaluations and Supplemental Functional Capacity Evaluations.

When the service is performed by multiple providers, each provider must bill for the amount of direct 1:1 time spent performing the evaluation using their individual provider account number.

These services include testing, a summary of findings, and full evaluation report. All summary reports must be submitted **within 10 days of when the service was performed and full evaluation reports within 30 days**.

**Note**: Ensure all documentation is submitted before billing or the bill may be denied.

### Examples of billing options for multiple provider evaluations

**Scenario**: The Occupational Therapist (OT) performed 3.2 hours of direct time and the Physical Therapist (PT) performed 0.8 hours of direct time for a Standard FCE.

| | |
|---|---|
| OT: | Bill 3 units of **1045M** |
| PT: | Bill 1 unit of **1045M** |
| Total units billed: 4<br>Maximum fee of **$829.05** | |

Documentation must include:

1) A summary of findings- State fund, in-state claims complete the Summary Report Form F245-434-000. Out of state claims complete a summary of findings equivalent to F245-434-000; and

2) Full evaluation report demonstrating:

- L&I's minimum evaluation elements were met; *and*
- Duration of the evaluation. Each provider must separately document the amount of direct 1:1 time spent performing the service; *and*
- Signature and date of all evaluators.

For follow up testing, include:

- Date of service, worker name, claim number and a summary of test findings, and
- List of all tests that were performed, *and*
- Results of all testing performed, *and*
- Duration of the service. Each provider must separately document the amount of direct 1:1 time spent performing the service, *and*
- Signature and date of all evaluators.

**Note**: Documentation must clearly note who performed each service and how much time each individual provider spent providing the direct 1:1 evaluation. Include this information on both the summary of findings and full evaluation report.

### Supplemental Functional Capacity Evaluation

1) For use when standard evaluation length is more than 6 hours.

**Examples**:

- Evaluating multiple jobs with opposite physical demands
- Performing a whole body and upper extremity focused evaluation
- Symptomatic neurological disease impacting testing tolerance

*AND/OR*

2) For use when follow up testing is indicated after completion of a Standard FCE.
    - The Attending Provider and/or Vocational Provider determined additional testing is needed to facilitate return to work decisions.

**Not Covered:**

- Additional time to perform missed or forgotten testing
- Updates to an incomplete/conflicting report

## Payment limits

Standard and Supplemental Functional Capacity Evaluations may only be billed once per worker every 30 days.

If the FCE is performed by multiple providers, the maximum fee applies once per worker regardless of how many providers and/or provider types performed the evaluation.

If the worker has multiple claims, the maximum fee for the FCE applies once per worker regardless of the number of claims a worker may have.

Standard and Supplemental Functional Capacity Evaluations may be provided over multiple days. If this occurs, the bill must span the dates of service to reflect the actual dates in which the evaluation was performed. For example, if the evaluation began on January 1st and was completed on January 3rd, the bill will reflect the “From Date of Service” as January 1st and the “To Date of Service” as January 3rd.

**Multiple Claims**: Split Billing: Refer to the General Provider Billing Manual F245-432-000.

# Payment policy: Physical medicine CPT® codes billing guidance

## Timed codes

Some physical medicine services (such as ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as “timed services” and are billed using “timed codes.”

Timed codes can be identified idn CPT® by the code description. The definition will include words such as “each 15 minutes.”

Providers must document in the daily medical record (chart note and flow sheet, if used):

- The amount of time spent for each time based service performed, *and*
- The specific interventions or techniques performed, including:
    - Frequency and intensity (if appropriate), *and*
    - Intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (for example, flow sheets, chart notes, and reports).

**Note**: Documenting a range of time (for example, 8-22 minutes) for a timed service isn‘t acceptable. Providers must document the actual amount of minutes spent performing the service.

The number of units you can bill is:

- Determined by the time spent performing each “timed service,” and
- Constrained by the total minutes spent performing these services on a given day.

To obtain the number of units of timed services that can be billed, add together the minutes spent performing each individual timed service and reference the table below.

 

| If the combined duration of all time based services **is at least**… | **and less than**… | **Then**, **when billing**, **report**: |
|---|---|---|
| 8 minutes | 23 minutes | 1 unit |
| 23 minutes | 38 minutes | 2 units |
| 38 minutes | 53 minutes | 3 units |
| 53 minutes | 68 minutes | 4 units |
| 68 minutes | 83 minutes | 5 units |
| 83 minutes | 98 minutes | 6 units |
| 98 minutes | 113 minutes | 7 units |
| 113 minutes | 128 minutes | 8 units |

### How to use this table

The above schedule of times doesn‘t imply that any of the first eight minutes should be excluded from the total count. The total time of active treatment counted includes all direct treatment time. Use the table above to determine the maximum number of units that can be billed for the date of service. Begin with applying the maximum number of units to the service performed for the longest amount of time and continue assigning units to each timed service, based on length of service performed, until the maximum number of billable units has been reached. Pre and post delivery services (for example, warmup and cool down) aren’t counted in determining the treatment time. See Determining what time counts towards timed codes. Detailed examples can be found below.

## Examples of how to document and bill timed codes

The following examples show how the required elements of interventions can be documented and billed. These examples aren’t reflective of a complete medical record for the patient’s visit. The other elements of reporting (SOAPER) **also must be documented**.

### Example 1

| Procedural intervention | Specific intervention | Purpose | Treatment time |
|---|---|---|---|
| Attended E-Stim and Ultrasound performed simultaneously | 5mA right forearm<br>1.5 W/cm2 ; 100% right forearm | Increase joint mobility | **8 minutes** |
| Whirlpool | Heat bath to right forearm and hand | Facilitate movement; reduce inflammation | **8 minutes** |
| Therapeutic exercise | Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets | Increase motion and strength for gripping | **10 minutes** |
| | | | Total treatment time = **26 minutes** |
| | | | Total timed intervention (treatment time spent performing timed services) = **18 minutes** |

At 18 total minutes of timed services, a maximum of **1 unit** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97022** (Whirlpool) x 1 unit.

**Note**: Untimed services are billed separately. In addition, please see the Prohibited Pairs section of the policy for more information as to which outpatient therapy CPT® codes cannot be billed if provided to one or more patients **during the same time period**.

### Example 2

| Procedural intervention | Specific intervention | Purpose | Treatment time |
|---|---|---|---|
| Therapeutic exercise | Left leg straight leg raises x 4 directions; 3 lbs. each direction. 10 reps x 2 sets | Strength and endurance training for lifting | **20 minutes** |
| Neuromuscular reeducation | One leg stance, 45 seconds left; 110 seconds on right using balance board x 2 sets each | Normalize balance for reaching overhead | **15 minutes** |
| Cold pack | Applied to left knee | Decrease edema | **10 minutes** |
| | | | Total treatment time = **45 minutes** |
| | | | Total timed intervention (treatment time spent performing timed services) = **35 minutes** |

At 35 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97112** (Neuromuscular reeducation) x 1 unit.

**Note**: Cold packs are considered bundled.

### Example 3

| Procedural intervention | Specific intervention | Purpose | Treatment time |
|---|---|---|---|
| Manual therapy | Soft tissue mobilization to medial knee - right | Mobilization | **12 minutes** |
| Therapeutic exercises | Prone hip extension 10 reps x 2 sets; hamstring stretch 3 reps x 2 sets; right single leg stance 3 sets of 5 for 15 second hold | Increase strength and range of motion | **25 minutes** |
| Cold pack | Applied to right knee | Decrease edema | **10 minutes** |
| Total treatment time = **47 minutes**<br>Total timed intervention (treatment time spent performing timed services) = **37 minutes** | | | |

At 37 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercise was performed for 25 minutes, which equates to 2 units of timed service. Because no additional units of timed services are allowed, manual therapy is not billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units

**Note**: Cold packs are considered bundled.

### Example 4

| Procedural intervention | Specific intervention | Purpose | Treatment time |
|---|---|---|---|
| Neuromuscular re-education | Squats on Airex Balance pad 10 reps x 2 sets; tandem balance on Bosu Ball 2 sets 30 seconds each; single stance on Airex Balance pad 2 sets x 5 | Normalize balance for reaching overhead | **8 minutes** |
| Manual therapy | Soft tissue mobilization to medial knee - right | Mobilization | **12 minutes** |
| Therapeutic exercises | Hamstring curls 10 reps x 2 sets; short arc quads 3 sets of 5 for 5 second hold; straight leg raise 3 sets of 5 for 15 second hold | Increase strength and range of motion | **25 minutes** |
| Cold pack | Applied to right knee | Decrease edema | **10 minutes** |
| | | | Total treatment time = **55 minutes** |
| | | | Total timed intervention (treatment time spent performing timed services) = **45 minutes** |

At 45 minutes of timed services, a maximum of **3 units** of timed services can billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercises was performed for 25 minutes, which equates to 2 units of timed service. The balance of billable units is 1 unit. Since more time was spent performing manual therapy, assign the last unit of service to manual therapy. Because no additional units of timed services are allowed, neuromuscular re-education is not billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units
- **97140** (Manual therapy) x 1 unit

**Note**: Cold packs are considered bundled.

## Prohibited pairs: Which CPT® codes can't be billed together

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to one or more patients **for the same time period**:

- Any two codes for "therapeutic procedures" requiring direct, one-on-one patient contact, *or*
- Any two codes for modalities requiring "constant attendance" and direct, one-on-one patient contact, *or*
- Any two codes requiring either constant attendance or direct, one-on-one patient contact, as described above (for example, any CPT® codes for a therapeutic procedure with any attended modality CPT® code), *or*
- Any code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy code (for example, CPT® code **97150** with CPT® code **97112**), *or*
- Any code for modalities requiring constant attendance with the group therapy code (for example, CPT® code **97150** with CPT® code **97035**), *or*
- An untimed evaluation or reevaluation code with any other timed or untimed codes, including constant attendance modalities, therapeutic procedures, and group therapy.

## Determining what time counts towards timed codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services:

- Pre and post delivery services (for example, warmup and cool down services) aren't counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist is working directly with the patient to deliver treatment services.
- The patient should already be in the treatment area (for example, on the treatment table or mat or in the gym) and prepared to begin treatment.
- The time counted is the time the patient is treated.
- The time the patient spends not being treated because of the need for toileting or resting shouldn't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

**Link**: More information about L&I's PT, OT, and massage therapy policies is available online.

# Payment policy: Physical therapy (PT) and occupational therapy (OT)

## Who must perform these services to qualify for payment

### PT services

PT services must be ordered by the worker's attending doctor, nurse practitioner, or the physician's assistant for the attending doctor. The services must be provided by a:

- Licensed physical therapist, *or*
- Physical therapist assistant serving under a licensed physical therapist's direction, *or*
- Athletic trainer serving under a licensed physical therapist's direction.

For details about students performing PT services, see the Therapy student and therapy assistant payment policy.

**Link**: For more information, see WAC 296-23-220.

### OT services

OT services must be ordered by the worker's attending doctor, nurse practitioner, or the physician's assistant for the attending doctor. The services must be provided by a:

- Licensed occupational therapist, *or*
- Occupational therapy assistant serving under a licensed occupational therapist's direction.

For details about students performing OT services, see the Therapy student and therapy assistant payment policy.

**Link**: For more information, see WAC 296-23-230.

### Physical medicine services

Physical medicine services may be provided by:

- Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation (physiatry), *or*

- Attending doctors who aren't board qualified or certified in physical medicine and rehabilitation. For non-board certified/qualified providers, special payment policies apply. (See Requirements for billing and Payment limits, below.)

**Link**: For more information, see WAC 296-21-290.

## Who won't be paid for physical medicine services

- Exercise physiologists, *or*
- Kinesiologists, *or*
- Physical or occupational therapist aides, *or*
- Gym Supervisors

## Services that can be billed

Physical and occupational therapists must use the appropriate CPT® and HCPCS codes **97161**-**97168**, **95992**, and **97010**-**97799**. These therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies. Some of these CPT® and HCPCS codes aren't covered or are bundled.

If more than one patient is treated at the same time, use CPT® code **97150**. For PT and OT evaluations and reevaluations, bill using CPT® codes **97161** through **97168**.

To report the evaluation by the physician or therapist to establish a plan of care, use CPT® codes **97161** through **97163** or **97165** through **97167**.

To revise the plan of care by reporting the evaluation of a patient who has been under a plan of care established by the physician or therapist, use CPT® codes **97164** and **97168**. CPT® codes **97164** and **97168** have no limit on how often they can be billed.

For information on billing phone calls or team conferences, see Chapter 10: Evaluation and Management Services.

**Link**: For information on Surgical dressings dispensed for home use, see Chapter 28: Supplies, Materials, and Bundled Services.

For billing requirements for prosthetic and orthotic devices, see Chapter 9: Durable Medical Equipment (DME).

### Other Physical medicine services

Board qualified and board certified physiatrists bill for services using:

- CPT® codes **97010** through **97799**.

Non-board certified/qualified physical medicine attending providers may perform physical medicine modalities and procedures described in CPT® codes **97010**-**97750** if their scopes of practice and training permit it, but for these services must bill local code **1044M**. The description for local code **1044M** is "Physical medicine modality(ies) and/or procedure(s) by attending doctor who isn't board qualified or certified in physical medicine and rehabilitation."

## Services that aren't covered

Physical medicine CPT® codes **97033** and **97169**-**97172** aren't covered.

Low level laser therapy **S8948** isn't a covered benefit. For more information, please see L&I's coverage decision for low level laser therapy.

Cryotherapy devices with or without compression for home use aren't covered benefits. These devices used in a clinical setting are considered bundled into existing physical medicine services. For more information, please review L&I's coverage decision for Cryotherapy Devices With or Without Compression.

Non-vasopneumatic compression devices without a cryotherapy component are not a covered benefit. For more information, please review L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component.

## Requirements for billing

Progress reports are due following 12 treatment visits or every one month, whichever comes first. PT and OTs treating workers covered by state-fund must use the Physical Medicine Progress Report form F245-453-000 and submit this to the insurer and the attending provider. Progress reports must include functional outcome measures.

Providers can use the Documenting Functional Improvement resource to help prepare these progress reports.

**Link**: For more information, see WAC 296-23-220 and WAC 296-23-230

 

# Payment limits

## Physical medicine services

Non-board certified/qualified physical medicine providers won't be paid for CPT® codes **97010**-**97799**.

Local code **1044M** is limited to six units per claim. After six units, the patient must be referred to a licensed physical or occupational therapist or physiatrist except when the attending doctor practices in a remote location where no licensed physical or occupational therapist or physiatrists is available.

## Bundled items or services

- Activity supplies used in work hardening, such as leather and wood,
- Application of hot or cold packs (this includes all forms of cryotherapy with or without compression. **97016** may not be used to bill for these services),
- Electrodes and gel,
- Exercise balls,
- Ice packs, ice caps, and ice collars,
- Thera-tape,
- Wound dressing materials used during an office visit and/or PT treatment.

**Link**: For complete lists of bundled codes, see Chapter 28: Supplies, Materials and Bundled Services.

## Daily maximum for services

The daily maximum allowable fee for PT and OT services is **$140.84**.

If PT, OT, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type. See Massage Therapy Payment Limits above for the daily maximum fee that applies to massage therapists.

When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **97161**-**97168**, **95992**, and **97010**-**97799**.

If the worker receives PT or OT services for two separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

The daily maximum allowable fee doesn't apply to:

- Physicians board certified in Physical Medicine, or
- Functional capacity evaluations (FCEs), or

- Work hardening services, or
- Work evaluations, or
- Job modification/prejob accommodation consultation services.

**Links**: For more information, see WAC 296-23-220 and WAC 296-23-230.

### Unrelated conditions

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition:

- Therapists must appropriately bill L&I only for the portion of the visit related to the accepted claim.
- Treatment rendered for a condition unrelated to an accepted L&I claim may be billed to a secondary insurer, if appropriate.

Only send chart notes related to the accepted L&I claim to the insurer, since the employer doesn't have the right to see information about an unrelated condition.

### Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to one unit per day. Refer to CPT® and HCPCS to determine whether a service is timed or untimed.

Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

### Work conditioning: Guidelines

- **Frequency**: At least three times per week and no more than 5 times per week.
- **Duration**: No more than 8 weeks for one set. One set equals up to 20 visits.
    - An additional 10 visits may be approved after review of progress.
- **Plan of Care**: Goals are related to:
    - Increasing physical capacities, *and*
    - Return to work function, *and*
    - Establishing a home program allowing the worker to progress and/or maintain function after discharge.
- **Documentation**: Besides standard documentation, the plan of care and progress report must include return to work capacities, which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances.
- **Treatment**: May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
    - PT and OT visits accumulate separately and both are allowed on the same date of service.
    - Billing reflects active treatment. Examples include CPT® **97110**, **97112**, **97530**, **97535**, and **97537**.
- **Billing**: Work conditioning programs are reimbursed as outpatient PT and OT under the daily fee cap.

# Payment policy: Powered traction therapy

## Services that can be billed

Powered traction devices are covered as a physical medicine modality.

## Payment limits

The insurer won't pay any additional cost when powered devices are used.

## Additional information: Why the insurer won't pay additional cost when powered devices are used

Published literature hasn't substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. Click here for more information.

# Payment policy: Telehealth for physical medicine services

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

The insurer prefers that PT and OT services be provided in person. Telehealth may be used only when hands-on services aren't required.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

The provider performing **telehealth** services may have to be licensed in the state where the worker is receiving **telehealth** services.

## Services that must be performed in person

In-person evaluation is required when:

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

 

## Services that are covered

Services that don't require a hands-on component are covered when performed via **telehealth**. Students, speech, physical and occupational therapists may conduct services via **telehealth**.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Store and Forward

**G2250** is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of a visit. Follow up must occur within 24 business hours of receiving the images or video recordings, and follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2250** isn't covered if the patient provides the image or video recording as follow-up from a visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to a visit within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

## Services that aren't covered

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- Work hardening,
- Functional Capacity Evaluations
- The services listed under "Services that must be performed in-person",
- Services that require hands-on and/or attended treatment of a patient,

- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| Originating site is… | Worker's home | | |
|---|---|---|---|
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

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

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same general limits as those already noted in this chapter apply, regardless how the service is provided to the worker.

Services conducted by **telehealth** are limited to two hours per day per worker, regardless of the service provided.

 

# Payment policy: Therapy student and therapy assistant student supervision

## General information

L&I has adopted a modified version of Medicare Part B's policy on physical and occupational therapy students. L&I considers supervised students an extension of their supervising therapist.

Please refer to the Definitions section at the beginning of this chapter to see the definitions of **student**, **supervising therapist**, and **student supervision**.

## Services that can be billed

Supervising therapists will direct all care provided by their students to injured workers and must bill for these services under the supervising therapist's provider number.

All billed services must meet the billing and documentation requirements applicable to the supervising therapist.

## Services that aren't covered

Any service provided by a student that is unsupervised (including skilled nursing facilities) aren't payable.

Students can't independently:

- Make clinical judgements;
- Provide evaluations, re-evaluations or assessments;
- Develop, manage or deliver services.

Any service that deviates from the requirements outlined in Medical Aid Rules and Fee Schedules isn't covered.

Two-way audio/visual direct supervision isn't covered (modifier –**FR**).

## Requirements for billing

All documentation must identify both the supervising therapist and the student and must be signed by both parties.

All services must be billed by the supervising therapist under their provider number and must comply with supervision and documentation requirements for physical medicine services.

### Supervising therapist responsibilities

Supervising therapists are responsible for:

- All services provided to injured workers by their students.
- Ensuring that the work students perform does not exceed their education, skills, and abilities, nor the supervising therapist's scope of practice.
- Providing **supervision** to the student regardless of what setting care is being rendered in (clinic, hospital or skilled nursing facility).
- Ensuring that all documentation requirements are met.
- Co-signing all documentation for services rendered to injured workers.
- Keep a copy of the private agreement between them and the student in accordance with WAC 296-20-02005.

## Payment limits

Students won't be directly reimbursed for their time or services.

**Links**: For more information, see WAC 296-20-015.

# Payment policy: Work hardening

## Prior authorization

**Work hardening programs** require:

- Prior approval by the worker's attending physician, *and*
- Prior authorization by the claim manager.

Providing **additional services** during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

**Program extensions** must be authorized in advance by the claim manager and are based on:

- Documentation of progress, *and*
- The worker's ability to benefit from the program extension up to two additional weeks.

## Who must perform these services to qualify for payment

Only L&I approved work hardening providers will be paid for work hardening services.

## Services that can be billed

### Work hardening

- For the evaluation, bill using local code **1001M**.
- For treatment, bill using CPT® codes **97545** and **97546**.

## Services that aren't covered

### Billing for less than two hours of service in one day (CPT® code 97545)

Services provided for less than two hours of total program time on any day don't meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. This should be considered as an absence in determining worker compliance with the program.

**Example**: The worker arrives for work hardening, but isn't able to participate fully that day.

# Requirements for billing

## Work hardening

CPT® codes should be billed that appropriately reflect the services provided.

A worker typically starts at four hours per day and gradually increases to 7-8 hours per day by week four.

## Billing less than one hour of CPT® code 97546

After the first two hours of service on any day, if less than 38 minutes of service are provided modifier **–52** must be billed. For that increment of time:

- CPT® code **97546** must be billed as a separate line item with modifier **–52**, and
- The charged amount must be prorated to reflect the reduced level of service.

**Example**: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include three lines:

| Code | Modifier | Charged amount | Units |
|---|---|---|---|
| **97545** | | Usual and customary | 1 |
| **97546** | | Usual and customary | 2 |
| **97546** | **–52** | 33% of usual and customary (completed 20 of 60 minutes) | 1 |

## Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

### Billing for evaluation and treatment on the same day (multiple disciplines)

If both the OT and the PT need to bill for one hour of evaluation and one hour of treatment on the same date of service, the services must be billed as follows:

| If the provider type is… | and the service provided is… | Then bill as: |
|---|---|---|
| OT | 1 hour of evaluation | 1 unit of **1001M** |
| PT | 1 hour of evaluation | 1 unit of **1001M** |
| OT (or PT) | 1 hour of treatment | 1 unit of **97545** with modifier **–52**<br>(billed amount proportionate to 1 hour) |
| PT (or OT) | 1 hour of treatment | 1 unit of **97546** |

### Examples of billing options for services in multidisciplinary programs

**Scenario**: The OT is responsible for the work simulation portion of the worker's program, which lasted four hours. On the same day, the worker performed two hours of conditioning/aerobic activity for which the PT is responsible.

The providers could bill for the six hours of services in either one of two ways:

| Billing option 1 | | |
|---|---|---|
| PT: | 1 unit **97545** | 2 hours |
| OT: | 4 units **97546** | 4 hours |
| **Total hours billed:** | | **6 hours** |

| Billing option 2 | | |
|---|---|---|
| OT: | 1 unit **97545**<br>+<br>2 units **97546** | 2 hours<br><br>2 additional hours |
| PT: | 2 units **97546** | 2 hours |
| **Total hours billed:** | | **6 hours** |

# Payment limits

## Work hardening

Work hardening programs are authorized for up to four weeks. Only one unit of **97545** (first two hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

These codes are subject to the following limits:

| Code | Description | Unit limit (four week program) | Unit price |
|---|---|---|---|
| **1001M** | Work hardening evaluation | 6 units<br>(1 unit = 1 hour) | **$137.46** |
| **97545** | Initial two hours per day | 20 units per program;<br>Maximum of one unit per day per worker<br>(1 unit = 2 hours) | **$162.44** |
| **97546** | Each additional hour | 70 units per program<br>Add-on, won't be paid as a stand-alone procedure.<br>(1 unit = 1 hour) | **$82.89** |

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes **97545** and **97546** takes into consideration that some work occurs outside of the time the client is present (for example, team conference, plan development).

Time spent in treatment conferences isn't covered as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using CPT® codes **97545** and **97546**.

### Program extensions

Additional units available for extended programs:

| Code | Description | Six week program limit |
|---|---|---|
| **1001M** | Work hardening evaluation | no additional units |
| **97545** | Initial two hours per day | 10 units (20 hours) |
| **97546** | Each additional hour | 50 units (50 hours) |

## Additional information: L&I's work hardening program

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program, and other work hardening program standards is available:

- On the Helping Workers Get Back to Work page,
- By calling the Therapy Services Program at **360-902-4480**, *or*
- By sending an email to Therapy@Lni.wa.gov

# Payment policy: Wound care

## Prior authorization

### Electrical stimulation for chronic wounds

If electrical stimulation for chronic wounds is requested for use on an outpatient basis, prior authorization is required using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy, *and*
- In addition to electrical stimulation, standard wound care must continue.

**Note**: In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

## Services that can be billed

### Debridement

Therapists must bill CPT® **97597**, **97598**, or **97602** when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies sent home with the patient for self-care may be billed with HCPCS codes appended with local modifier **–1S**.

**Link**: For more information on billing with local modifier **–1S**, see the Surgical dressings for home use section (Requirements for billing and Payment limits) of Chapter 28: Supplies, Materials, and Bundled Services.

### Electrical stimulation for chronic wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is covered for the following chronic wound indications:

- Stage III and IV pressure ulcers,
- Arterial ulcers,
- Diabetic ulcers,
- Venous stasis ulcers.

To bill for electrical stimulation for chronic wounds, use HCPCS code **G0281**.

**Link**: More information on electrical stimulation for chronic wounds is available online.

## Requirements for billing

### Debridement

When performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool), therapists must bill CPT® **97597**, **97598**, or **97602**.

### Electrical stimulation for chronic wounds

In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

## Payment limits

### Debridement

Wound dressings and supplies used in the office are bundled and aren't payable separately.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** (Washington state laws) for physical medicine | Washington Administrative Code (WAC) 296-21-290 |
| **Becoming an L&I Provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Electrical stimulation for chronic wounds** | Electrical stimulation for chronic wounds |
| **Fee schedules** for all healthcare professional services | Fee schedules on L&I's website |
| **Keeping of records** | WAC 296-20-02005 |
| **Massage therapy** administrative rules | WAC 296-23-250 |
| **Occupational therapy** administrative rules | WAC 296-23-230 |
| **Physical Medicine Progress Report** Form | Form F245-453-000 |
| **Physical therapy** administrative rules | WAC 296-23-220 |
| **Powered traction devices** for intervertebral decompression | Powered traction devices for intervertebral decompression |
| L&I's general policies and rules for **PT**, **OT**, and **massage therapy** | PT, OT, and massage rules on L&I's website |
| Payment policies for **supplies, materials, and bundled services** | Chapter 28: Supplies, Materials, and Bundled Services |
| **TENS coverage decision** | State Health Technology Clinical Committee (HTCC) published TENS decision |
| **Work hardening program** at L&I | **Program reviewer**: 360-902-4480<br>Worker hardening rules on L&I's website |

| If you're looking for more information about… | Then see… |
|---|---|
| **L&I's coverage decision for Chronic Migraine and Chronic Tension-type Headaches** | Chronic migraine headache coverage decision |
| **L&I's coverage decision for low level laser therapy** | Low level laser therapy coverage decision |
| **L&I's coverage decision for Cryotherapy Devices with or without Compression** | Cryotherapy devices with or without compression coverage decision |
| **L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component** | Non-vasopneumatic devices without cryotherapy component coverage decision |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 26: Radiology Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Full spine study**: A full spine study is a radiologic exam of the entire spine: anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic, and lumbar spine). (See definition of incomplete full spine study, below.)

**Incomplete full spine study**: An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. (See definition of full spine study, above.)

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–7N (X-rays and laboratory services in conjunction with an IME)**

When X-rays, laboratory, and other diagnostic tests are provided with an exam, identify the service(s) by adding the modifier **–7N** to the usual procedure number.

**–26 (Professional component)**

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See below for information on the use of the **–TC** modifier.)

**–52 (Reduced services)**

Payments are made at the fee schedule level or billed charge, whichever is less.

**–76 (Repeat procedure or service by same physician or other qualified health care professional)**

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to and E/M service.

**–77 (Repeat procedure by another physician or other qualified health care professional)**

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to and E/M service.

**–LT (Left side)**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

**–RT (Right side)**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

 

**–TC (Technical component)**

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See above for information on the use of the **–26** modifier.)

**–UN (Two patients served)**

**–UP (Three patients served)**

**–UQ (Four patients served)**

**–UR (Five patients served)**

**–US (Six or more patients served)**

# Payment policy: Contrast material

## Requirements for billing

Use the following HCPCS codes to bill for contrast material:

- Low osmolar contrast material (LOCM): **Q9951**, **Q9965** - **Q9967**
- High contrast osmolar material (HOCM): **Q9958** - **Q9964**

For LOCM, bill one unit per ml.

Providers may use either HOCM or LOCM. The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart.

Separate payment will be made for contrast material for imaging studies.

## Payment limits

HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml.

 

# Payment policy: Nuclear medicine

## Payment limits

The standard multiple surgery policy applies to the following radiology CPT® codes for nuclear medicine services:

- **78306**,
- **78802**, *and*
- **78803**.

The multiple procedure reduction will be applied when these codes are billed:

- With other codes subject to the standard multiple surgery policy, *and*
- For the same patient:
    - On the same day by the same physician, *or*
    - By more than one physician of the same specialty in the same group practice.

**Link**: For more information about the standard multiple surgery payment policy, refer to Chapter 29: Surgery Services.

# Payment policy: Radiology consultation services

## Services that aren't covered

CPT® code **76140** isn't covered.

## Requirements for billing

Providers who perform radiology consultation services must bill the specific X-ray CPT® code with modifier **–26**.

Attending health care providers who request second opinion radiology consultation services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6,
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis,
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?, and
- Does this disc protrusion shown on MRI look new or preexisting?

## Payment limits

The insurer won't pay separately for review of films taken previously or elsewhere if a face to face service is performed on the same date as the X-ray review.

Review of records and diagnostic studies is bundled into the E/M service, chiropractic care visit, or other procedure(s) performed. For more information about E/M services, see Chapter 10: Evaluation and Management Services.

Payment for radiology consultation services will be made at the professional component (modifier **–26**) rate for each specific radiology service performed. A written report of the consultation is required. The written report must justify the level, type, and extent of the services billed.

Documentation such as "X-rays are negative" or "X-rays are normal" don't fulfill the reporting requirements and the insurer **won't pay** for the professional component in these circumstances.

 

# Payment policy: Radiology reporting requirements

## Global radiology services

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the imaging study). When billing for radiology services globally the reporting requirements for both the technical (–TC) and professional (–26) components must be met.

### Technical component (modifier–TC)

Any provider who is billing separately for the technical component (–TC) is required to submit documentation to the insurer. The documentation must include the following:

- Patient name, age, sex, date of service,
- Name of ordering provider,
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable).

### Professional component (modifier –26)

Documentation (charting of justification, findings, diagnoses, and test result integration) for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier **–26** or as part of the global service.

Any provider who produces and interprets their own imaging studies, and any radiologist who over reads imaging studies must produce a report of radiology findings to bill for the professional component.

The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, and date of procedure, *and*
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- Brief sentence summarizing history and/or reason for the study, such as:
    - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
    - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*

- Description of, or listing of, imaging findings:
    - Advanced imaging reports should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
    - Radiology reports on plain films of skeletal structures should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*
    - Radiology reports on chest plain films should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*
- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the report. For example:
    - For a skeletal plain film report with imaging findings of normal osseous density and contours and no joint abnormalities, the impression could be: “No evidence of fracture, dislocation, or gross osseous pathology.”
    - For a skeletal plain film report with imaging findings of reduced bone density and thinned cortices, the impression could be: “Osteoporosis, compatible with the patient’s age.”
    - For a chest report with imaging findings of vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be: “Emphysema.”

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes. Examples include:

- “Imaging rules out fracture, so rehab can proceed.”
- “Flexion/extension plain films indicate hypermobility at C5/C6, and spinal manipulation will avoid that region.”

**Note:** Providers performing the professional component (modifier –26) must bill under their individual L&I provider ID.

# Requirements for billing

## Billing code modifiers

- Use HCPCS modifiers **–RT** (right side) and **–LT** (left side) with CPT® codes **70010-79999** to identify duplicate procedures performed on opposite sides of the body.

- **Global radiology services** include both a technical component and professional component
- **Technical component** of a radiology service is performed, then modifier **–TC** must be used, and only the technical component fees are allowable, *and*
- **Professional component** of a radiology service is performed, then modifier **–26** must be used, and only the professional component fees are allowable.

Note: The professional component of the radiology service (–26) must be billed under the L&I provider number issued to the provider actually performing the service.

# Payment limits

Chart notes such as "X-rays are negative" or "X-rays are normal" don’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances.

# Payment policy: Use of ultrasounds

## Who must perform these services to qualify for payment

Facilities billing for the technical component must have an L&I provider ID and provide documentation to support the service rendered.

Providers performing the professional component (modifier **–26**) must bill under their individual L&I provider ID.

Providers and/or technicians performing ultrasounds must have the appropriate licensure per Department of Health requirements.

## Services that can be billed

Refer to the fee schedule for codes covered by the insurer. Refer to CPT® for additional guidelines.

The use of ultrasounds for treatment such as guided needle placement and for quick assessments in emergency departments are separately reimbursable services.

## Services that aren’t covered

Office based ultrasounds used for evaluation and diagnosis are considered bundled into the evaluation and management (E/M) service and can’t be billed separately. No separate payment will be made for these services.

**HCPCS codes R0070 and R0075 are not payable for mobile ultrasound services.**

## Requirements for billing

### Technical component (modifier –TC)

In addition to the requirements in the radiology reporting documentation policy above, for the technical component, the following documentation is required:

- Patient name, age, sex,
- Date and time of ultrasound exam,
- Output display standard (thermal index & mechanical),
- Name of ordering provider,
- Label of the anatomic location and laterality, when appropriate,
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Indication for exam,

- Specific ultrasound examination performed, including all joint spaces and structures examined, *and*
- Address where exam took place (for mobile providers)

### Professional Component (Modifier –26)

In addition to the requirements in the radiology reporting documentation policy above, for the professional component, the following documentation is required:

- Patient's name, age, sex, and date of procedure,
- Relevant clinical information, including indication for the exam and/or relevant ICD-10 code,
- The specific method use for endocavity techniques, if performed,
- A description of the studies and/or procedures performed,
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Anatomic measurements, if taken,
- A description of examination findings,
- Impression, conclusion, or summary statement,
- Specific diagnosis, if appropriate,
- Recommendation for follow-up, if necessary,
- Accounting of any failure to include standard views or other necessary components, if necessary,
- Statement of comparison of relevant imaging studies if reviewed, *and*
- Details on any provider-to-provider communication if there are delays which may have an adverse effect on the patient's outcome.

## Payment limits

CPT® codes **76881** and **76882** are limited to **one unit per extremity per day.**

**76881** and **76882** aren't payable in conjunctions with each other when performed on the same anatomical region on the same date of service. Refer to CPT® for additional restrictions and requirements.

# Payment policy: X-ray services

### Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

### Custody

X-rays must be retained for 10 years.

**Links**: For more information on custody requirements, see WAC 296-20-121 and WAC 296-23-140(1).

## Services that can be billed

### Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving:
  - Extremities,
  - Pelvis,
  - Vertebral column, *or*
  - Skull,
- Chest or abdominal films that don't involve the use of contrast media, *and*
- Diagnostic mammograms.

### Incomplete full spine studies

(See definitions of **full spine study** and **incomplete full spine study** in Definitions at the beginning of this chapter.)

For a single view bill **72081**.

For 2 or 3 views bill **72082**.

For 4 or 5 views bill **72083**.

For 6 or more views bill **72084**.

# Services that aren't covered

## Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion x-ray, vertebral motion analysis and spinal x-ray digitization.

DSV isn't a covered benefit. CPT® code 76496 shouldn't be used to the bill the insurer for these services.

**Link**: For more information about DSV, see the Dynamic Spinal Visualization coverage decision.

# Requirements for billing

Attending health care providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain, *or*
- PA and lateral chest films to determine cause for dyspnea.

## Global radiology services

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the study). If only the:

- **Technical component** of a radiology service is performed, then modifier **–TC** must be used, and only the technical component fees are allowable, *and*
- **Professional component** of a radiology service is performed, then modifier **–26** must be used, and only the professional component fees are allowable.

## Repeat X-rays

The insurer won't pay for excessive or unnecessary X-rays.

Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

## Billing code modifiers –RT and –LT

HCPCS modifiers **–RT** (right side) and **–LT** (left side) don't affect payment. They may be used with CPT® radiology codes **70010**-**79999** to identify duplicate procedures performed on opposite sides of the body.

## Payment limits

HCPCS codes for transportation of portable X-ray equipment **R0070** (one patient) or **R0075** (multiple patients) may be paid in addition to the appropriate radiology code(s). **R0075** will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table. For transport portable X-ray services:

| If the **number of patients served** is… | Then the appropriate **HCPCS code** to bill is… | Along with this billing code **modifier**: | The **maximum fee**, effective July 1, 2022 is: |
|---|---|---|---|
| 1 | **R0070** | — | **$193.63** |
| 2 | **R0075** | **–UN** | **$96.82** |
| 3 | **R0075** | **–UP** | **$64.56** |
| 4 | **R0075** | **–UQ** | **$48.40** |
| 5 | **R0075** | **–UR** | **$38.72** |
| 6 or more | **R0075** | **–US** | **$32.28** |

### Number of views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exam of the cervical spine are payable as outlined below:

| If the **CPT® code** is… | Then it is **payable**: |
|---|---|
| **72020** | Once for a single view |
| **72040** | Once for 2 to 3 cervical views |
| **72050** | Once for 4 or more cervical views |
| **72052** | Once, 6 or more views, regardless of the number of cervical views it takes to complete the series |

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for X-ray custody requirements | Washington Administrative Code (WAC) 296-20-121<br>WAC 296-23-140(1) |
| **Becoming an L&I Provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| Payment policies for **physical medicine services** | Chapter 25: Physical Medicine Services |
| Payment policies for **surgery** | Chapter 29: Surgical Services |
| Professional Services **Fee Schedules** | Fee schedules on L&I's website |
| **Dynamic Spinal Visualization** coverage decision | Dynamic spinal visualization coverage decision |

## Need more help?

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**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 27: Reports and Forms

**Effective July 1, 2022**

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

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# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**By Report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report, see WAC 296-20-01002.

**Job analysis (JA)**: A 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 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.

**Job description**: 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.

**Job offer**: 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.

**Link**: For more information about Job offers, see RCW 51.32.090(4).

# Payment policy: Copies of medical records

## Who must perform these services to qualify for payment

Only providers who have provided healthcare services to the worker may bill HCPCS codes **S9981** or **S9982**.

## Services that can be billed

All records to support billed services must be provided to the department, at no cost. If the insurer requests records from a healthcare provider that are for services not provided under the claim, the insurer will pay for the requested 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.

Providers may bill for CD/DVDs of medical records requested by the insurer using HCPCS code **S9981**. Payment will be made per complete record requested by the insurer.

Providers may bill for paper copies of medical records requested by the insurer using HCPCS code **S9982**. Payment will be made per copied page.

L&I may request records before, during or after the delivery of services to ensure workers receive proper and necessary medical care and to ensure provider compliance with the department's MARFS. The provider must submit the requested records within 30 calendar days from receipt of the request.  Failure to do so may result in denial or recoupment of bill payment(s).

**Note**: Requested records must be submitted within 30 days; failure to submit records in a timely manner may result in denial or recoupment of bills.

## Payment limits

Payment for **S9981** and **S9982** includes all costs, including postage.

**S9981** and **S9982** aren't payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

**Links**: For more information, see WAC 296-20-02005 and WAC 296-20-02010.

# Payment policy: Reports and forms

## Services that can be billed

To bill for special reports or forms required by the insurer, providers should use the CPT® or local billing codes listed in the following table. The fees listed in the table below include postage for sending documents to the insurer. When required, the insurer will send special reports and forms.

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **60 Day Report** | **99080** | **$51.11** | 60 day reports are required per WAC 296-20-06101 and don't need to be requested by the insurer.<br>Not payable for records required to support billing or for review of records included in other services.<br>Limit of 1 per provider per 60 days per claim. |
| **Special Report** | **99080** | **$51.11** | **Must be requested by insurer or vocational counselor.**<br>**For reports created by provider.**<br>Not payable for records or reports required to support billing or for review of records included in other services.<br>Don't use this code for forms or reports with assigned codes.<br>Limit of 1 per day.<br>Bill this code for starring a work history form. |

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **AP Final Report** | **1026M** | **$29.36** | **May be requested by insurer or submitted by attending provider.**<br>Payable only to attending provider.<br>Limit of 1 per day. |
| **Loss of Earning Power** (LEP) | **1027M** | **$22.23** | **Must be requested by insurer.**<br>Payable only to attending provider.<br>Limit of 1 per day. |
| **Report of Accident** (ROA) Workplace Injury, or Occupational Disease for State Fund claims | **1040M** | **$44.44**<br><br>**$33.44**<br><br>**$23.44** | MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.<br>Paid when initiated by the worker or by a provider listed above.<br>Limit of 1 per claim.<br><br>**When submitted within 5 business days after first treatment date**<br><br>**When submitted 6-8 business days after first treatment date**<br><br>**When submitted 9 or more business days after first treatment date** |

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **Provider's Initial Report** (PIR) – for Self Insured claims | **1040M** | **$44.44** | MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.<br>Paid when initiated by the worker or by a provider listed above.<br>Limit of 1 per claim.<br>**When submitted within 5 business days after first treatment date** |
| | | **$33.44** | **When submitted 6-8 business days after first treatment date** |
| | | **$23.44** | **When submitted 9 or more business days after first treatment date** |
| **Application to Reopen Claim** | **1041M** | **$57.77** | MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.<br>May be initiated by the worker or insurer (see WAC 296-20-097).<br>Limit of 1 per request. |
| **Occupational Disease History Report** | **1055M** | **$215.60** | **Must be requested by insurer.**<br>Payable only to attending provider.<br>Includes review of worker information and preparation of report on relationship of occupational history to present condition(s).<br>Link to instructions on this form. |

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **Attending Provider Review of Independent Medical Exam** (IME) | **1063M** | **$44.45** | **Must be requested by insurer.**<br>Payable only to attending provider.<br>Limit of one (1) per request.<br>Attending provider must respond to request using letter sent by claim manager. |
| **Attending Provider Supplemental Review of IME** with written report | **1065M** | **$33.34** | **Must be requested by insurer.**<br>Payable only to attending provider when submitting a separate report of IME review. This report expands upon the provider's response from 1063M.<br>Limit of 1 per request. |
| **Provider Review of Video Materials** with written report | **1066M** | **By report** | **Must be requested by insurer.**<br>Payable once per provider per day.<br>Report must include actual time spent reviewing the video materials. Report should include findings and observations gained from the review.<br>Won't pay in addition to CPT® code 99080 or local codes 1104M or 1198M. |

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **Activity Prescription Form** (APF) | **1073M** | **$57.77** | Submit the Activity Prescription Form (APF):<br>• With the Report of Accident when there are work related physical restrictions, or<br>• When documenting a change in your patient's medical status or capacities.<br>Limits:<br>A provider may submit up to 6 APFs per worker within the first 60 days of the initial visit date and then up to 4 times per 60 days thereafter.<br>The insurer will review and allow or deny any APFs submitted over the limits listed above.<br>Providers will be paid for properly completed APFs requested by the insurer, even if the provider has already reached the limit by self-generating prior APFs.<br>Payable once per provider per worker per day.<br>APF information is available online. |

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **AP response to VRC/Employer request about RTW** | **1074M** | **$35.56** | Responding to written communication with vocational counselors (VRC) and employers such as questionnaires.<br>1074M is not payable when performed on the same day as a team conference, office visit, or online communication with a VRC or employer.<br>A copy of the written communication must be sent to the insurer. |
| **Subacute Opioid Request Form for Pain without Documentation** | **1076M** | **$35.56** | Use this code if submitting the Subacute Opioid Request Form but results of screenings are documented in the medical record. (See WAC 296-20-03056.) |
| **Subacute Opioid Request Form for Pain with Documentation** | **1077M** | **$66.68** | Use this code if submitting the Subacute Opioid Request Form and copies of all required screenings (urine drug test, risk of opioid addiction, current or former substance use disorder and depression, if indicated) for increased reimbursement. (See WAC 296-20-03056.) |
| **Opioid Request Form for Chronic Pain** | **1078M** | **$35.56** | Use this code if submitting the Chronic Opioid Request Form. (See WAC 296-20-03057 and WAC 296-20-03058.) |

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **Review of FCE Reports/ Summary** | **1097M** | **$57.77** | **Must be requested by insurer, employer, or vocational counselor.**<br>Payable to attending provider, IME examiner, or consultant.<br>Limit of one per day per provider per worker. |

**Links**: More information on reports and forms listed above is provided in WAC 296-20-06101.

Many L&I forms are available and can be downloaded from L&I's website and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811.

# Payment policy: Review of job offers, job analyses, and job descriptions

**Job analyses** and **job descriptions** identify the physical requirements of a potential job for the worker.

The medical provider reviews the **JA** or **job description(s)** to determine whether the worker can perform a specific job. The provider sends the insurer (and vocational provider, if applicable) a response, indicating whether the worker can perform the job described, or if not, specifying any modifications needed to enable the worker to do the job.

## Prior authorization

Prior authorization is required for review of **JAs** and **job descriptions** if not requested by the insurer, employer or vocational provider.

## Who must perform these services to qualify for payment

### Job offers

Attending providers must review the physical requirements documented in the **job description** or **job analysis** of any **job offer** submitted by the employer of record and determine whether the worker can perform that job.

### JAs and job descriptions

Attending providers, Independent Medical Examiners and consulting physicians will be paid for review of **job descriptions** or **JAs**.

A **job description/JA** review may be performed at the request of the employer, the insurer, Vocational Rehabilitation Counselor (VRC), or Third Party Administrator (TPA). This service is payable in addition to other services performed on the same day. The provider must send a copy of each **job description** or **job analysis** reviewed to the insurer.

**Note**: Reviews requested by other persons (for example, attorneys or workers) won't be paid.

## Services that can be billed

| If the **report or form** is… | Then bill using this **CPT® or local billing code**: | Which has a **maximum fee** of: | Also, be aware of these **special notes** about the report or form: |
|---|---|---|---|
| **Review of Job Descriptions or JA** | **1038M** | **$57.77** | **Must be requested by insurer, employer or vocational counselor.**<br>Payable to attending provider, IME examiner or consultant.<br>Limit of 1 per day.<br>Isn't payable to IME examiner on the same day as the IME is performed. |
| **Review of Job Descriptions or JA,** each additional review | **1028M** | **$43.34** | **Must be requested by insurer, employer or vocational counselor.**<br>Payable to attending provider, IME examiner or consultant.<br>For IME examiners on day of exam: may be billed for each additional JA after the first 2.<br>For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using 1038M). |

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for information in this chapter | Washington Administrative Code (WAC) 296-20-06101<br>WAC 296-20-097<br>WAC 296-20-03056<br>WAC 296-20-03057<br>WAC 296-20-03058 |
| **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 services | Fee schedules on L&I's website |
| **L&I forms** | L&I's website |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

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# Chapter 28: Supplies, Materials, and Bundled Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Acquisition cost**: The acquisition cost equals:

- The wholesale cost, *plus*
- Shipping and handling, *plus*
- Sales tax.

**By Report (BR)**: A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the full legal definition of By Report, see WAC 296-20-01002.

**Bundled codes**: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services. Pharmacy and DME providers can bill HCPCS codes listed as bundled in the fee schedules. This is because, for these provider types, there isn't an office visit or a procedure into which supplies can be bundled.

**Link**: For the legal definition of Bundled codes, see WAC 296-20-01002.

**Primary surgical dressings**: Therapeutic or protective coverings directly applied to wounds or lesions on the skin or caused by an opening on the skin. These dressings include items such as:

- Telfa,
- Adhesive strips for wound closure, *and*
- Petroleum gauze.

**Secondary surgical dressings**: Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. These dressings include items such as:

- Adhesive tape,
- Roll gauze,
- Binders, *and*
- Disposable compression material.

**Supplies**: Supplies include, but aren't limited to:

- Drugs administered in a provider's office,
- Medical and surgical supplies, *and*
- Prefabricated orthotics.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–NU (New purchased DME)**

Use the –NU modifier when a new DME item is to be purchased.

**–RR (Rented DME)**

Use the –RR modifier when DME is to be rented.

**–1S (Surgical dressings for home use)**

Bill the appropriate HCPCS code for each dressing item using the –1S modifier for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

# Payment policy: Acquisition cost policy

## General information

This policy doesn't apply to hospital bills. For the Hospital **acquisition cost** policy, see Chapter 35: Hospitals.

## Requirements for billing

### Billing acquisition cost

The total **acquisition cost** should be billed as one charge. The **acquisition cost** equals:

- The wholesale cost, *plus*
- Shipping and handling, *plus*
- Sales tax.

Sales tax and shipping and handling charges aren't paid separately and must be included in the total charge of the supply. An itemized statement showing total cost must be attached to bills. Bills without an itemized statement may be denied.

Supply codes without a fee listed will be paid at their **acquisition cost**.

### Wholesale invoices

Providers must keep wholesale invoices for all **supplies** and materials in their office files for a minimum of 5 years.

A provider must submit a hard copy of the wholesale invoice to the insurer:

- When billing for a supply item that costs **$150.00** or more, *or*
- Upon request.

**Note**: The insurer may delay payment of the provider's bill if the insurer hasn't received this invoice.

# Payment policy: Casting materials

## Services that can be billed

Bill for casting materials with HCPCS codes **Q4001**-**Q4051**.

## Services that aren’t covered

No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider’s practice expense.

# Payment policy: Catheterization

## Services that can be billed

Separate payment is allowed for placement of a temporary indwelling catheter when treatment is:

- Performed in a provider's office, *and*
- Used to treat a temporary obstruction.

**Link**: For more information about catheterization to obtain specimen(s) for lab tests, see the Specimen collection and handling payment policy in Chapter 23: Pathology and Laboratory Services.

## Payment limits

Separate payment isn't allowed when placement of a temporary indwelling catheter is performed:

- On the same day as a major surgical procedure, *or*
- During the postoperative period of a major surgical procedure that has a follow up period.

 

# Payment policy: Hot or cold therapy durable medical equipment (DME)

## Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for DME providers only and is **Bundled** for all other provider types.

## Services that aren't covered

Hot water bottles, heat and/or cold wraps aren't covered.

Hot or cold therapy DME isn't covered. For example, heat devices for home use, including heating pads. These devices either aren't covered or are **Bundled**.

**Link**: For more information, see WAC 296-20-1102.

## Payment limits

Application of hot or cold packs (CPT® code **97010**) is **Bundled** for all providers.

**Link**: For more information, see the payment policy for Hot and cold therapy DME in Chapter 9: Durable Medical Equipment (DME).

# Payment policy: Miscellaneous supplies

## Services that can be billed

HCPCS billing code **E1399** can be billed for a miscellaneous supply that meets both of these criteria:

- The supply (or DME item) doesn't have a valid HCPCS code assigned, *and*
- The item must be appropriate relative to the injury or type of treatment being received by the worker.

## Services that aren't covered

The insurer won't pay CPT® code **99070**, which represents miscellaneous **supplies** and materials provided by the provider.

## Requirements for billing

All bills for **E1399** items must have:

- Either the **–NU** or **–RR** modifier, *and*
- A description must be on the paper bill or in the remarks section of the electronic bill.

These specific miscellaneous **supplies** must be billed using HCPCS code **E1399**:

- Therapy putty and tubing, *and*
- Anti-vibration gloves.

 

# Payment policy: Services and supplies

## General information

Services and **supplies** must be medically necessary and must be prescribed by an approved provider for the direct treatment of an accepted condition.

Providers must bill specific HCPCS or local codes for **supplies** and materials provided during an office visit or with other office services.

For covered medical and surgical **supplies** that pay **By Report**, providers must bill their usual and customary fees. To find out which codes pay **By Report**, see the Medical and Surgical Supplies section of the Professional Services Fee Schedule.

**Links**: For more information on billing usual and customary fees, see WAC 296-20-010(2).

## Services that aren't covered

The insurer won't pay CPT® code **99070**, which represents miscellaneous **supplies** and materials provided by the provider.

## Payment limits

Under the fee schedules, some services and supply items are considered **Bundled** into the cost of other services (associated office visits or procedures) and won't be paid separately. These include:

- **Supplies** used in the course of an office visit, *and*
- Fitting fees, which are **Bundled** into the office visit or into the cost of any DME.

For medical and surgical **supplies** that pay **By Report** (except **E1399**) the insurer will pay 80% of the billed charge.

To see which billing codes are **Bundled**, see L&I's Professional Services Fee Schedule; in the dollar value column, such items show the word **Bundled** (instead of a dollar amount).

# Payment policy: Supply Codes, Bundled

## Bundled CPT® supply codes

These CPT® service codes are **Bundled**:

- **99070**, *and*
- **99071**.

## Bundled HCPCS supply codes

In the following table, items with an asterisk (*) are used as orthotics/prosthetics and may be paid separately **for permanent conditions** if they are provided in the physician's office.

If the condition is **acute or temporary**, these items aren't considered prosthetics.

For example:

- Foley catheters and accessories for permanent incontinence or ostomy **supplies** for permanent conditions may be paid separately when provided in the physician's office, *and*
- The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction wouldn't be paid separately because it is treating a temporary problem, *and*
- If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthetic/orthotic and would be paid separately.

 

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A0380** | Basic life support mileage |
| **A0382** | Basic support routine suppls |
| **A0384** | Bls defibrillation supplies |
| **A0390** | Advanced life support mileag |
| **A0392** | Als defibrillation supplies |
| **A0394** | Als IV drug therapy supplies |
| **A0396** | Als esophageal intub suppls |
| **A0398** | Als routine disposble suppls |
| **A0420** | Ambulance waiting 1/2 hr |
| **A0422** | Ambulance 02 life sustaining |
| **A0424** | Extra ambulance attendant |
| **A4206** | 1 CC sterile syringe & needle |
| **A4207** | 2 CC sterile syringe & needle |
| **A4208** | 3 CC sterile syringe & needle |
| **A4209** | 5+ CC sterile syringe & needle |
| **A4211** | Supp for self-adm injections |
| **A4212** | Non coring needle or stylet |
| **A4213** | 20+ CC syringe only |
| **A4215** | Sterile needle |
| **A4216** | Sterile water/saline, 10 ml |
| **A4217** | Sterile water/saline, 500 ml |
| **A4218** | Sterile saline or water |
| **A4244** | Alcohol or peroxide per pint |
| **A4245** | Alcohol wipes per box |
| **A4246** | Betadine/phisohex solution |
| **A4247** | Betadine/iodine swabs/wipes |
| **A4248** | Chlorhexidine antisept |
| **A4250** | Urine reagent strips/tablets |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A4252** | Blood ketone test or strip |
| **A4253** | Blood glucose/reagent strips |
| **A4256** | Calibrator solution/chips |
| **A4257** | Replace Lensshield Cartridge |
| **A4258** | Lancet device each |
| **A4259** | Lancets per box |
| **A4262** | Temporary tear duct plug |
| **A4263** | Permanent tear duct plug |
| **A4265** | Paraffin |
| **A4270** | Disposable endoscope sheath |
| **A4300** | Cath impl vasc access portal |
| **A4301** | Implantable access syst perc |
| **A4305** | Drug delivery system >=50 ML |
| **A4306** | Drug delivery system <=5 ML |
| **A4310** | Insert tray w/o bag/cath |
| **A4311** | Catheter w/o bag 2-way latex |
| **A4312** | Cath w/o bag 2-way silicone |
| **A4313** | Catheter w/bag 3-way |
| **A4314** | Cath w/drainage 2-way latex |
| **A4315** | Cath w/drainage 2-way silcne |
| **A4316** | Cath w/drainage 3-way |
| **A4320** | Irrigation tray |
| **A4321** | Cath therapeutic irrig agent |
| **A4322** | Irrigation syringe |
| **A4326*** | Male external catheter |
| **A4327*** | Fem urinary collect dev cup |
| **A4328*** | Fem urinary collect pouch |
| **A4330** | Stool collection pouch |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A4331** | Extension drainage tubing |
| **A4332** | Lube sterile packet |
| **A4333** | Urinary cath anchor device |
| **A4334** | Urinary cath leg strap |
| **A4335*** | Incontinence supply |
| **A4336** | Urethral insert |
| **A4338*** | Indwelling catheter latex |
| **A4340*** | Indwelling catheter special |
| **A4344*** | Cath indw foley 2 way silicn |
| **A4346*** | Cath indw foley 3 way |
| **A4349** | Disposable male external cat |
| **A4351** | Straight tip urine catheter |
| **A4352** | Coude tip urinary catheter |
| **A4353** | Intermittent urinary cath |
| **A4354** | Cath insertion tray w/bag |
| **A4355** | Bladder irrigation tubing |
| **A4356*** | Ext ureth clmp or compr dvc |
| **A4357*** | Bedside drainage bag |
| **A4358*** | Urinary leg or abdomen bag |
| **A4360** | Disposable ext urethral dev |
| **A4361*** | Ostomy face plate |
| **A4362*** | Solid skin barrier |
| **A4363** | Ostomy clamp, replacement |
| **A4364*** | Adhesive, liquid or equal |
| **A4366*** | Ostomy vent |
| **A4367*** | Ostomy belt |
| **A4368*** | Ostomy filter |
| **A4369*** | Skin barrier liquid per oz |

 

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A4371*** | Skin barrier powder per oz |
| **A4372*** | Skin barrier solid 4x4 equiv |
| **A4373*** | Skin barrier with flange |
| **A4375*** | Drainable plastic pch w fcpl |
| **A4376*** | Drainable rubber pch w fcplt |
| **A4377*** | Drainable plstic pch w/o fp |
| **A4378*** | Drainable rubber pch w/o fp |
| **A4379*** | Urinary plastic pouch w fcpl |
| **A4380*** | Urinary rubber pouch w fcplt |
| **A4381*** | Urinary plastic pouch w/o fp |
| **A4382*** | Urinary hvy plstc pch w/o fp |
| **A4383*** | Urinary rubber pouch w/o fp |
| **A4384*** | Ostomy faceplt/silicone ring |
| **A4385*** | Ost skn barrier sld ext wear |
| **A4387*** | Ost clsd pouch w att st barr |
| **A4388*** | Drainable pch w ex wear barr |
| **A4389*** | Drainable pch w st wear barr |
| **A4390*** | Drainable pch ex wear convex |
| **A4391*** | Urinary pouch w ex wear barr |
| **A4392*** | Urinary pouch w st wear barr |
| **A4393*** | Urine pch w ex wear bar conv |
| **A4394*** | Ostomy pouch liq deodorant |
| **A4395*** | Ostomy pouch solid deodorant |
| **A4396** | Peristomal hernia supprt blt |
| **A4398*** | Ostomy irrigation bag |
| **A4399*** | Ostomy irrig cone/cath w brs |
| **A4400*** | Ostomy irrigation set |
| **A4402*** | Lubricant per ounce |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A4404*** | Ostomy ring each |
| **A4405*** | Nonpectin based ostomy paste |
| **A4406*** | Pectin based ostomy paste |
| **A4407*** | Ext wear ost skn barr <=4sq |
| **A4408*** | Ext wear ost skn barr >4sq |
| **A4409*** | Ost skn barr w flng <=4 sq I |
| **A4410*** | Ost skn barr w flng >4sq |
| **A4411** | Ost skn barr extnd =4sq |
| **A4412** | Ost pouch drain high output |
| **A4413*** | 2 pc drainable ost pouch |
| **A4414*** | Ostomy sknbarr w/o conv<=4sq in |
| **A4415*** | Ostomy skn barr w/o conv >4 sqi |
| **A4416*** | Ost pch clsd w barrier/filtr |
| **A4417*** | Ost pch w bar/bltinconv/fltr |
| **A4418*** | Ost pch clsd w/o bar w filtr |
| **A4419*** | Ost pch for bar w flange/flt |
| **A4420*** | Ost pch clsd for bar w lk fl |
| **A4421*** | Ostomy supply misc |
| **A4422*** | Ost pouch absorbent material |
| **A4423*** | Ost pch for bar w lk fl/fltr |
| **A4424*** | Ost pch drain w bar & filter |
| **A4425*** | Ost pch drain for barrier fl |
| **A4426*** | Ost pch drain 2 piece system |
| **A4427*** | Ost pch drain/barr lk flng/f |
| **A4428*** | Urine ost pouch w faucet/tap |
| **A4429*** | Urine ost pouch w bltinconv |
| **A4430*** | Ost urine pch w b/bltin conv |
| **A4431*** | Ost pch urine w barrier/tapv |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A4432*** | Os pch urine w bar/fange/tap |
| **A4433*** | Urine ost pch bar w lock fln |
| **A4434*** | Ost pch urine w lock flng/ft |
| **A4435** | 1pc ost pch drain hgh output |
| **A4450** | Non-waterproof tape |
| **A4452** | Waterproof tape |
| **A4455** | Adhesive remover per ounce |
| **A4456** | Adhesive remover, wipes |
| **A4458** | Reusable enema bag |
| **A4461** | Surgicl dress hold non-reuse |
| **A4463** | Surgical dress holder reuse |
| **A4465** | Non-elastic extremity binder |
| **A4470** | Gravlee jet washer |
| **A4480** | Vabra aspirator |
| **A4520** | Incontinence garment anytype |
| **A4550** | Surgical trays |
| **A4554** | Disposable underpads |
| **A4556** | Electrodes, pair |
| **A4557** | Lead wires, pair |
| **A4558** | Conductive paste or gel |
| **A4559** | Coupling gel or paste |
| **A4649** | Surgical supplies |
| **A4670** | Automatic bp monitor, dial |
| **A4930** | Sterile, gloves per pair |
| **A5051*** | Pouch clsd w barr attached |
| **A5052*** | Clsd ostomy pouch w/o barr |
| **A5053*** | Clsd ostomy pouch faceplate |
| **A5054*** | Clsd ostomy pouch w/flange |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A5055*** | Stoma cap |
| **A5061*** | Pouch drainable w barrier at |
| **A5062*** | Drnble ostomy pouch w/o barr |
| **A5063*** | Drain ostomy pouch w/flange |
| **A5071*** | Urinary pouch w/barrier |
| **A5072*** | Urinary pouch w/o barrier |
| **A5073*** | Urinary pouch on barr w/flng |
| **A5081*** | Stoma plug or seal, any type |
| **A5082*** | Continent stoma catheter |
| **A5083*** | Stoma absorptive cover |
| **A5093*** | Ostomy accessory convex inse |
| **A5102*** | Bedside drain btl w/wo tube |
| **A5105*** | Urinary suspensory |
| **A5112*** | Urinary leg bag |
| **A5113*** | Latex leg strap |
| **A5114*** | Foam/fabric leg strap |
| **A5120** | Skin barrier, wipe or swab |
| **A5121*** | Solid skin barrier 6x6 |
| **A5122*** | Solid skin barrier 8x8 |
| **A5126*** | Disk/foam pad +or- adhesive |
| **A5131*** | Appliance cleaner |
| **A6010** | Collagen based wound filler |
| **A6011** | Collagen gel/paste wound fil |
| **A6021** | Collagen dressing <=16 sq in |
| **A6022** | Collagen drsg>16<=48 sq in |
| **A6023** | Collagen dressing >48 sq in |
| **A6024** | Collagen dsg wound filler |
| **A6025** | Silicone gel sheet, each |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A6154** | Wound pouch each |
| **A6196** | Alginate dressing <=16 sq in |
| **A6197** | Alginate drsg >16 <=48 sq in |
| **A6198** | Alginate dressing > 48 sq in |
| **A6199** | Alginate drsg wound filler |
| **A6203** | Composite drsg <= 16 sq in |
| **A6204** | Composite drsg >16<=48 sq in |
| **A6205** | Composite drsg > 48 sq in |
| **A6206** | Contact layer <= 16 sq in |
| **A6207** | Contact layer >16<= 48 sq in |
| **A6208** | Contact layer > 48 sq in |
| **A6209** | Foam drsg <=16 sq in w/o bdr |
| **A6210** | Foam drg >16<=48 sq in w/o b |
| **A6211** | Foam drg > 48 sq in w/o brdr |
| **A6212** | Foam drg <=16 sq in w/border |
| **A6213** | Foam drg >16<=48 sq in w/bdr |
| **A6214** | Foam drg > 48 sq in w/border |
| **A6215** | Foam dressing wound filler |
| **A6216** | Non-sterile gauze<=16 sq in |
| **A6217** | Non-sterile gauze>16<=48 sq |
| **A6218** | Non-sterile gauze > 48 sq in |
| **A6219** | Gauze <= 16 sq in w/border |
| **A6220** | Gauze >16 <=48 sq in w/bordr |
| **A6221** | Gauze > 48 sq in w/border |
| **A6222** | Gauze <=16 in no w/sal w/o b |
| **A6223** | Gauze >16<=48 no w/sal w/o b |
| **A6224** | Gauze > 48 in no w/sal w/o b |
| **A6228** | Gauze <= 16 sq in water/sal |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A6229** | Gauze >16<=48 sq in watr/sal |
| **A6230** | Gauze > 48 sq in water/salne |
| **A6231** | Hydrogel dsg<=16 sq in |
| **A6232** | Hydrogel dsg>16<=48 sq in |
| **A6233** | Hydrogel dressing >48 sq in |
| **A6234** | Hydrocolld drg <=16 w/o bdr |
| **A6235** | Hydrocolld drg >16<=48 w/o b |
| **A6236** | Hydrocolld drg > 48 in w/o b |
| **A6237** | Hydrocolld drg <=16 in w/bdr |
| **A6238** | Hydrocolld drg >16<=48 w/bdr |
| **A6239** | Hydrocolld drg > 48 in w/bdr |
| **A6240** | Hydrocolld drg filler paste |
| **A6241** | Hydrocolloid drg filler dry |
| **A6242** | Hydrogel drg <=16 in w/o bdr |
| **A6243** | Hydrogel drg >16<=48 w/o bdr |
| **A6244** | Hydrogel drg >48 in w/o bdr |
| **A6245** | Hydrogel drg <= 16 in w/bdr |
| **A6246** | Hydrogel drg >16<=48 in w/b |
| **A6247** | Hydrogel drg > 48 sq in w/b |
| **A6248** | Hydrogel drsg gel filler |
| **A6250** | Skin seal protect moisturizr |
| **A6251** | Absorpt drg <=16 sq in w/o b |
| **A6252** | Absorpt drg >16 <=48 w/o bdr |
| **A6253** | Absorpt drg > 48 sq in w/o b |
| **A6254** | Absorpt drg <=16 sq in w/bdr |
| **A6255** | Absorpt drg >16<=48 in w/bdr |
| **A6256** | Absorpt drg > 48 sq in w/bdr |
| **A6257** | Transparent film <= 16 sq in |

 

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A6258** | Transparent film >16<=48 in |
| **A6259** | Transparent film > 48 sq in |
| **A6260** | Wound cleanser any type/size |
| **A6261** | Wound filler gel/paste /oz |
| **A6262** | Wound filler dry form / gram |
| **A6266** | Impreg gauze no h20/sal/yard |
| **A6402** | Sterile gauze <= 16 sq in |
| **A6403** | Sterile gauze>16 <= 48 sq in |
| **A6404** | Sterile gauze > 48 sq in |
| **A6407** | Packing strips, non-impreg |
| **A6410** | Sterile eye pad |
| **A6411** | Non-sterile eye pad |
| **A6412** | Occlusive eye patch |
| **A6413** | Adhesive bandage, first-aid |
| **A6441** | Pad band w>=3 <5/yd |
| **A6442** | Conform band n/s w<3/yd |
| **A6443** | Conform band n/s w>=3<5/yd |
| **A6444** | Conform band n/s w>=5/yd |
| **A6445** | Conform band s w <3/yd |
| **A6446** | Conform band s w>=3 <5/yd |
| **A6447** | Conform band s w >=5/yd |
| **A6448** | Lt compres band <3/yd |
| **A6449** | Lt compres band >=3 <5/yd |
| **A6450** | Lt compres band >=5/yd |
| **A6451** | Mod compr band w>=3<5/yd |
| **A6452** | High compr band w>=3<5yd |
| **A6453** | Self-adher band w <3/yd |
| **A6454** | Self-adher band w>=3 <5/yd |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **A6455** | Self-adher band >=5/yd |
| **A6456** | Zinc paste band w >=3<5/yd |
| **A6457** | Tubular dressing |
| **A9150** | Misc/exper non-prescript dru |
| **A9273** | Hot/cold H20bot/cap/col/wrap |
| **A9900** | Supply/accessory/service |
| **J3535** | Metered dose inhaler drug |
| **J7599** | Immunosuppressive drug noc |
| **J7699** | Inhalation solution for DME |
| **J7799** | Non-inhalation drug for DME |
| **J8498** | Antiemetic rectal/sup nos |
| **J8499** | Oral prescript drug non chemo |
| **J8597** | Antiemetic drug oral nos |
| **J8999** | Oral prescription drug chemo |
| **L8614** | Cochlear device |
| **T4521** | Adult size brief/diaper sm |
| **T4522** | Adult size brief/diaper med |
| **T4523** | Adult size brief/diaper lg |
| **T4524** | Adult size brief/diaper xl |
| **T4525** | Adult size pull-on sm |
| **T4526** | Adult size pull-on med |
| **T4527** | Adult size pull-on lg |
| **T4528** | Adult size pull-on xl |
| **T4533** | Youth size brief/diaper |
| **T4534** | Youth size pull-on |
| **T4535** | Disposable liner/shield/pad |
| **T4536** | Reusable pull-on any size |
| **T4537** | Reusable underpad bed size |

| This **HCPCS supply code** is bundled: | And it has this **abbreviated description**: |
|---|---|
| **T4539** | Reuse diaper/brief any size |
| **T4540** | Reusable underpad chair size |
| **T4541** | Large disposable underpad |
| **T4542** | Small disposable underpad |
| **T4544** | Adlt disp und/pull on abv xl |

# Payment policy: Surgical dressings dispensed for home use

## Requirements for billing

Providers must bill the appropriate HCPCS code for each dressing item, along with the local billing code modifier **–1S** for each item.

## Payment limits

**Primary surgical dressings** and **secondary surgical dressings** dispensed for home use are payable at **acquisition cost** when all of these conditions are met:

- They are dispensed to a patient for home care of a wound, *and*
- They are medically necessary, *and*
- The wound is due to an accepted work related condition.

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. Separate payment isn't allowed.

Items such as elastic stockings, support hose, and pressure garments aren't **secondary surgical dressings** and must be billed with the appropriate HCPCS code.

Surgical dressing **supplies** and codes billed without the local modifier **–1S** are considered **Bundled** and won't be paid.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and is not separately payable, even to **DME** suppliers. For details on coverage of pneumatic compression devices, see Chapter 9: Durable Medical Equipment.

 

# Payment policy: Surgical trays and supplies used in the physician's office

## Payment limits

L&I follows CMS's policy of bundling HCPCS codes for surgical trays and **supplies** used in a physician's office. Surgical trays and **supplies** won't be paid separately.

### Special note: Surgical dressings and other items dispensed for home use

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier **–1S**.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for topics relevant to this chapter | Washington Administrative Code (WAC) 296-20-1102<br>WAC 296-20-01002 |
| **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 |
| Payment policies for **catheterization to obtain specimens for lab tests** | Chapter 23: Pathology and Laboratory Services |
| Payment policies for **durable medical equipment (DME)** | Chapter 9: Durable Medical Equipment |
| Payment policies for **hospital acquisition cost policy** | Chapter 35: Hospitals |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 29: Surgery Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Certified or accredited facility or office**: L&I defines a certified or accredited facility or office that has certification or accreditation from one of the following organizations:

- Medicare (CMS – Centers for Medicare and Medicaid Services),
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
- Accreditation Association for Ambulatory Health Care (AAAHC),
- American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF),
- American Osteopathic Association (AOA),
- Commission on Accreditation of Rehabilitation Facilities (CARF).

**Endoscopy**: For the purpose of these payment policies, “endoscopy” will be used to refer to any invasive procedure performed with the use of a fiber optic scope or other similar instrument.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–22 (Increased Procedural Services)**

Procedures with this modifier will be individually reviewed prior to payment. A report is required for this review and it must include justification for the use of the modifier explaining increased complexity required for proper treatment. Payment varies based on the report submitted.

**–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)**

Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. Documentation must be submitted with the billing form when this modifier is used. Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

**–25 (Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure)**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

**–26 (Professional component)**

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See above for information on the use of the **–TC** modifier.)

**–50 (Bilateral surgery)**

The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier **–50** should be applied to the second line item.

**–51 (Multiple surgeries)**

For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

**–54 (Surgical care only)**

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

 

**–55 (Postoperative management only)**

When one physician performs the postoperative management and another physician has performed the surgical procedure.

**–56 (Preoperative management only)**

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.

### Utilization rules for modifiers -54, -55, and -56

When providing less than the global surgical package, providers should use modifiers **–54**, **–55**, and **–56**. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

**–57 (Decision for surgery)**

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow up period. It shouldn't be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

**–58 (Staged or related procedure or service by the same physician during the postoperative period)**

Used to report a surgical procedure that is staged or related to the primary surgical procedure and is performed during the global period.

**–62 (Two surgeons)**

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases. Both surgeons must submit separate operative reports describing their specific roles.

**–66 (Team surgery)**

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Each surgeon must submit separate operative reports describing their specific roles.

 

**–78 (Return to the operating room for a related procedure during the postoperative period)**

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

**–79 (Unrelated procedure or service by the same physician during the postoperative period)**

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

**–80 (Assistant surgeon)**

**–81 (Minimum assistant surgeon)**

**–82 (Assistant surgeon)** (when qualified resident surgeon not available)

**–FT (Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.)**

Use to report when a critical care E/M visit is performed within the global period but is unrelated, or when one or more additional critical care E/M visits performed on the same day are unrelated.

For instance, this modifier may be used for critical care performed by a surgeon during a global period; however, the critical care must be unrelated to the procedure/surgery done.

### Assistant surgeon modifiers

Physicians who assist the primary physician in surgery should use modifiers **–80**, **–81**, or **–82** depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable. If fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in your report to receive payment.

**–SU (Procedure performed in physician's office)**

Denotes the use of facility and equipment while performing a procedure in a provider's office.

**–TC (Technical component)**

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See above for information on the use of the **–26** modifier.)

# Payment policy: Autologous chondrocyte implant (ACI)

## Services that aren't covered

Autologous chondrocyte implants are not covered. For details, see L&I's coverage decision.

# Payment policy: Angioscopy

## Payment limits

Payment for angioscopies CPT® code **35400** is limited to only one unit based on its complete code description encompassing multiple vessels.

**Note**: The work involved with varying numbers of vessels was incorporated in the RVUs.

# Payment policy: Bilateral surgeries

## Requirements for billing

Bilateral surgeries should be billed as two line items:

- Modifier **–50** must be applied to the second line item, *and*
- The second line item is paid at the lesser of the billed charge, or 50% of the fee schedule maximum.

Bilateral surgeries are considered one procedure when determining the highest valued procedure before applying multiple surgery rules.

**Link**: To see if modifier **–50** is valid with the procedure performed, check the Professional Services Fee Schedule.

### Example 1: Billing for bilateral surgeries

| Line item | CPT® code (and modifier) | Maximum payment (non-facility setting) | Bilateral policy applied | Allowed amount |
|---|---|---|---|---|
| 1 | **64721** | **$803.90** | — | **$803.90**(1) |
| 2 | **64721-50** | **$803.90** | **$401.95**(2) | **$401.95** |
| | | | **Total** allowed amount in non-facility setting: | **$1,205.85**(3) |

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

### Example 2: Billing for bilateral surgeries and multiple procedures

| Line item | CPT® code (and modifier) | Max payment (non-facility setting) | Bilateral policy applied | Multiple procedure policy applied | Allowed amount |
|---|---|---|---|---|---|
| 1 | **63042** | **$2,292.18** | — | — | **$2,292.18** (1) |
| 2 | **63042-50** | **$2,292.18** | **$1,146.09** (2) | — | **$1,146.09** |
| | | | | Subtotal: | **$3,438.55** (3) |
| 3 | **22612-51** | **$2,804.73** | — | **$1402.36**(4) | **$1,402.36** |
| | | | | Total allowed amount in non-facility setting: | **$4,840.91**(5) |

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.

(4) The third line item billed with modifier **–51** is paid at 50% of the maximum payment.

(5) Represents total allowable amount.

# Payment policy: Bone growth stimulators

## Prior authorization

These HCPCS (billing) codes for bone growth stimulators require prior authorization:

- **E0747** (Osteogenesis stimulator, electrical, noninvasive, other than spinal application), and
- **E0748** (Osteogenesis stimulator, electrical, noninvasive, spinal application), and
- **E0749** (Osteogenesis stimulator, electrical (surgically implanted)), and
- **E0760** (Osteogenesis stimulator, low intensity ultrasound, noninvasive).

The insurer, with prior authorization, pays for bone growth stimulators for specific conditions when proper and necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, *and*
- Implanted electrical stimulators that supply a direct current to the bone.

# Payment policy: Bone morphogenic protein (BMP)

## Prior authorization

The insurer may cover the use of bone morphogenic protein 7 (rhBMP-7) as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. The insurer may also cover the use of rhBMP-2 for primary anterior open or laparoscopic lumbar fusion at one level between L4 and S1, or revision lumbar fusion on a compromised patient for whom autologous bone and bone marrow harvest are not feasible or not expected to result in fusion.

All of the guidelines for bone morphogenic protein treatment must be met before the insurer will authorize the procedures. In addition, lumbar fusion guidelines must be met.

## Services that aren't covered

Bone morphogenic protein-2 (rhBMP-2) isn't covered for use in long bone nonunion fractures.

Bone morphogenic protein-7 (rhBMP-7) isn't covered for use in lumbar fusion.

BMP isn't covered for use in cervical spinal fusion or any other indication.

## Requirements for billing

CPT® codes used depend on the specific procedure being performed.

 

# Payment policy: Closure of enterostomy

## Payment limits

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy.

CPT® code **44139** will be denied if it is billed with CPT® code **44625** or **44626**.

# Payment policy: Endoscopy procedures

## Endoscopy family groupings

**Endoscopy** procedures are grouped into clinically related families. Each **endoscopy** family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an **endoscopy** family is listed in the Endo Base column in the Professional Services Fee Schedule.

## How multiple endoscopy procedures pay

When multiple **endoscopy** procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- The **endoscopy** procedure with the highest dollar value is 100% of the fee schedule value, *then*
- For subsequent **endoscopy** procedures, payment is the difference between the family member and the base fee (see Example 1, below), *then*
- When the maximum fee for the family member is less than the maximum base fee, the payment is $0.00 for the family member (see Example 2, below), *then*
- No additional payment is made for a base procedure when a family member is billed.

Once payment for all **endoscopy** procedures is calculated, each family is defined as an endoscopic group.

If more than one endoscopic group or other non-**endoscopy** procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4, below).

Multiple endoscopies that aren't related (each is a separate and unrelated procedure) are priced as follows:

- 100% of fee schedule value for each unrelated procedure, *then*
- Apply the standard multiple surgery policy.

## Payment limits

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless:

- A documented, separately identifiable service is provided, and
- Modifier **–25** is used.

### Example 1: Billing for two endoscopy procedures in the same family

| Line item | CPT® code | Maximum payment (non-facility setting) | Endoscopy policy applied | Allowed amount |
|---|---|---|---|---|
| Base (1) | **29805** | **$844.93** | **$0.00** (2) | — |
| 1 | **29820** | **$965.63** | **$120.70** (4) | **$120.70** (5) |
| 2 | **29824** | **$1,217.74** | **$1,217.74** (3) | **$1,217.74** (5) |
| | | | Total allowed amount in non-facility setting: | **$1,338.44** (6) |

(1) Base code listed is reference only (not included on bill form).

(2) Payment isn't allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same **endoscopy** family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Amount allowed under the **endoscopy** policy.

(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only one family of endoscopic procedures was billed.

### Example 2: Billing for endoscopy family member with fee less than base procedure

| Line item | CPT® code | Maximum payment (non-facility setting) | Endoscopy policy applied | Allowed amount |
|---|---|---|---|---|
| Base (1) | 43235 | **$562.49** | — | — |
| 1 | 43241 | **$250.92** | **$0.00** (3) | |
| 2 | 43243 | **$416.81** | **$416.81** (2) | **$416.81** (4) |
| | | | Total allowed amount in non-facility setting: | **$416.81** (5) |

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an **endoscopy** family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the **endoscopy** policy.

(5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

### Example 3: Billing for two surgical procedures billed with an endoscopic group (highest fee)

| Line item | CPT® code | Maximum payment (non-facility setting) | Endoscopy policy applied | Standard multiple surgery policy applied |
|---|---|---|---|---|
| 1 | **11402** | **$316.33** | — | **$158.16** (5) |
| 2 | **11406** | **$579.14** | — | **$289.57** (5) |
| Base (1) | **29830** | **$820.55** | — | — |
| 3 | **29835** | **$918.06** | **$97.51** (3) | **$97.51** (4) |
| 4 | **29838** | **$1,068.50** | **$1,068.50** (2) | **$1,068.50** (4) |
| Total allowed amount in non-facility setting: | | | | **$1,613.74** (6) |

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued **endoscopy** procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued **endoscopy** procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or **endoscopy** group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

### Example 4: Billing for one surgical procedure (highest fee) billed with an endoscopic group

| Line item | CPT® code | Maximum payment (non-facility setting) | Endoscopy policy applied | Standard multiple surgery policy applied |
|---|---|---|---|---|
| 1 | 23412 | **$1,526.34** | | **$1,526.34** (4) |
| Base (1) | 29805 | **$844.93** | | |
| 2 | 29820 | **$965.63** | **$120.70** (3) | **$60.35** (5) |
| 3 | 29824 | **$1,217.74** | **$1,217.74** (2) | **$608.87** (5) |
| Total allowed amount in non-facility setting: | | | | **$2,195.56** (6) |

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued **endoscopy** procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued **endoscopy** procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or **endoscopy** group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

# Payment policy: Epidural adhesiolysis

## Services that can be billed

Epidural adhesiolysis is covered under certain conditions. For details, see L&I's coverage decision.

# Payment policy: Global surgery

## Global surgery follow up periods

Many surgeries have a follow up period during which charges for normal post-operative care are bundled into the global surgery fee.

The global surgery follow up period for each surgery is listed in the Follow Up column in the Professional Services Fee Schedule.

A new post-operative period begins with the subsequent procedure.

## What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless modifier **–24**, **–57** or **FT** are appropriately used:

- E/M codes:
  - **99211**-**99215**,
  - **99218**-**99220**,
  - **99231**-**99239**,
  - **99291**-**99292**,
  - **99304**-**99310**,
  - **99315**-**99318**,
  - **99334**-**99337**,
  - **99347**-**99350**,
- Ophthalmological codes: **92012**-**92014**

The following services and supplies **are included** in the global surgery follow up period and are considered bundled into the surgical fee:

- The operation itself, *and*
- Pre-operative visits, in or out of the hospital, beginning on the day before the surgery, *and*
- Services by the primary surgeon, in or out of the hospital, during the post-operative period, *and*
- The following services:
  - Dressing changes, *and*
  - Local incisional care and removal of operative packs, *and*

 

  - Removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, *and*
  - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric, and rectal tubes, *and*
  - Change and removal of tracheostomy tubes, *and*
  - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

## What isn't included in the follow up period

The following services and supplies aren't included in the global surgery follow up period:

- Casting materials aren't part of the global surgery policy and are paid separately, *and*
- The initial consultation or evaluation by the surgeon to determine the need for surgery, *and*
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care, *and*
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications, *and*
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery, *and*
- Diagnostic tests and procedures, including diagnostic radiological procedures, *and*
- Distinct surgical procedures during the post-operative period which aren't reoperations or treatment for complications, *and*
- Treatment for post-operative complications which requires a return trip to the operating room, *and*
- Immunotherapy management for organ transplants, *and*
- Critical care services (CPT® codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the provider, *and*
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

 

## Who must perform these services to qualify for payment

The follow up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the patient; identified by modifiers **–56**, **–54**, and **–55**),
- Assistant surgeon (identified by modifiers **–80**, **–81**, and **–82**),
- Two surgeons (identified by modifier **–62**),
- Team surgeons (identified by modifier **–66**),
- Anesthesiologists and CRNAs.

### Documentation of services

Providers (to include providers participating in multiple and team surgeries) must submit documentation in workers' individual operative reports to verify the level, type, and extent of surgical services. Surgeons using an assistant surgeon must document the name and actions of the assistant surgeon.

## Payment limits

**Professional inpatient services** (CPT® codes **99221**-**99223**) are only payable during the follow up period if they are performed on an emergency basis.

**Example**: They aren't payable for scheduled hospital admissions.

Codes that are considered bundled aren't payable during the global surgery follow up period.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

**Pneumatic compression devices** used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and is not separately payable, even to DME suppliers. For details on coverage of pneumatic compression devices, see Chapter 9: Durable Medical Equipment.

 

# Payment policy: Lumbar Intervertebral Artificial Disc Replacement

## Services that aren't covered

Lumbar intervertebral artificial disc replacements are not covered. For more information, see L&I's coverage decision.

# Payment policy: Meniscal allograft transplantation

## Services that can be billed

Meniscal allograft transplantation is covered under certain conditions. For details, see L&I's coverage decision.

# Payment policy: Microsurgery

## Services that can be billed

CPT® code **69990** is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

## Payment limits

CPT® code **69990** isn't payable when:

- Using magnifying loupes or other corrected vision devices, *or*
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), *or*
- Another code describes the same procedure being done with an operative microscope.

**Example**: CPT® code **69990** can't be billed with CPT® code **31535** because CPT® code **31536** describes the same procedure using an operating microscope.

These CPT® codes aren't allowed with CPT® **69990**:

- **15756**-**15758**,
- **15842**,
- **19364**,
- **19368**,
- **20955**-**20962**,
- **20969**-**20973**,
- **22551**,
- **22552**,
- **22856**-**22861**,
- **26551**-**26554**,
- **26556**,
- **31526**,
- **31531**,
- **31536**,
- **31541**-**31546**,
- **31561**,
- **31571**,
- **43116**,
- **43180**,
- **43496**,
- **46601**,
- **46607**,
- **49906**,
- **61548**,
- **63075**-**63078**,
- **64727**,
- **64820**-**64823**,
- **65091**-**68850**,
- **0184T**,
- **0308T**.

# Payment policy: Minor surgical procedures

## Services that can be billed

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the post-operative period and modifier **–24** is used, or
- The provider who performs the procedure also reports a significant, separately identifiable service on the same date and modifier **–25** is used (also see Requirements for billing, below, and using CPT® billing code modifier **–25** in Chapter 10).

## Services that aren't covered

Modifier **–57**, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

## Requirements for billing

When billing with modifier **–25**, the insurer follows CPT® guidelines for the billing of an E/M service on the same day as performing a minor surgical procedure. An E/M service isn't considered a significant, separately identifiable service if the evaluation is related to the procedure. In this case, the evaluation is considered part of the preoperative and/or postoperative care and is therefore bundled into the payment for the minor surgical procedure.

However, if the evaluation is related to another condition, an E/M service may be billed.

**Example**: A worker is seen for a work related scalp laceration in which the provider determined sutures are needed but the worker also reports dizziness. The evaluation of the scalp laceration is considered inclusive of the preoperative service work for the laceration repair and therefore is included in the billing of the surgical code.

The evaluation of the worker's dizziness is considered a significant, separately identifiable service, and

- Modifier **–25** must be used, and
- Appropriate documentation is required describing both the minor surgical procedure and the E/M service

## Payment limits

Modifier **–57** is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

# Payment policy: Pre, intra, or post-operative services

## Services that can be billed

The insurer will allow separate payment when different providers perform the pre-operative, intra-operative, or post-operative components of the surgery. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

## Requirements for billing

When different providers perform pre-operative, intra-operative, or post-operative components of the surgery, modifiers (**–54**, **–55**, or **–56**) must be used.

If different providers perform different components of the surgery (pre, intra, or post-operative care), the global surgery policy applies to each provider.

**Example**: If the surgeon performing the operation transfers the patient to another provider for the post-operative care, the same global surgery policy, including the restrictions in the follow up day period, applies to both providers.

 

# Payment policy: Procedures performed in a physician's office

## Services that can be billed

Procedures performed in a provider's office are paid at non-facility rates that include office expenses.

## Services that aren't covered

Services billed with modifier **–SU** aren't covered.

## Requirements for billing

Providers' offices must meet ASC requirements to qualify for separate facility payments.

**Link**: For information about these requirements, see WAC 296-23B.

# Payment policy: Registered nurses as surgical assistants

## Who must perform these services to qualify for payment

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of their valid and current registered nurse license, *and*
- A letter granting onsite hospital privileges for each institution where surgical assistant services will be performed.

# Payment policy: Standard multiple surgeries

## How multiple surgeries pay

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

- 100% of the global fee schedule value for the procedure or procedure group with the highest value, according to the fee schedule, and
- 50% of the global fee schedule value for the second through fifth procedures with the next highest values, according to the fee schedule.

When different types of surgical procedures are performed on the patient on the same day, the payment policies will always be applied in the following sequence:

- Multiple **endoscopy** procedures, *then*
- Other modifier policies, *then*
- Standard multiple surgery policy.

## Requirements for billing

All surgical procedure codes subject to the standard multiple surgery policy must be billed as a separate line item.

For additional instructions on billing bilateral procedures, see the payment policy on bilateral procedures earlier in this chapter.

# Payment policy: Tobacco Cessation Treatment for Surgical Care

## Services that can be billed

The department has published a coverage decision for Tobacco Cessation Treatment for Surgical Care.

## Requirements for billing

CPT codes **99406** and **99407** may be billed for tobacco cessation counseling.

Billing for each claim is limited to a maximum of eight units of any combination of the two codes.

# Payment policy: Stem cell therapy for musculoskeletal conditions

## Services that aren't covered

Stem cell therapy for musculoskeletal conditions is not covered. For details, see L&I's coverage decision.

# Payment policy: Unlisted Surgical Procedures

## General information

Some covered procedures don't have a specific code or payment level listed in the fee schedule. Thus, provider must list the most similar procedure code or codes to the services performed including units of service in their surgical report.

## Requirements for billing

When reporting such a service, the appropriate unlisted procedure code must be billed.

The insurer also requires:

- Within the surgical report, supporting documentation including a full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using the established procedure codes. Modifiers must be included.
- The provider must also list the most similar procedure code or codes to the services performed including units of service.

 

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for Ambulatory Surgery Center (ASC) payment | Washington Administrative Code (WAC) 296-23B |
| Ambulatory Surgery Center **Fee Schedule** | Fee schedules on L&I's website |
| **Autologous chondrocyte implant** (ACI) | Autologous chondrocyte implant coverage decision |
| **Becoming an L&I Provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Bone growth stimulators** | Bone growth stimulators coverage decision |
| **Bone morphogenic protein** (BMP) | Bone morphogenic protein coverage decision |
| **Condition and Treatment Index** | Condition and treatment index on L&I's website |
| **Epidural adhesiolysis** | Epidural adhesiolysis coverage decision |
| **Medical treatment guideline** for Lumbar fusion arthrodesis | Lumbar fusion arthrodesis treatment guidelines |
| **Meniscal allograft transplantation** | Meniscal allograft transplantation coverage decision |
| Professional Services **Fee Schedules** | Fee schedules on L&I's website |
| **Tobacco Cessation Treatment** for Surgical Care | Tobacco cessation treatment for surgical care coverage decision |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 30: Vocational Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Note**: The term “provider” in the following definitions includes vocational rehabilitation counselors.

**By Report (BR)**: A code listed in the fee schedule as BR doesn’t have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

**Link**: For the legal definition of By Report, see WAC 296-20-01002.

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Telehealth:** Face-to-face services delivered by a qualified provider through a real-time, two-way, audio video connection. These services aren’t appropriate without a video connection.

 

# Payment policy: Billing by referral type

## Prior authorization

All vocational services require prior authorization.

Vocational services are authorized by referral type. The State Fund uses six referral types:

- Vocational recovery,
- Assessment,
- Plan development,
- Plan implementation,
- Forensic, *and*
- Stand-alone job analysis.

Each referral is a separate authorization for services.

Option 2 vocational counseling and job placement services are authorized when the department accepts a worker's Option 2 election. For more information on Option 2 services, see Option 2 Vocational Services.

## How insurers will pay

Insurers will pay:

- Interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate, *and*
- Forensic evaluators at 120% of the VRC professional rate.

All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. For more information, see the payment policy for Fee caps later in this chapter.

**Link**: For more detailed information on billing, consult the Statement for Miscellaneous Services (F245-072-000).

## Services that can be billed

The following several tables show billing codes by referral type.

### Vocational recovery

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0800V** | Vocational recovery services (VRC) | **$10.19** |
| **0801V** | Vocational recovery services (intern) | **$8.69** |
| **0802V** | Vocational recovery services extension (VRC) | **$10.19** |
| **0803V** | Vocational recovery services extension (intern) | **$8.69** |

### Assessment

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0810V** | Assessment services (VRC) | **$10.19** |
| **0811V** | Assessment services (Intern) | **$8.69** |

### Vocational evaluation, pre-job and job modification consultation

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0821V** | Vocational evaluation (VRC) | **$10.19** |
| **0823V** | Pre-job or job modification consultation (VRC) | **$10.19** |
| **0824V** | Pre-job or job modification consultation (Intern) | **$8.69** |

### Plan development

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0830V** | Plan development services (VRC) | **$10.19** |
| **0831V** | Plan development services (Intern) | **$8.69** |

 

### Plan implementation

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0840V** | Plan implementation services (VRC) | **$10.19** |
| **0841V** | Plan implementation services (Intern) | **$8.69** |

### Forensic services

The VRC assigned to a forensic referral must directly perform **all the services** needed to resolve the vocational issues and make a supportable recommendation.

**Exception**: Vocational evaluation services may be billed by a third party if authorized by the insurer.

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0881V** | Forensic services (Forensic VRC) | **$12.19** |

### Stand-alone job analysis

The codes in the following table are used for **stand-alone and provisional job analyses**. (Also see Payment limits, below.)

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **0808V** | Stand-alone job analysis (VRC) | **$10.19** |
| **0809V** | Stand-alone job analysis (intern) | **$8.69** |
| **0378R** | Stand-alone job analysis (non-VRC) | **$10.09** |

## Payment limits

### Stand-alone job analysis

For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager.

Bills for dates of service beyond the 15th day won't be paid.

### Travel, wait time, and mileage

L&I supports in-person meetings to encourage effective engagement, collaborative problem solving, and delivery of quality vocational services.

The vocational provider may bill, round trip, from their primary branch office to their destination for that referral. The primary branch office is designated by the vocational provider on their Vocational Provider and Firm Application (F252-088-000),

When submitting bills, the vocational provider should:

- Round to the nearest number if necessary.
- Bill all services for the same worker, for the same date of service, on one bill form.

**For example:**

VRC travels from primary branch office to attending provider's (AP) office to meet with the worker and the AP. VRC will bill the round trip time and miles from their primary branch office to the AP's office.

## Splitting travel when there is more than one claim

If traveling for more than one claim (per worker or for multiple workers), the vocational provider can bill a round trip from their primary branch to include their destinations for the multiple referrals. For out of state cases, VRC may only bill from the branch office nearest the worker.

- Split charges equally between all claims, rounding to the nearest number if necessary.
- For two claims, bill half to each claim.
- For three or more claims split the charges accordingly (three claims = by thirds, four claims = by fourths)

**For example:**

VRC travels from their primary branch office to a meeting with worker on Referral A, then to onsite job analysis meeting on Referral B, then to a meeting at AP's office on Referral C, and then back to their primary branch office. VRC will bill a third of the total time and mileage under each referral.

| Code | Description | Maximum fee |
|---|---|---|
| **0891V** | Travel/wait time (VRC or forensic VRC) 1 unit = 6 minutes | **$5.11** per 6 minutes |
| **0892V** | Travel/wait time (intern) 1 unit = 6 minutes | **$5.11** per 6 minutes |
| **0893V** | Professional mileage (VRC) 1 unit = 1 mile | **State rate** |
| **0894V** | Professional mileage (intern) 1 unit = 1 mile | **State rate** |
| **0895V** | Air travel (VRC, Intern, or forensic VRC) | **By Report** |
| **0896V** | Ferry charges (VRC, intern or forensic VRC) | **By Report** |
| **0897V** | Hotel charges (VRC, intern or forensic VRC) out-of-state only | **By Report** |

### Vocational evaluation and related codes for non-vocational providers

Certain non-vocational providers may deliver the above services with the following codes:

| Code | Description | Maximum fee |
|---|---|---|
| **0389R** | Pre-job or job modification consultation, 1 unit = 6 minutes | **$12.28** per 6 minutes |
| **0390R** | Vocational evaluation, 1 unit = 6 minutes | **$10.09** per 6 minutes |
| **0391R** | Travel/wait (non-VRC), 1 unit = 6 minutes | **$5.56** per 6 minutes |
| **0392R** | Mileage (non-VRC), one unit = 1 mile | **State rate** |
| **0393R** | Ferry charges (non-VRC)<br>Requires documentation with a receipt in case file | **State rate** |

 

When a worker has two or more open claims requiring time-loss compensation and vocational services, the insurer may make a separate but concurrent vocational referral for each claim. In such cases, vocational evaluators are expected to split the billing equally amongst the referrals. When providing vocational evaluation on multiple referrals and/or claims, follow these instructions:

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims.
- If there are three (or more) claims, the vocational evaluation bills are to be split accordingly (three claims = by thirds, four claims = by fourths), based on the number of concurrent referrals received.

 

# Payment policy: Fee caps for vocational services

## Fee cap policy for referrals

Vocational services are subject to fee caps. Travel, wait time, and mileage charges aren't included in the fee cap for any referral type.

| If the **description** of the fee cap referral is… | Then the **applicable codes** are: | And the **maximum fee** is: |
|---|---|---|
| Vocational recovery referral cap, per referral | **0800V**, **0801V** | **$7,168.90** |
| Assessment referral cap, per referral | **0810V**, **0811V** | **$7,168.90** |
| Plan development referral cap, per referral | **0830V**, **0831V** | **$6,854.57** |
| Plan implementation referral cap, per referral | **0840V**, **0841V** | **$7,771.08** |
| Stand-alone job analysis referral cap, per referral | **0808V**, **0809V**, **0378R** | **$522.78** |

## Fee cap policy for vocational evaluation services

The fee cap for vocational evaluation services applies to multiple referral types and is allowed once per claim.

For example, if **$698.00** of vocational evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment under another referral type.

| If the **description** of the service is… | Then the **applicable codes** are: | And the **maximum fee** per claim is: |
|---|---|---|
| Vocational evaluation services | **0821V**, **0390R** | **$1,499.96** |

# Fee cap exceptions for vocational recovery, AWA, and plan implementation referrals

Exception codes must be used to authorize an extra number of billable hours.

Any use of these exception codes requires prior authorization by the vocational services specialist (VSS) for State Fund claims, or for self-insured claims, by the self-insured employer or its third-party administrator (if applicable).

## Vocational recovery referrals

For vocational recovery referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$999.23.**

| Code | Description | Maximum fee |
|---|---|---|
| **0802V** | Vocational recovery services exception (VRC) | **$10.19** per 6 minutes |
| **0803V** | Vocational recovery services exception (intern) | **$8.69** per 6 minutes |

## AWA referrals

For AWA referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$999.23**.

| Code | Description | Maximum fee |
|---|---|---|
| **0812V** | Assessment services exception (VRC) | **$10.19** per 6 minutes |
| **0813V** | Assessment services exception (intern) | **$8.69** per 6 minutes |

## Plan implementation referrals

For plan implementation referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$2,309.49**.

| Code | Description | Maximum fee |
|---|---|---|
| **0842V** | Plan implementation services exception (VRC) | **$10.19** per 6 minutes |
| **0843V** | Plan implementation services exception (intern) | **$8.69** per 6 minutes |

 

## Fee cap considerations

When nearing the fee cap, the vocational provider may request a fee cap exception. Once approved, they may bill the exception code(s) up to the additional cap.

**The vocational provider may request a new referral when they are nearing the fee cap exception.**

L&I may close the original referral using the outcome code ADMX and create a new referral. This decision will be made on a case-by-case basis. If a new referral isn't created, the vocational provider must submit a closing report.

- Providers won't be able to enter a fee cap reached closure outcome with their closing report. Only L&I can enter this closure code.

**If both the original fee cap and the fee cap exception are spent, and a new referral isn't granted,** the vocational provider must notify the VSS or the self-insured employer or its third-party administrator (if applicable) of the situation. The vocational provider must submit a closing report.

## Flat rate policy for 30-day progress reports

There is a **$50** flat rate for each 30-day progress report. Progress report fees do not count toward professional hour fee caps.

| Code | Description | Flat rate |
|---|---|---|
| **0910V** | 30-day progress report (VRC) | **$50.00** per 30-day progress report |
| **0910V** | 30-day progress report (intern) | **$50.00** per 30-day progress report |

### How to submit bills

You can only bill one progress report per referral every 30 days.

To bill for more than one progress report for the same referral on the same invoice, use separate line items of one unit and $50 each for each date of service. If you bill for more than one report on the same line, all but one will be denied.

If the worker has multiple claims with open referrals, you should bill the progress report under the most recent claim. If time-loss is only involved in one claim, progress reports should be billed under that claim.

**Link**: For more information, see WAC 296-19A.

# Payment policy: Job Modification and Pre-Job Accommodation

## Prior authorization

Prior authorization is required for services provided by an occupational therapist (OT), physical therapist (PT) and ergonomic specialist.

- The need for a job modification or pre-job accommodation must be identified and documented by L&I, the attending health-care provider, treating occupational or physical therapist, employer, worker, or assigned vocational rehabilitation counselor.
- Consultations for a specific job modification or pre-job accommodation must be preauthorized after the need has been identified.

## Who must perform these services to qualify for payment

### Consultations

The provider of a job modification or pre-job accommodation consultation must be a:

- Licensed occupational therapist or physical therapist, *or*
- Vocational rehabilitation provider, vocational rehabilitation provider intern, *or*
- Ergonomic specialist.

### Telehealth

When the consultant is unable to go onto the worksite, **telehealth** may be used as an alternative method to complete the consultation. Qualified PT or OT providers may have to be licensed in the state where the worker is receiving **telehealth** services, per that state's licensing requirements.

## Services that can be billed

In some cases, the department may reimburse for consultation services.

| Code | Description | Activities | Maximum fee |
|---|---|---|---|
| 0823V | **Pre-job or job modification consultation**<br>Vocational Rehabilitation Provider | Discussing/consulting about modifications to a job. This may include:<br>• Exploring ways a job may be modified within the individual's abilities and the needs of the employer. This may include modifying time, duties, environment, and/or use of alternative equipment.<br>• Discussing available L&I benefits to include stay at work, preferred worker, and job modification with the employer, worker, and/or attending provider.<br>• Communication with others about modifying a job to include the worker, employer, health-care providers, vocational provider, insurer, and/or vendor.<br>• Documenting findings and recommendations,<br>• Instruction in work practices (such as body mechanics, ergonomic principles),<br>• Obtaining bids,<br>• Completing and submitting the Job Modification/Pre-job Assistance Application and any associated follow up, and<br>• Assisting an employer with accessing return to work incentives. | **$10.19** per 6 minutes |

| Code | Description | Activities | Maximum fee |
|---|---|---|---|
| 0824V | **Pre-job or job modification consultation**<br>Vocational Rehabilitation Provider Intern | Same as above | **$8.69** per 6 minutes |
| 0389R | **Pre-job or job modification consultation, analysis of physical demands**<br>OT, PT, Ergonomic Specialist | Same as above<br><br>Analyzing job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only). | **$12.28** per 6 minutes |
| 0391R | **Travel/wait time** (non-VRC) | Traveling to work/training site or to an equipment vendor to meet with the worker as part of direct consultation services. | **$5.56** per 6 minutes |
| 0392R | **Mileage** (non-VRC), per mile. | Mileage to work/training site or to an equipment vendor to meet with the worker as part of direct consultation services. | **State rate** |
| 0393R | **Ferry charges** (non-VRC). | Ferry travel if required to travel to work/training site as part of direct consultation services. | **State rate** |

 

## Authorized equipment vendors

The following codes can be billed by equipment vendors:

| Code | Description | Activities | Maximum fee |
|---|---|---|---|
| **0380R** | **Job modification** | Equipment/tools:<br>• Installation,<br>• Set up,<br>• Basic training in use,<br>• Delivery (includes mileage),<br>• Tax,<br>• Custom modification/ fabrication.<br>Work area modification or reconfiguration. | Maximum allowable for **0380R** is **$5,000.00** per job or job site. |
| **0385R** | **Pre-job accommodation** | Equipment/tools:<br>• Installation,<br>• Set up,<br>• Basic training in use,<br>• Delivery (includes mileage),<br>• Tax,<br>• Custom modification/ fabrication.<br>Work/training area modification or reconfiguration. | Maximum allowable for **0385R** is **$5,000.00** per claim.<br>Combined costs of **0380R** and **0385R** for the same return to work goal can't exceed **$5,000.00.** |

## Obtaining equipment from consultants

Consultants may supply the equipment/tools only if:

- Custom design and fabrication of unique equipment or tool modification is required, *and*
- Prior authorization is obtained, *and*
- Proper justification and cost estimates are provided.

## Services that aren't covered

- Performing services as described in WAC 296-19A-340.
- Services prior to any communication with those directly involved in claim.

## Payment limits

The combined costs of both codes **0380R** and **0385R** for same return to work goal can't exceed **$5,000.00**.

For self-insured claims, pre-job accommodations can't be approved. However, self-insured employers may pay any pre-job accommodation expenses for injured workers who no longer work for them.

**Links**: Additional information regarding Job Modifications and Pre-Job Accommodations is available online.

# Payment policy: Option 2 vocational services

The insurer may pay for authorized Option 2 vocational counseling and/or job placement services if the worker's training plan was approved on or after July 31, 2015.

Option 2 vocational counseling services include, but aren't limited to:

- Help in accessing available community services to assist the worker with reentering the workforce
- Assistance in developing a training plan
- Coaching and guidance as requested by the worker
- Interests and skills assessment, if the worker requests or agrees such is needed to reach the worker's training or employment goals
- Other services directly related to vocational counseling, such as job readiness and interview practice

Option 2 job placement services may include, but aren't limited to:

- Help in developing an action plan for return to work
- Job development, including contacting potential employers on the worker's behalf
- Job search assistance
- Job application assistance
- Help in obtaining employment as a preferred worker, if certified, up to and including educating the employer on preferred worker incentives
- Other services directly related to job placement, such as targeted resume development and referral to community resources such as WorkSource

**Link**: More information on Option 2 vocational services is available online.

## Limits

Interns can't provide Option 2 vocational services

Option 2 vocational services must be provided within five years following the date of the department's order confirming the worker's Option 2 election

Total of all payments for all Option 2 vocational services for a worker won't exceed 10 percent of the worker's maximum Option 2 training fund, nor will the total exceed the remaining balance of the worker's Option 2 training fund at the time payment is made

Option 2 travel and wait time aren't payable; other services that aren't payable are listed in WAC 296-19A-340.

### Reports

To receive payment for Option 2 vocational services, the VRC must provide the insurer with a copy of a summary of services, signed by the worker and VRC, with each billing. State Fund claims require form F280-063-000 and self-insured claims require form F280-064-000.

### Billing

The VRC can't bill the worker directly for Option 2 vocational services.

For self-insured claims, contact the self-insured employer or its third-party administrator for billing instructions.

For State Fund billing, use referral number **9999999** and the billing codes below:

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| **R0399** | Option 2 vocational counseling (VRC) | **$10.19** |
| **R0398** | Option 2 job placement services (VRC) | **$10.19** |

**Note**: The VRC can't bill the insurer for completing the Option 2 vocational services summary form.

# Payment policy: Quality Assurance

## General information

**Quality assurance activities**: For the State Fund, vocational firms must perform quality assurance (QA) activities to comply with WAC 296-19A-210.

## Services that can be billed

Payment is allowed for QA activities regarding claims listed on the department-provided, randomized list of claims. QA activities include, but aren't limited to:

- Following the department's validation guidance and reporting requirements while completing department-provided validation template(s).
- Discussing validation results with the vocational rehabilitation counselor assigned to the claim to reinforce quality work and to support continued improvement.

## Limits

A vocational firm's everyday business operations are not considered quality assurance activities. The activities outlined in WAC 296-19A-340 are considered overhead and the department won't pay for these services.

Aggregate data collection and reporting are not payable. For the purposes of this policy, data in this context refers to numbers. Specific examples include QA elements published by the department such as the number of:

- Open vocational recovery referrals.
- Engagement activities for a worker.
- Meetings with identified claim parties.

# Payment policy: Special services, non-vocational providers

## Prior authorization

Code **0388R** (for special services provided during AWA, plan development, and plan implementation) requires prior authorization.

For State Fund claims, VRCs must contact the VSS or claim manager (CM) to arrange for prior authorization. For self-insured claims, contact the self-insured employer or its third-party administrator (if applicable) for prior authorization.

**Link**: A list of SIE/TPAs is available online.

## Who must perform these services to qualify for payment

A non-vocational provider can use the R codes. A vocational provider delivering services for a referral assigned to a different payee provider may also use the R codes.

## Services that can be billed

L&I established procedure local billing code **0388R** to be used for special services provided during AWA, plan development and plan implementation, such as:

- Commercial driver's license (CDL),
- Pre-employment physical examinations,
- Background checks,
- Driving abstracts,
- Fingerprinting,
- College placement testing and enrollment fees.

Code **0388R** has a description of "Plan, providers," and pays **By Report**.

## Requirements for billing

Code **0388R** must be billed by a medical or a miscellaneous non-physician provider on a **Statement for Miscellaneous Services** billing form (F245-072-000). The referral ID and referring vocational provider account number must be included on the bill.

As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you):

- You can't bill as a vocational provider (provider type **68**), *and*
    - You must either use another provider account number that is authorized to bill the ancillary services codes (type **34**, **52**, or **55**), *or*
    - Obtain a miscellaneous services provider account number (type **97**) and bill the appropriate codes for those services.

These providers use the **Statement for Miscellaneous Services** billing form but must include the following specific information to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, *and*
- The service provider ID for the assigned vocational provider in the Name of physician or other referring source box at the top of the form, *and*
- The non-vocational provider's own provider account numbers at the bottom of the form.

## Payment limits

Code **0388R** can't be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

For code **0388R**, there is a limit of 1 unit per day, per claim.

 

# Payment policy: Additional requirements for all vocational services providers

## Inappropriate referral: ADMA billing

Vocational providers may use ADMA outcome *VRC or firm declines referral* for up to 14 days after the referral assignment. This outcome is to be used when the referral isn't appropriate. Examples include:

- Conflict of interest, or
- Concerns about capacity.

Prior to entering an ADMA outcome, the VRC or firm needs to contact the claim manager to discuss the reasons for declining the referral.

A maximum of three professional hours may be billed for reviewing the file and preparing a brief rationale. The VRC sends the rationale using an EVOC message.

## Preferred worker certification for workers who choose Option 2

Vocational providers must consider assisting a worker in obtaining preferred worker certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining preferred worker certification for up to 14 days after an Option 2 selection has been made.

## Insurer Activity Prescription Form (APF), 1073M

For State Fund claims, healthcare providers won't be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

Employers can obtain physical capacity information by:

- Using completed APFs available on the department's Claim and Account Center, *or*
- Requesting an APF through the claim manager when updated physical capacity information is needed.

## Other VRC requests to attending providers for return to work information

Attending providers may respond to requests regarding return to work issues. Examples include:

- Return to work decisions based on a functional capacity evaluation (FCE),
- Request for worker to participate in FCE,
- Job modification or pre-job modification reviews,
- Proposed work hardening program,
- Plan for graduated, transitional, return to work.

## Resume Services (State Fund claims only)

A resume isn't only an important job-seeking tool; it's also an opportunity to engage the worker in thinking about return to work. L&I encourages vocational providers to develop a resume with workers who are in an open vocational referral, within the following parameters:

- Participation of the worker is voluntary.
- The VRC assigned to the referral meets in-person with the worker to develop the resume. If that isn't possible, the assigned VRC may provide resume services telephonically, by **telehealth**, or by email. The VRC:
    - Ensures the resume accurately reflects the workers work experience and education and includes volunteer experience, other relevant information, and/or hobbies, if applicable.
    - Gives the worker copies of the resume in format(s) that meet the worker's needs such as paper and/or digital copies.
    - Coordinates a referral to L&I WorkSource partnership staff and encourages the worker to take the resume to WorkSource and register for assistance in finding a job. The VRC may accompany the worker to WorkSource if the worker prefers.
    - Sends the resume to the claim file with the Resume Cover Sheet (F242-418-000) and documents the resume service activities in the next vocational report.
- A cover letter may be developed as part of these services.
- The service is available once per referral.
- For each referral, L&I pays a maximum of **$330.88** for VRC and/or intern time.

 

| Code | Description | Maximum fee |
|---|---|---|
| **0844V** | Resume services (VRC) | **$10.19** per 6 minutes |
| **0845V** | Resume services (intern) | **$8.69** per 6 minutes |

## Services that can't be billed

Billable services don't include performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals (except for activities noted in WAC 296-19A-340). Activities associated with reports (other than composing or dictating complete draft of the report) not billable include:

- Editing, revising, or typing,
- Filing,
- Distributing or mailing.

Also not billable is time spent on any administrative and clerical activity to include:

- Typing,
- Copying,
- Faxing, mailing, or distributing,
- Filing,
- Payroll,
- Recordkeeping,
- Delivering or picking up mail.

## Vocational evaluation

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing,
- Interest testing,
- Work samples,
- Academic achievement testing,
- Situational assessment,
- Specific and general aptitude and skill testing.

 

A provider (vocational or non-vocational) who administers and/or interprets and reports on vocational evaluation and evaluation results must ensure that he or she is qualified to administer and/or interpret and report on the evaluations in regard to the specific instrument(s) being used.

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation, and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational evaluation is not covered during a vocational recovery referral.

### Test administration billing

When billing for testing services on multiple referrals and/or claims, test administration time must be split equally in whole units, charging the same dollar amount on each claim/referral. For example, if a provider performs 4.5 hours of appropriate group testing for three workers, then billing for each worker shouldn't exceed 1.5 hours.

### Vocational providers

Vocational providers (provider type **68**) must use procedure code **0821V** to bill for vocational evaluation services. Use code **0821V** for:

- The formal testing itself, *or*
- A meeting that is directly related to explaining the purposes or findings of testing.

### Non-vocational providers

Non-vocational providers must use procedure code **0390R**. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, *and*
- Service provider ID for the assigned vocational provider in the Name of the physician or other referring source box at the top, *and*
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form,
- Obtain the vocational referral ID number from the VRC and place on the billing form,
- Obtain the VRC's service provider number and place in the Name of the physician or other referring source box at the top, *and*
- Place the school's provider account number at the bottom of the form.

 

## Retraining plans that exceed statutory benefit limit

The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit. Additional vocational assistance can only be considered following previous retraining attempts that depleted available money and/or time.

The VSS won't approve a plan with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers may not develop or submit such a plan.

## How to bill when multiple providers work on a single referral

Multiple providers may deliver services on a single referral if they have the same payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where a provider covers the caseload of an ill provider.

When more than one provider works on a referral, each provider must bill separately for services delivered on the referral, and each provider must use:

- His/her individual provider account number, *and*
- The payee provider account number, *and*
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the assigned provider's performance rating.

## Split billing across multiple referrals

When a worker has two or more open time loss claims, the insurer may make a separate referral for each claim. In cases where the insurer makes two (or more) concurrent referrals for vocational services, vocational providers are expected to split the billing. When providing vocational services on multiple referrals and/or claims, follow these instructions:

- To accurately capture the work done without overbilling, combine billable hours over a larger interval of work (up to the entire billing period) rather than bill for each single activity.

 

**Examples:**

- A provider has two open referrals for the same worker and the provider bills once per week. They provided a total of 90 minutes during this billing period. They would bill eight units under each claim.
- A provider has two open referrals for the same worker and the provider bills daily. They provided a total of 40 minutes during this billing period. They would bill four units under each claim.

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims as directed above.
- If there are three (or more) claims requiring time loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (three claims = by thirds, four claims = by fourths), based on the number of concurrent referrals received. These requirements also apply when billing for testing services. For example, if provider performs 4.5 hours of testing for a worker with more than one claim and referral, the billing must be split equally among the claims.

**Note**: Vocational providers must document multiple referrals and split billing for audit purposes.

## Appropriate timing of outcome recommendations for State Fund claims

State Fund has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral. The VRC must complete the report before a *VocLink Connect* outcome recommendation is made to State Fund. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which isn't complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include VRC no longer available and VRC or firm declines referral.

In all other cases, the paper report must be submitted to the claim file when the recommendation is submitted. The VRC should confirm the report was received in the claim file for billing and payment.

## Submitting a vocational assessment or retraining plan for self-insured claims

Answers to the following common questions can be found in various WACs:

- What is the Self-Insurance Vocational Reporting Form? (WAC 296-15-4302)
- What must the self-insurer do when an assessment report is received? (WAC 296-15-4304)
- When must a self-insurer submit a vocational rehabilitation plan to the department? (WAC 296-15-4306)
- What must the vocational rehabilitation plan include? (WAC 296-15-4308)
- What must the self-insurer do when the department denies the vocational rehabilitation plan? (WAC 296-15-4310)
- What must the self-insurer do when the vocational rehabilitation plan is successfully completed? (WAC 296-15-4312)
- What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? (WAC 296-15-4314)

## Change in status: Responsibilities of service providers and firms

The insurer must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status includes:

- VRC or intern ends their association with a firm, *or*
- VRC assigned to a referral is no longer available to provide services on the referral(s), *or*
- Firm closes.

Change in status responsibilities apply to both State Fund and Self-Insurance vocational providers. Forms for reporting change in status are available on L&I's website.

**Link**: For more information, see WAC 296-19A-270.

### Failure to report change in status

A firm or service provider that fails to notify L&I of changes in status may be in violation of WAC and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in WAC 296-19A-270.

## Approved plan services that occur prior to plan start date

The insurer may cover these are services/fees prior to a plan start date:

- Registration fees billed as retraining tuition (billing code **R0310**), *and*
- Books, supplies, and equipment (billing code **R0312**), *and*
- Rent, food, utilities, and furniture rental. Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, **0301R**, isn't payable prior to a plan start date. Travel that occurs prior to a plan start date is generally:

- To a jobsite to evaluate whether a particular job goal is reasonable, *or*
- To a school to pay for registration, books or look over the campus.

These types of trips aren't part of a retraining plan and should be billed by the worker under **V0028**. Travel to appointments with the VRC is also billed under **V0028**.

## Selected plan procedure code definitions

L&I has defined the following retraining codes:

- **R0312**, Retraining books, equipment, and supplies are consumable goods such as:
    - Books,
    - Paper,
    - Pens,
    - CDs,
    - Disposable gloves,
    - Calculator,
    - Software,
    - Survey equipment,
    - Computers,
    - Welding gloves & hood,
    - Professional uniforms, including shoes,
    - Bicycle repair kits,
    - Mechanics tools.
- **R0390**, Retraining childcare. Providers must be licensed. If a worker is unable to attend training without the use of training funds to pay child care, all anticipated childcare needs must be identified by the VRC in the proposed retraining plan. The total cost of the identified childcare, in addition to other allowable costs, must fit within the statutory retraining benefit limit.

The insurer doesn't have the authority to purchase:

- Glasses,
- Hearing aids,
- Dental work,
- Clothes for interviews,
- Other items as a way to remove barriers during retraining.

## Reimbursement for food

The insurer reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan with authorized board and lodging.

Food charges combined in weekly or monthly date spans aren't allowed.

Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable.

**Note**: The provider and/or the worker should also retain a copy of receipts.

The vocational provider must review billed food charges:

- To remove inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.), *and*
- To ensure each date of purchase is itemized on the bill.

The worker won't be reimbursed over the monthly allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker doesn't exceed their monthly allotment for food.

The vocational provider will:

- Review the receipts, *and*
- Deduct personal and other non-covered items, *and*
- Sign the Statement for Retraining and Job Modification Services form (F245-030-000).

Once the vocational provider signs the **Statement for Retraining and Job Modification Services** form, the insurer will assume the provider has:

- Reviewed the bill and receipts, *and*
- Removed inappropriate charges, *and*
- Verified the charges are within the workers per diem allotment for that month.

## Mileage on Plan Time/Cost/Travel Encumbrance

The insurer reimburses mileage only in whole miles.

Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Plan Time/Cost/Travel Encumbrance form (F245-454-000) should be referred to the VSS.

**Link**: For more information, see WAC 296-19A.

## Telehealth services

In-person visits are preferred for vocational services, however, **telehealth** may be an appropriate alternative in certain situations where vocational services can be completed via two-way audio and visual connection.

The following services should have priority for in-person meetings when possible:

- Job analyses,
- Plan development rights and responsibilities,
- Initial meetings with the worker.

**Note**: Per WAC 296-19A-090, for plan development services, the initial meeting between the assigned vocational rehabilitation provider and the worker must be in person.

**Q3014** is payable only to vocational providers who are renting their office space for telehealth purposes. Vocational providers may be reimbursed for renting their office space for workers who need a **telehealth** visit with a medical provider. In these circumstances, no other service may be provided to the worker by the vocational provider. Bill using **Q3014** if providing this service. When a provider bills Q3014 on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the Q3014 service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- Purchase, rental, installation, or maintenance of telecommunication equipment or systems, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person. The same limits noted in this payment policy apply regardless of how the service is rendered to the worker.

 

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for corrective action for failure to notify about changes in status | Washington Administrative Code (WAC) 296-19A-270 |
| **Administrative rules** for vocational services | WAC 296-19A |
| **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 and vocational services | Fee schedules on L&I's website |
| **Job modifications and pre-job accommodations policies** | Job modifications on L&I's website<br>Pre-job accommodations on L&I's website |
| **L&I's Claim and Account Center** | Claim and Account Center |
| **Quality assurance by vocational firms** | Vocational Firm Quality Assurance Plan |
| **Statement for Miscellaneous Services** | F245-072-000 on L&I's website |
| **Option 2 Vocational Services** | WAC 296-19A-631, 633, 635, 637<br>Option 2 details on L&I's website<br>Self-Insured Option 2 Vocational Services Summary<br>State Fund Option 2 Vocational Services Summary |
| **Services that aren't covered** | WAC 296-19A-340 |
| **Statement for Retraining and Job Modification Services** form | F245-030-000 on L&I's website |

| If you're looking for more information about… | Then see… |
|---|---|
| **Notify L&I of changes in status** | Email Private Sector Rehab Services PSRS@LNI.WA.GOV |
| **Vocational Provider and Firm Application** | F252-088-000 on L&I's website |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 31: Washington RBRVS Payment System

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Relative value units (RVUs)**: 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.

**Link**: A list of current RVUs can be accessed on Medicare's website.

**Resource based relative value scale (RBRVS)**: RBRVS is a payment method used by many healthcare insurers to develop fee schedules for services and procedures provided by healthcare professionals. Each fee is based on the relative value of resources required to deliver a service or procedure.

This chapter includes details on the RBRVS, which L&I uses to pay for most professional services. These services have a fee schedule indicator (FSI) of R in L&I's Professional Services Fee Schedule.

 

# Payment policy: Basis for calculating RBRVS payment levels

## Payment methods

### Fee development

**RBRVS** fee schedule allowances are based on:

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

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted **RVU** (see **RVU** geographic adjustments, below).

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

The conversion factor has the same value for all services priced according to the **RBRVS**. L&I may annually adjust the conversion factor.

**Links**: The conversion factor is published in WAC 296-20-135, and the process for adjusting the conversion factor is defined in WAC 296-20-132.

### RVU geographic adjustments

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, 2022 are:

- 100.9% of the work component **RVU**,
- 105.8% of the practice expense **RVU**, *and*
- 83.2% of the malpractice **RVU**.

### Calculation for maximum fees

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

1. Multiply each **RVU** component by its geographic adjustment factor, *then*
2. Sum the geographically adjusted **RVU** components, rounding to the nearest hundredth, *then*
3. Multiply the rounded sum by L&I's **RBRVS** conversion factor, *and finally*
4. Round to the nearest penny.

**Note**: Two state agencies, L&I and Health Care Authority (HCA), use a common set of **RVUs** and geographic adjustment factors for procedures, but use different conversion factors.

## Site of service payment differential

Based on where the service was performed, the insurer will pay professional services at the **RBRVS** rates for:

- Facility settings (such as hospitals and ASCs), *and*
- Non-facility settings.

The site of service payment differential is based on CMS's payment policy.

**Link**: The maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

## Requirements for billing

Due to the site of service payment differential (see above), it is important to include a valid two digit place of service code on your bill.

# Payment policy: Facility setting services paid at the RBRVS rate

## Payment methods

When services are performed in a facility setting, the insurer makes 2 payments:

- One to the professional provider, *and*
- One to the facility.

The payment to the facility includes resource costs such as:

- Labor,
- Medical supplies, *and*
- Medical equipment.

**Note**: To avoid duplicate payment of resource costs, these costs are excluded from the **RBRVS** rates for professional services in facility settings.

## Requirements for billing

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

Professional services billed with the following place of service codes will be paid at the rate for **facility settings**:

| If the **place of service description** is… | Then bill using this **2-digit place of service code**: |
|---|---|
| Ambulance (air or water) | 42 |
| Ambulance (land) | 41 |
| Ambulatory surgery center | 24 |
| Birthing center | 25 |
| Comprehensive inpatient rehabilitation facility | 61 |

| If the **place of service description** is… | Then bill using this **2-digit place of service code**: |
|---|---|
| Comprehensive outpatient rehabilitation facility | 62 |
| Emergency room hospital | 23 |
| Hospice | 34 |
| Indian health service free standing facility | 05 |
| Indian health service provider based facility | 06 |
| Inpatient hospital | 21 |
| Inpatient psychiatric facility | 51 |
| Military treatment facility | 26 |
| Outpatient hospital | 22 |
| Psychiatric facility partial hospitalization | 52 |
| Psychiatric residential treatment center | 56 |
| Skilled nursing facility | 31 |
| Tribal 638 free standing facility | 07 |
| Tribal 638 provider based facility | 08 |
| Other unlisted facility | 99 |
| (Place of service code not supplied) | (none) |

 

# Payment policy: Non-facility setting services paid at the RBRVS rate

## Payment methods

When services are provided in non-facility settings, the professional provider typically bears the costs of:

- Labor,
- Medical supplies, *and*
- Medical equipment

These costs are included in the **RBRVS** rate for non-facility settings.

Professional services will be paid at the **RBRVS** rate for non-facility settings when the insurer doesn't make a separate payment to a facility.

When the insurer doesn't make a separate payment directly to the provider of the professional service, the facility will be paid for the service at the **RBRVS** rate for non-facility settings.

## Requirements for billing

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

Professional services billed with the following place of service codes will be paid at the rate for **non-facility settings**:

| If the **place of service description** is… | Then bill using this **2-digit place of service code**: |
|---|---|
| Assisted living facility | 13 |
| Community mental health center | 53 |
| Correctional facility | 09 |
| Custodial care facility | 33 |
| End stage renal disease treatment facility | 65 |
| Federally qualified health center | 50 |

| If the **place of service description** is… | Then bill using this **2-digit place of service code**: |
|---|---|
| Group home | 14 |
| Home | 12 |
| Homeless shelter | 04 |
| Independent clinic | 49 |
| Independent laboratory | 81 |
| Intermediate care facility/mentally retarded | 54 |
| Mass immunization center | 60 |
| Mobile unit | 15 |
| Nonresidential substance abuse treatment center | 57 |
| Nursing facility | 32 |
| Office | 11 |
| Pharmacy | 01 |
| Residential substance abuse treatment center | 55 |
| Rural health clinic | 72 |
| School | 03 |
| State or local public health clinic | 71 |
| Temporary lodging | 16 |
| Urgent care facility | 20 |
| Walk in retail health clinic | 17 |

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for the conversion factor | Washington Administrative Code (WAC) 296-20-132<br>WAC 296-20-135 |
| **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 professional services | Fee schedules on L&I's website |
| **A list of the current RVUs** used in calculating the insurer's conversion factor | RVUs on the CMS website |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 32: Ambulatory Surgery Centers (ASCs)

**Effective July 1, 2022**

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

## Table of Contents

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**–50 (Bilateral procedures)**

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.

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.

 

# Payment policy: All ASC services

## Prior authorization

Procedures not on L&I's ASC fee schedule require prior authorization. Specifically:

- Under certain conditions, the director, the director's designee, or self-insurer, at their sole discretion, may determine that a procedure not listed on L&I's ASC fee schedule 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.
- The healthcare provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. Requests for coverage under these special circumstances require prior authorization. The written request must contain:
    - A description of the proposed procedure with associated CPT® or HCPCS procedure codes, *and*
    - The reason for the request, *and*
    - 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.

## What facilities qualify for payment

To qualify for payment for ASC services, an ASC must:

- Be licensed by the state(s) in which it operates, unless that state does not require licensure, *or*
- Have at least one of the following credentials:
    - Medicare (CMS) Certification as an ASC, *or*
    - Accreditation as an ASC by a nationally recognized agency acknowledged by CMS, and
- Have an active ASC provider account with L&I.

 

## Services that can be billed

L&I uses the CMS list of procedure codes covered in an ASC, plus additional procedures determined to be appropriate.

L&I's rates for ASC procedures are based on a modified version of the current system developed by CMS for ASC services. L&I expanded the CMS list by adding some procedures CMS identified as excluded procedures.

**Link**: All procedures covered in an ASC are listed online in the fee schedule.

## Services that aren't covered

Procedure codes not listed in L&I's ASC fee schedule are not covered in an ASC.

## Additional information: Who to contact to become accredited or Medicare certified as an ASC

### For national accreditation, contact:

- Accreditation Association for Ambulatory Health Care
- American Association for Accreditation of Ambulatory Surgery Facilities
- American Osteopathic Association
- Commission on Accreditation of Rehabilitation Facilities
- Joint Commission on Accreditation of Healthcare Organizations

### For Medicare certification, contact:

Department of Health, **Office of Health Care Survey**
Facilities and Services Licensing
PO BOX 47874
Olympia, WA 98504-7874
360-236-4983

 

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for ASC payment policies | Washington Administrative Code (WAC) 296-23B |
| **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 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 33: Brain Injury Rehabilitation Services

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren’t appropriate without a video connection.

 

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

# Payment policy: Brain injury rehabilitation services

## Prior authorization

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment.

### State Fund claims

To determine whether or not to authorize post-acute brain injury rehabilitation for a claim, both an ONC and L&I claim manager will review the claim separately. (See Approval criteria, below.)

The Provider Hotline can't authorize brain injury treatment; however, the Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

### Self-insured claims

Contact the SIE or TPA for authorization (see Approval criteria, below).

**Link**: Contact information for the SIE or TPA is available via L&I's self-insured lookup tool.

## 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,
- The brain injury is related to the industrial injury or is retarding recovery,
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program,
- 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.

## Who must perform these services to qualify for payment

Only providers approved by the department can provide post-acute brain injury rehabilitation services for workers.

### Qualifying programs

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

- Evaluation,
- Treatment, *and*
- Follow up.

When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to:

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

### Specific L&I provider account number required

Providers participating in the Brain Injury Program must have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation to treat and bill for a complete course of brain injury evaluation and treatment. Providers will be issued a provider-specific ID number (separate from any provider ID they may already have with L&I) which will enable payment via the brain injury program billing codes. Providers billing for individual services and therapies don’t need to obtain a special provider account number.

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 or by emailing PHL@lni.wa.gov.

 

# Services that can be billed

## Nonhospital based programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs:

| Local code | Description | Maximum fee |
|---|---|---|
| **8950H** | Comprehensive brain injury evaluation | **$4,944.60** |
| **8951H** | Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day) | **$1,121.66** |
| **8952H** | Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day) | **$781.20** |

## Hospital based programs

The following revenue codes and payment amounts for hospital-based outpatient post-acute brain injury rehabilitation treatment programs:

| Local rev code | Description | Maximum fee |
|---|---|---|
| **0014** | Comprehensive brain injury evaluation | **$4,944.60** |
| **0015** | Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day) | **$1,121.66** |
| **0016** | Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day) | **$781.20** |

# Requirements for billing

For State Fund claims billing, providers participating in the Brain Injury Program must bill for brain rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. (See who must perform these services to qualify for payment, above.)

 

## 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 worker's mental, emotional, social, and physical status, and functioning. The evaluation must be provided by a multidisciplinary team that includes all of the following:

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

Additional medical consultations are referred through the program's physician. For State Fund claims, each consultation may be billed under the provider account number of the consulting physician. Services must be preauthorized by an L&I claim manager or the self-insured employer.

## Therapy assessments documentation requirements

The following documentation is required of providers when billing 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 to 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 must be sent to the insurer regularly, including all preadmission and discharge reports.

# Payment limits

## Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation, may be performed in any combination depending on the worker's condition, and **can't be billed separately**:

- 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, *and*
- Comprehensive report.

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 isn't 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, *and*
- Office supplies and materials required for service(s) delivery.

 

## Treatment

These 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 **can't 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, *and*
- Follow up interviews with the worker or family, which may include home visits and phone contacts.

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

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

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

- Telephone calls,
- Home visits, *and*
- Therapy assessments.

 

# Payment policy: Telehealth for brain injury rehabilitation services

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

## Services that must be performed in person

In-person evaluation is required when:

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

## Services that are covered

**Telehealth** procedures and services that are covered include:

- Post-acute brain injury rehabilitation, full day (**8951H,** rev code 0015).
- Half-day (**8952H,** rev code 0016).

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

### Q3014 billing examples

**Example 1:** A worker, whose originating site is their attending provider's office, attends an in-person Evaluation and Management (E/M) appointment. The originating site provider documents all necessary information as part of this visit. Then, the worker requests the use of the provider's space to participate in a telehealth consultation with a distant site provider who is located in another office. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The provider at the originating site location with the worker bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider, but no other code is payable for this event to the originating site provider. The originating provider is required to separately document the activity as part of their bill for **Q3014**, and they submit separate documentation and a bill for the E/M visit that occurred earlier, noting the two distinct events in each documentation. The distant site consulting provider bills a consultation code, but they can't bill **Q3014**.

 

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider bills… | E/M visit code<br>*and*<br>**Q3014** | Originating site provider documents… | E/M visit<br>*and*<br>originating site visit **Q3014** (separate documentation) |
| Distant site provider bills… | Consultation code | Distant site provider documents… | Consultation |

**Example 2**: A worker, whose originating site is their physician's office, attends an appointment for a telehealth consultation with a distant site provider. The originating site provider or their assistant arranges a secure and private space for the worker to participate in the consultation. The originating site provider bills the insurer **Q3014** for allowing this worker the use of their space for a visit with a distant site provider. The originating site provider is required to separately document the activity as part of their bill for **Q3014**. This provider can only bill **Q3014**, and the distant site consultant bills for their services provided. This distant site provider can't bill **Q3014**.

| | | | |
|---|---|---|---|
| Originating site is… | Attending provider's office | | |
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Services that aren't covered

The same services that aren't covered in this chapter apply to this policy.

**G2010** isn't a covered service.

Telephonic visits don't replace video two-way communication and can't be billed using non-telephonic E/M services codes. Case management services may be delivered telephonically (audio only) and are detailed in Chapter 10: Evaluation and Management (E/M) Services.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- Comprehensive brain injury evaluations (**8950H**, rev code 0014),
- The services listed under "Services that must be performed in-person",
- Hands-on services,
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

### Q3014 billing examples

**Example 1**: A worker, whose originating site is their home, attends a telehealth appointment with their provider. **Q3014** isn't payable to the provider in this example. No reimbursement is payable to the worker for using their home or their equipment for this visit.

| Originating site is… | Worker's home | | |
|---|---|---|---|
| Originating site provider **bills**… | n/a | Originating site provider **documents**… | n/a |
| Distant site provider **bills**… | No billable services | Distant site provider **documents**… | n/a |

**Example 2:** A worker, whose originating site is their attending provider's office, attends a telehealth consultation. The distant site consulting provider cannot bill **Q3014** because the worker is in a different location than the distant site provider. However, the originating site provider whose space the worker is utilizing may bill **Q3014**, so long as they provide appropriate documentation of the service provided. No other service is payable to the originating site provider.

| Originating site is… | Attending provider's office | | |
|---|---|---|---|
| Originating site provider **bills**… | **Q3014** | Originating site provider **documents**… | Originating site visit **Q3014** |
| Distant site provider **bills**… | Consultation code | Distant site provider **documents**… | Consultation |

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of treatment service and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

## 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 |

## Need more help?

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

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 34: Chronic Pain Management

**Effective July 1, 2022**

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

## Table of Contents

# Definitions

**The following terms are utilized in this chapter and are defined as follows:**

**Distant site:** The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

**Important associated conditions**: Medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

**Originating site:** The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

**SIMP (structured intensive multidisciplinary program)**: A chronic pain management program with the following four components:

- **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
- **Intensive** means the Treatment Phase is delivered on a daily basis, six to eight hours per day, five days per week, for up to four consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
- **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare professionals with expertise in pain management in at least the areas of medicine, psychology, and physical therapy or occupational therapy. The **SIMP** may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits, *and*
- **Program** means an interdisciplinary pain rehabilitation program that provides outcome focused, coordinated, goal oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

**Telehealth:** Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

**Treatment plan**: An individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

 

**Valid tests and instruments**: Those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

# Modifiers

**The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:**

**-GT (Via interactive audio and video telecommunication systems)**

Used to indicate a telehealth procedure was performed. Documentation to support the service must be submitted. Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

# Payment policy: Structured, intensive, multidisciplinary program (SIMP)

## General requirements

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP**.

Prior authorization is required for all workers to participate in a **SIMP** for functional recovery from chronic pain. See details about Prior authorization requirements later in this Payment policy section.

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

**Note**: Portions of this policy are supported by WAC 296-20-12055 through WAC 296-20-12095.

## Program design: Phases of an approved SIMP

An approved **SIMP** has three phases:

- Evaluation Phase,
- Treatment Phase, and
- Follow up Phase.

See below for details about each of these three phases.

### 1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes **treatment plan** development and a report. Only one evaluation is allowed per authorization but it can be conducted over one to two days.

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*
- Review of medical records and reports, including diagnostic tests and previous efforts at pain management, *and*
- Assessment of any **important associated conditions** that may hinder recovery, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease, *and*
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs, *and*
- Psychological and social assessment by a licensed clinical psychologist using **valid tests and instruments**, *and*
- Identification of the worker's family and support resources, *and*
- Identification of the worker's reasons and motivation for participation and improvement, *and*
- Identification of factors that may affect participation in the program, *and*
- Assessment of pain and function using **valid tests and instruments**; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
    - Activities of Daily Living (ADLs),
    - Range of Motion (ROM),
    - Strength,
    - Stamina, *and*
    - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the **SIMP** vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for **SIMP** claimants section of this chapter), *and*

 

- A summary report of the evaluation and a preliminary recommended **treatment plan**. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

### 2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts six to eight hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the **treatment plan**, *and*
- **Education and skill development** on the factors that contribute to pain, responses to pain, and effective pain management, *and*
- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using **valid tests and instruments**, *and*
- **Ongoing assessment** of **important associated conditions**, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment, *and*
- **Performance** of real or simulated work or daily functional tasks, *and*
- **SIMP vocational services**: these may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and*
- **A discharge care plan** for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase, *and*
- **A report** at the conclusion of the Treatment Phase that addresses all the following questions:
    - To what extent did the worker meet his or her treatment goals?

- What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?
- What changes if any, have occurred in the worker's pain level and functional capacity as measured by **valid tests and instruments**?
- What changes if any, have occurred in the worker's ability to manage pain?
- What is the status of the worker's readiness to return to work or daily activities?
- What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
- How much and what kind of follow up care does the worker need?

### 3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within six months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

#### Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), or
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

#### Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

- Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.

- Non face-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

### Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems,
- What was done during the Follow up Phase,
- What resulted from the follow up care, and
- Measures of pain and function using **valid tests and instruments**.

This summary report must be submitted at the first and third month marks.

### Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with **valid tests and instruments**, *and*
- Evaluating whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase, *and*
- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing **important associated conditions** and psychological status especially as related to reintegration in the workplace, home, and community, *and*

- Assessing what kind of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist, *and*
- Adjusting the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*
- Teaching new techniques or skills that were not part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain, *and*
- Making recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources, *and*
- Holding case conferences with the:
- Interdisciplinary team of clinicians, *and/or*
- Worker's attending provider, *and/or*
- Other individuals closely involved with the worker's care and functional recovery.

### Follow up Phase special considerations

When determining what follow up services the worker needs, **SIMP** providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a **SIMP** provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the **SIMP** provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*
- If a **SIMP** provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

**Link**: More information about Helping Workers Get Back to Work is available online.

# Prior authorization

## General referral and prior authorization requirements

All **SIMP** services require prior authorization by the claim manager and a referral from the worker's attending provider. An occupational nurse consultant, claim manager, or insurer-assigned vocational counselor may recommend a **SIMP** for the worker, but only the attending provider can make a referral.

**Note**: Only the attending provider can refer a worker for a **SIMP**.

## SIMP referral

**SIMP** services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the attending provider refers a worker to a **SIMP**, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

## Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the **SIMP** provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the **SIMP** provider recommends the worker move on to the Treatment Phase, the **SIMP** provider must provide the insurer with a report and **treatment plan** as described under the Evaluation Phase, *or if the worker*
- **Doesn't meet the requirements**, the **SIMP** provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*

- The goals the worker must meet before he or she can return and participate in the program, *also*
- If the worker is found to have **important associated conditions** during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the **SIMP** provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

### Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

## SIMP provider requirements

To provide chronic pain management program services to eligible workers, **SIMP** service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see Definitions at the beginning of this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, *and*
- Communicate with providers who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's attending provider, *and*
- Inform the claim manager if the worker:
- Stops services prematurely,
- Has unexpected adverse occurrences, *or*
- Doesn't meet the worker requirements, *and*
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

### CARF accreditation requirements

Providers must maintain CARF accreditation and provide the Department of Labor & Industries (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.

## Worker requirements

An injured worker must make a good faith effort to participate and comply with the **treatment plan** prescribed for him or her by the **SIMP** provider. To complete a **SIMP** successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her **treatment plan**, *and*
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her **treatment plan**, *and*
- Agree to be evaluated and comply with treatment prescribed for any **important associated conditions** that hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease), *and*
- Attend each day and each session that is part of his or her **treatment plan**. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward **treatment plan** goals, *and*
- Cooperate and comply with his or her **treatment plan**, *and*
- Not pose a threat or risk to himself or herself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

## Services that can be billed

### SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table.

The fee schedule applies to injured workers only in an outpatient program:

| Description | Local code | Duration / limits | Units of service | Maximum fee |
|---|---|---|---|---|
| **SIMP Evaluation Services** | **2010M** | One evaluation per authorization, which may be conducted over one to two days. | Bill only 1 unit for evaluation even if conducted over 2 days | **$1,284.61** |
| **SIMP Treatment Services**, each 6-8 hour day | **2011M** | Not to exceed 20 treatment days (6-8 hours per day). | 1 day equals 1 unit of service | **$822.82** per day |
| **SIMP Follow up Services: Face-to-face services** with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community | **2014M** | Not to exceed four hours per day and not to exceed 24 hours total (time must be billed in 1 minute units). | 1 minute equals 1 unit of service | **$1.73** per minute (**$103.84** per hour) |
| **SIMP Follow up Services: Non face-to-face** coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community | **2015M** | Not to exceed 40 hours (time must be billed in 1 minute units). | 1 minute equals 1 unit of service | **$1.35** per minute (**$81.13** per hour) |
| **Mileage** for traveling to and from the worker's community | **0392R** | Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services. | 1 mile equals 1 unit of service | Current Washington State mileage rate |

## Requirements for billing

Outpatient chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form.

### Billing for partial days for the treatment phase

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the patient was scheduled for less than 8 hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after two hours (25% of the treatment day). The clinic would bill **$822.82** x 25% = **$205.71**

## Payment limits

### SIMP evaluation services

Only one evaluation per authorization is allowed, which may be conducted over the course of one to two days. If the evaluation is conducted over a two day period, bill only one unit and span the dates.

### SIMP treatment services

These services can't exceed 20 treatment days (6-8 hours per day).

### SIMP follow up services

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Face-to-face services (local code **2014M**) can't:

- Exceed four hours per day, *and*
- 24 hours total.

**Note**: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit.

# Payment policy: Telehealth for chronic pain management

## General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication requirements. In-person visits are preferred for gathering objective medical findings, however, telehealth may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

**Telehealth** services must occur either from a medical or vocational **origination site** or the worker's home. The selection of a provider is the worker's choice by law. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

## Services that must be performed in person

In-person evaluation is required when:

- The provider has determined the worker is not a candidate for **telehealth** either generally or for a specific service, *or*
- The worker does not want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

## System requirements

**Telehealth** services and teleconsultations require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the patient and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

## Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

## Services that are covered

**Telehealth** procedures and services that are covered include:

- SIMP treatment services (**2011M**).
- SIMP follow up services, face-to-face (**2014M)**.

The insurer will pay an **originating site** facility fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** facility fee, use HCPCS code **Q3014**.

**Q3014** is payable to the **originating site** provider when no other billable service occurs.

## Services that aren't covered

The same services that aren't covered in this chapter apply to this policy.

**G2010** isn't a covered service.

### Telehealth procedures

**Telehealth** procedures and services that aren't covered include:

- SIMP evaluation services (**2010M**),
- The services listed under "Services that must be performed in person",
- Hands-on services,
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

### Telehealth locations

**Q3014** isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

## Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

**Distant site** providers must use place of service **-02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **-10** to denote the **telehealth** visit when the worker is located in their home.

Bill using the **–GT** modifier to indicate **telehealth**.

### Documentation requirements

For the purposes of this policy, the following must be included in addition to the documentation and coding requirements for services billed, as noted in MARFS:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

## Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

In addition, exercise and work-conditioning activities are restricted to 2 hours per day per worker when performed via **telehealth**.

# Payment policy: Vocational services for SIMP claimants

## Prior authorization

### Vocational referrals

Prior to authorizing participation in a **SIMP**, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

- Is working, *or*
- Is scheduled to return to work, *or*
- Has been found employable or not likely to benefit from vocational services.

## Requirements for a Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with **SIMP** treatment and the claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the **outcomes** listed in the Return to Work Action Plan **must be included** with the Treatment Phase summary report.

If a vocational counselor is assigned, he or she will work with the **SIMP** vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

**Note**: Don't forget to include the outcomes from the Return to Work Action Plan in your Treatment Phase Summary Report.

## Return to Work Action Plan roles and responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the **SIMP** vocational counselor, the attending provider, and the worker are involved.

The specific roles and responsibilities of each are as follows:

### The SIMP vocational counselor will:

- Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
- Present the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the **SIMP** recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.

### The insurer assigned vocational counselor will:

- Co-develop the Return to Work Action Plan with the **SIMP** vocational counselor, *and*
- Attend the chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
- Negotiate with the attending provider when the initial Return to Work Action Plan isn't approved in order to resolve the attending provider's concerns, *and*
- Obtain the worker's signature on the Return to Work Action Plan, *and*
- Communicate with the **SIMP** vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
- Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

### The attending provider will:

- Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
- Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.

 

**The worker will:**

- Participate in the selection of a return to work goal, *and*
- Review and sign the final Return to Work Action Plan, *and*
- Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

**Link**: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

# Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** supporting **SIMP** payment policies | Washington Administrative Code (WAC) 296-20-12055 through WAC 296-20-12095 |
| **Becoming an L&I provider** | Become A Provider on L&I's website |
| **Billing** instructions and forms | Chapter 2: Information for All Providers |
| **Crime Victims Compensation Program** contact information | **Phone**: 1-800-762-3716 (toll free)<br>**Fax**: 1-360-902-5333<br>Crime Victims on L&I's website |
| **Fee schedules** for all healthcare services | Fee schedules on L&I's website |
| **Return to work**: "Helping Workers Get Back to Work" | Helping Workers Get Back to Work on L&I's website |
| **Self-insured claims** authorization from the self-insured employer (SIE) or their third party administrator (TPA) | Contact list of SIE/TPAs on L&I's website |
| **Worker refuses to cooperate with care plan**: Legal issues defined in Washington state laws | Revised Code of Washington (RCW) 51.32.11 |

## Need more help?

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

 

Washington State Department of Labor & Industries

**Payment Policies for Healthcare Services**

**Provided to Injured Workers and Crime Victims**

# Chapter 35: Hospitals

**Effective July 1, 2022**

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

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# Payment policy: All hospitals

## Payment methods

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury.

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.

**Links**: Hospital payment policies established by L&I are reflected in the Hospital Billing Instructions (call L&I's Provider Hotline at 1-800-848-0811 for a current copy) and in WAC 296-20, WAC 296-21, WAC 296-23, and WAC 296-23A.

## Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a **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 a patient admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via a POAC rate. For information about POAC rates for outpatient hospital visits, see the State Fund payment methods section for Outpatient hospitals later in this chapter.

## Payment limits

No copayments or deductibles are required or allowed from workers.

Payments won't exceed allowed billed charges.

# Payment policy: Hospital acquisition cost policy

## Payment methods

Items covered under the hospital acquisition cost policy will be paid using a hospital specific POAC rate.

Nonhospital facilities will be paid a statewide average POAC rate.

# Payment policy: Inpatient hospital acute care

## Self-insured employer payment methods

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

## Crime Victims Compensation Program payment methods

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

## State Fund provider network coverage requirements

Services from both network and non-network providers can be covered:

- If done in an emergency room at an acute care hospital, or
- If done prior to discharge for a patient who was directly hospitalized from an initial emergency room visit.

**Links**: For more information about the network, see WAC 296-20-01010(3).

For information on who may treat, see WAC 296-20-015(1).

## State Fund payment methods

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

- An All Patient Refined Diagnosis Related Group (APR DRG) system. L&I currently uses APR DRG Grouper version 38. For exclusions and exceptions, see WAC 296-23A-0470, *or*
- A statewide per diem rate for those APR DRGs that have low volume, *or*
- A POAC rate for hospitals excluded from the APR DRG system.

**Link**: The current APR DRG Assignment List is available online.

## Payment methods for hospital types or locations

| **Hospital types or locations…** | **Payment method** for inpatient hospital acute care services is: |
|---|---|
| Hospitals not in Washington State | Paid by an out of state POAC rate.<br>The POAC rates are 64.2% for hospitals within the United States and 100% for hospitals outside the United States. |
| Hospitals in Washington State that are excluded:<br>• Children's hospitals,<br>• Health Maintenance Organizations (HMOs),<br>• Military hospitals,<br>• Veterans Administration facilities,<br>• State psychiatric facilities. | Paid 100% of allowed charges. |
| Hospitals in Washington State that are major teaching hospitals:<br>• Harborview Medical Center,<br>• University of Washington Medical Center.<br>*OR*<br>All other Washington hospitals | Paid on a per case basis for admissions falling within designated APR DRGs. For low volume APR DRGs, Washington hospitals are paid using the statewide per diem rates for the designated APR DRG categories below:<br>• Chemical dependency,<br>• Psychiatric,<br>• Rehabilitation,<br>• Medical,<br>• Surgical. |

## Hospital inpatient acute care rates

**Links**: For information on how specific rates are determined see WAC 296-23A.

The APR DRG Assignment List with APR DRG codes and descriptions and length of stay is in the fee schedule.

## APR DRG base rates

| If the **hospital** is… | Then the **base rate** is: |
|---|---|
| Harborview Medical Center | **$13,146.84** |
| University of Washington Medical Center | **$11,641.76** |
| All other Washington hospitals | **$10,879.83** |

## APR DRG per diem rates

| If the **payment category** is… | Then the **rate** is… | And the **definition** is: |
|---|---|---|
| Psychiatric APR DRG per diem | **$1,179.30** multiplied by the number of days allowed by L&I. | APR DRGs identified as Psych |
| Chemical dependency APR DRG per diem | **$975.14** multiplied by the number of days allowed by L&I. | APR DRGs identified as Chem Dep |
| Rehabilitation APR DRG per diem | **$1,731.36** multiplied by the number of days allowed by L&I. | APR DRGs identified as Rehab |
| Medical APR DRG per diem | **$2,483.05** multiplied by the number of days allowed by L&I. | APR DRGs identified as Medical |
| Surgical APR DRG per diem | **$5,209.90** multiplied by the number of days allowed by L&I. | APR DRGs identified as Surgical |

## Additional inpatient acute care hospital rates

| If the **payment category** is… | Then the **rate** is… | And the **definition** is: |
|---|---|---|
| **Transfer-out cases** | Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the APR DRGs average length of stay. If the worker's stay is less than the average length of stay, a per-day rate is established by dividing the APR DRG payment amount by the average length of stay for the APR 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 worker's stay is equal to or greater than the average length of stay, the APR 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 rate multiplied by allowed billed charges. | Cases where the cost (see note below table) of the stay is less than 10% of the statewide APR DRG rate or a statutory amount inflated to current dollars, whichever is greater. |
| **High outlier cases** (costs are greater than the threshold) | APR DRG payment rate plus 100% of costs in excess of the threshold. | Cases where the cost (see note below table) of the stay exceeds a statutory amount inflated to current dollars or 2 standard deviations above the statewide average cost for each DRG and SOI combination, whichever is greater. |

## How costs are determined

Costs are determined by multiplying allowed billed charges by the hospital specific POAC rate. Hospitals outside of the United States will be paid at a POAC rate of 100% of allowed charges. High and low outlier amounts are listed on the APR-DRG Assignment sheet on L&I's fee schedule page.

# Payment policy: Outpatient hospitals

## Self-insured employer payment methods

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

## Crime Victims Compensation Program payment methods

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using POAC rates 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:

- Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system.
- An amount established through L&I's Professional Services Fee Schedule for items not covered by the APC system
- A POAC rate for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule

**Links**: For a description of L&I's OPPS system, see WAC 296-23A (Section 4), WAC 296-23A-0220, and WAC 296-23A-0700 through WAC 296-23A-0780.

## How the above payment methods are applied

| **Hospital types or locations…** | Then the **payment method** for hospital outpatient services is: |
|---|---|
| Hospitals not in Washington State | Paid by out of state POAC rates.<br>The rates are 64.2% for hospitals within the United States and 100% for hospitals outside the United States. |
| Hospitals in Washington State that are excluded:<br>• Children's hospitals,<br>• Military hospitals,<br>• Veterans Administration facilities,<br>• State psychiatric facilities. | Paid 100% of allowed charges |
| Rehabilitation hospitals,<br>Cancer hospitals,<br>Critical access hospitals,<br>Private psychiatric facilities | Paid a facility specific POAC rate or a fee schedule amount depending on procedure |
| All other hospitals in Washington State | Paid on an APC basis for services falling within designated APCs.<br>For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility specific POAC rate. |

### Additional payment details

When ER visits develop into inpatient stays, hospitals should bill all charges on an inpatient bill. Use the inpatient admit date as the first covered date.

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

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

Hospitals outside the United States will be paid at a POAC rate of 100%.

## 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 rate for new or current pass-through devices.

New or current drug or biological pass-through items will be paid by fee schedule or a POAC rate (if no fee schedule exists).

## Hospital OPPS payment process

| **Question**: | If the **answer** is… | Then the **payment method** is: |
|---|---|---|
| 1. Does L&I cover the service? | No | Don't pay |
| | Yes | Go to question 2 |
| 2. Does the service coding pass the Outpatient Code Editor (OCE) edits? | No | Don't pay |
| | Yes | Go to question 3 |
| 3. Are the service codes listed on the inpatient-only list? | No | Go to question 4 |
| | Yes | Pay POAC rate |
| 4. Is the service packaged? | No | Go to question 5 |
| | Yes | Don't pay. Go to question 7 |
| 5. Is there a valid APC for the service? | No | Go to question 6 |
| | Yes | Pay the APC amount and total the APC payment(s) for outlier consideration. Go to question 7 |
| 6. Are the service codes listed in a fee schedule? | No | Pay POAC rate |
| | Yes | Pay the facility amount for the service |
| 7. Does the service quality for outlier? | No | No outlier payment |
| | Yes | Pay outlier amount |

### Additional payment details

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

Outlier amounts are in addition to regular APC payments.

## OPPS relative weights and payment rates

The relative weights published by CMS are used for the OPPS program.

Each hospital's blended APC rate was determined using a combination of the average hospital specific APC rate and the statewide average APC rate.

**Links**: 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 APC rates via separate letter from L&I or by accessing the Hospital Rates link in the fee schedule.

## OPPS outlier payments

L&I uses a modified version of the CMS outlier payment policy.

## Links to related topics

| If you're looking for more information about… | Then see… |
|---|---|
| **Administrative rules** for hospital payment policies | Washington Administrative Code (WAC) 296-20<br>WAC 296-21<br>WAC 296-23<br>WAC 296-23A<br>WAC 296-30-090 |
| **Administrative rules** for the State Fund provider network and Who may treat | WAC 296-20-01010<br>WAC 296-20-015 |
| **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 hospitals) | Fee schedule on L&I's website |
| **Residential treatment facilities for mental health** | Chapter 17: Mental Health Services |

## Need more help?

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

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, 2022**

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

## Table of Contents

# Payment policy: All residential care services

## General requirements

The insurer covers:

- Proper and necessary residential care services that require **twenty-four 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 physician, *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: Residential services, including boarding homes, assisted living facilities, and adult family 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.

## Services that can be billed

The numeric score determined by the Residential Care Assessment Tool will determine which billing code to use. The three 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<br>Basic level | **8893H** | L&I RF Low |
| 21 – 36<br>Intermediate level | **8894H** | L&I RF Medium |
| 37 – 57<br>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<br>RCW 51.36.110 |

## Need more help?

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

 