Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 27: Reports and Forms

Effective July 1, 2024

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.

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 CDs/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**	**$52.91**	60-day reports aren't required unless requested by the insurer or if legible comprehensive chart notes are submitted and include the required information per WAC 296-20-06101. Not payable for records required to support billing, for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Limit of 1 per provider per 60 days per claim.

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:
Special Report	**99080**	**$52.91**	**Must be requested by insurer or vocational counselor.** **For reports created by provider.** Not payable for records or reports required to support billing or for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Don't use this code for forms or reports with assigned codes. Limit of 1 per day. Bill this code for starring a work history form.
Department of Transportation (DOT) Medical Examination & Certification	**99499**	**By Report**	Bill this code for completing a DOT Medical Examination and completing the certification form. Must be conducted by a licensed "medical examiner" with the Federal Motor Carrier Safety Administration (FMCSA). MD, DO, ND, ARNP, PA eligible in Washington State. Prior authorization required.
AP Final Report	**1026M**	**$30.40**	**May be requested by insurer or submitted by attending provider.** Payable only to attending provider. Limit of 1 per day.
Loss of Earning Power (LEP)	**1027M**	**$23.01**	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per day.

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:
Report of Accident (ROA) Workplace Injury, or Occupational Disease for State Fund claims	**1040M**		MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim. For additional information, see Chapter 2: Information for All Providers.
		$46.01	**When submitted within 5 business days after first treatment date**
		$36.01	**When submitted 6-8 business days after first treatment date**
		$26.01	**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**		MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim. For additional information, see Chapter 2: Information for All Providers.
		$46.01	**When submitted within 5 business days after first treatment date**
		$36.01	**When submitted 6-8 business days after first treatment date**
		$26.01	**When submitted 9 or more business days after first treatment date**
Application to Reopen Claim	**1041M**	**$59.81**	MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.
Occupational Disease History Report	**1055M**	**$223.21**	**Must be requested by insurer.** Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s). Visit our website for instructions.

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**	**$46.02**	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per request. Attending provider must respond to request using letter sent by claim manager. Not payable to a Master Level Therapist (MLT).
Attending Provider Supplemental Review of IME with written report	**1065M**	**$34.51**	**Must be requested by insurer.** Payable only to attending provider when submitting a separate report of IME review. This report expands upon the provider's response from **1063M**. Limit of 1 per request.
Provider Review of Video Materials with written report	**1066M**	**By Report**	**Must be requested by insurer.** Payable once per provider per day. Report must include actual time spent reviewing the video materials. Report should include findings and observations gained from the review. 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**	**$59.81**	Submit the Activity Prescription Form (APF): • With the Report of Accident when there are work related physical restrictions, or • When documenting a change in the worker's medical status or capacities. Limits: 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. The insurer will review and allow or deny any APFs submitted over the limits listed above. 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. Payable once per provider per worker per day.

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**	**$36.81**	Responding to written communication with vocational counselors (VRC) and employers such as questionnaires. 1074M is not payable when performed on the same day as a team conference, office visit, or online communication with a VRC or employer. Not payable to an MLT. A copy of the written communication must be sent to the insurer.
Subacute Opioid Request Form for Pain without Documentation	**1076M**	**$36.81**	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**	**$69.03**	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**	**$36.81**	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**	**$59.81**	**Must be requested by insurer, employer, or vocational counselor.** Payable to attending provider, IME examiner, or consultant. Limit of 1 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 by emailing PHL@Lni.wa.gov.

Documentation requirements

In addition to the specific reports and forms requirements in the above table, documentation must include all required elements including, the name and title of the person completing it (either with a hand-written signature, signature stamp or electronic signature) and the date it was completed. These are required even if the report or form doesn't have a field for it.

Links: See Chapter 2: Information for All Providers and WAC 296-20-01002 for more information on documentation requirements.

Payment policy: Review of job offers, job analyses, and job descriptions

General information

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**	**$59.81**	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Isn't payable to IME examiner on the same day as the IME is performed. Not payable to MLTs.
Review of Job Descriptions or JA, each additional review	**1028M**	**$44.87**	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. For IME examiners on day of exam: may be billed for each additional **JA** after the first 2. For IME examiners after the day of exam: may be billed for each additional **JA** after the initial (initial is billed using **1038M**).

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 WAC 296-20-097 WAC 296-20-03056 WAC 296-20-03057 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
Penalty for failing to file accident reports and assist injured workers	RCW 51.48.060
Penalty adjusted for inflation	RCW 51.48.095

Need more help?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

