

**Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims**

Chapter 30: Vocational Services

Effective July 1, 2024



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: A code listed in the fee schedule as “By Report” 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, see [WAC 296-20-01002](#).

Distant site: The location of the provider who performs telehealth services. This provider isn’t 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.

Remote: Vocational services provided by a qualified vocational rehabilitation counselor via audio only or face-to-face through a real-time, two-way, audio video connection.

Registration fee: Any fee charged by a school to process student applications and establish a student record system.

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.

Worker or student: An individual who has an L&I claim number and qualifies for workers’ compensation retraining benefits. For the purposes of this policy, the terms worker and student are used interchangeably.

Withdrawal or termination date: The earliest of any of the following dates:

- The date the school recorded the student’s last day of attendance, or
- The date a student is terminated for violation of published school policy, or
- The date a student is terminated for failing to meet performance requirements, or
- The date the student notifies the school in writing that they will withdraw.

Vocational rehabilitation counselors (VRC) or provider: The term “provider” in the above definitions includes vocational rehabilitation counselors.



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 6 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.



Note: The firm must assign a VRC upon referral.



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)	\$10.55
0801V	Vocational recovery services (intern)	\$8.99
0802V	Vocational recovery services exception (VRC)	\$10.55
0803V	Vocational recovery services exception (intern)	\$8.99

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0810V	Assessment services (VRC)	\$10.55
0811V	Assessment services (Intern)	\$8.99
0812V	Assessment services exception (VRC)	\$10.55
0813V	Assessment services exception (intern)	\$8.99

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)	\$10.55
0823V	Pre-job or job modification consultation (VRC)	\$10.55
0824V	Pre-job or job modification consultation (Intern)	\$8.99

Plan development

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0830V	Plan development services (VRC)	\$10.55
0831V	Plan development services (Intern)	\$8.99

Plan implementation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0840V	Plan implementation services (VRC)	\$10.55
0841V	Plan implementation services (Intern)	\$8.99
0842V	Plan implementation services exception (VRC)	\$10.55
0843V	Plan implementation services exception (intern)	\$8.99

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)	\$12.62

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)	\$10.55
0809V	Stand-alone job analysis (intern)	\$8.99
0378R	Stand-alone job analysis (non-VRC)	\$10.45

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	\$12.71 per 6 minutes
0390R	Vocational evaluation, 1 unit = 6 minutes	\$10.45 per 6 minutes

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.

When a worker has 2 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 3 (or more) claims, the vocational evaluation bills are to be split accordingly (3 claims = by thirds, 4 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	\$7,421.96
Assessment referral cap, per referral	0810V, 0811V	\$7,421.96
Plan development referral cap, per referral	0830V, 0831V	\$7,096.53
Plan implementation referral cap, per referral	0840V, 0841V	\$8,045.40
Stand-alone job analysis referral cap, per referral	0808V, 0809V, 0378R	\$541.23

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 of a subsequent evaluation 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	\$1,552.91

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 **\$1,034.51**.

Code	Description	Maximum fee
0802V	Vocational recovery services exception (VRC)	\$10.55 per 6 minutes
0803V	Vocational recovery services exception (intern)	\$8.99 per 6 minutes

AWA referrals

For AWA referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **\$1,034.51**.

Code	Description	Maximum fee
0812V	Assessment services exception (VRC)	\$10.55 per 6 minutes
0813V	Assessment services exception (intern)	\$8.99 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 **\$2,391.02**.

Code	Description	Maximum fee
0842V	Plan implementation services exception (VRC)	\$10.55 per 6 minutes
0843V	Plan implementation services exception (intern)	\$8.99 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 utilizing the remaining referral funds.

- 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 utilizing the remaining referral funds.

Flat rate policy for 30-day progress reports

There is a **\$50** flat rate for each 30-day progress report. Progress report fees don't 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 1 progress report per referral every 30 days.

To bill for more than 1 progress report for the same referral on the same invoice, use separate line items of 1 unit and \$50 each for each date of service. If you bill for more than 1 report on the same line, all but 1 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 1 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	<p>Pre-job or job modification consultation</p> <p>Vocational Rehabilitation Provider</p>	<p>Discussing/consulting about modifications to a job. This may include:</p> <ul style="list-style-type: none"> • 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. • Discussing available L&I benefits to include stay at work, preferred worker, and job modification with the employer, worker, and/or attending provider. • Communication with others about modifying a job to include the worker, employer, health-care providers, vocational provider, insurer, and/or vendor. • Documenting findings and recommendations, • Instruction in work practices (such as body mechanics, ergonomic principles), • Obtaining bids, • Completing and submitting the Job Modification/Pre-job Assistance Application and any associated follow up, and • Assisting an employer with accessing return to work incentives. 	<p>\$10.55 per 6 minutes</p>

Code	Description	Activities	Maximum fee
0824V	Pre-job or job modification consultation Vocational Rehabilitation Provider Intern	Same as above	\$8.99 per 6 minutes
0389R	Pre-job or job modification consultation, analysis of physical demands OT, PT, Ergonomic Specialist	Same as above Analyzing job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only).	\$12.71 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.	\$5.76 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. 1 unit=1 mile	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: <ul style="list-style-type: none"> • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work area modification or reconfiguration.	Maximum allowable for 0380R is \$5,000.00 per job or job site.
0385R	Pre-job accommodation	Equipment/tools: <ul style="list-style-type: none"> • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work/training area modification or reconfiguration.	Maximum allowable for 0385R is \$5,000.00 per claim. 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, *and*
- They agree to send insurer a PDF picture of the final product.

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 5 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)	\$10.55
R0398	Option 2 job placement services (VRC)	\$10.55



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 aren't 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 aren't 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: Remote services

General Information

Remote services may be appropriate where vocational services can be completed effectively via audio only or audio-visual platform.

Services that should be performed in person

In alignment with the worker-centric model, **remote** services are an option, but in some situations these aren't possible or aren't preferred by the worker. In-person services should be provided when:

- The vocational provider has determined the worker isn't a candidate for **remote** services, either generally or for a specific service, *or*
- The worker doesn't want to participate remotely.

In-person services are particularly important for:

- Job analyses,
- Plan development rights and responsibilities,
- Initial meetings with the worker.

Originating Site Fee (Q3014)

Vocational providers may be reimbursed an **originating site** fee (**Q3014**) for allowing use of their office space to workers who need a **telehealth** visit with a medical provider.

When billing the **originating site** fee, no other service can be provided to the same worker by the vocational provider. When a vocational provider bills **Q3014** on the same day they render in-person services to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The vocational provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person services that occurred on the same day. When **Q3014** is the only code billed, documentation is still required to support the service.

Q3014 isn't covered when:

- **Remote** services performed via telephone, *or*
- The **originating site** vocational provider performs another service during the workers' **telehealth** service with a medical provider (such as a team conference), *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The services are provided via audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** or **remote** related services.

Services that aren't covered

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems aren't covered.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** or **remote** appointment.

For **remote** services delivered, bill the applicable codes as if delivering care in person.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the distant site provider in addition to the documentation requirements for the vocational services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **remote** services with an audio and visual connection. This must be noted for each such visit and isn't required for audio only connections.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.



Payment policy: School billing, cancellation, and refund

General information

Schools and training programs are L&I-approved training providers that equip **workers** with the knowledge, skills, and abilities they need to be successful in the workforce. Approved providers are either accredited, licensed, or otherwise meet L&I provider requirements.

Workers must have an authorized vocational training plan.

A training provider must have an L&I provider account to be paid for services. Resources for billing are available on the insurer's [website](#).

Prior authorization

Prior authorization is required to bill for **student** application fees and/or placement tests (code **0388R**). This authorization can be granted before a training plan has been approved.

An L&I-approved training plan is required before training begins. This training plan documents the allowed dollar limits, date spans, and billing codes for each vendor. The authorized expenses must be either on an encumbrance form ([F245-454-000](#) for an Option 1 training plan) or on an authorization letter (for an Option 2 plan). See [Resources for Training Providers](#).

Who must perform these services to qualify for payment

To be paid for services, a training provider must have an L&I provider account and prior authorization from L&I.

To maintain status as an approved training provider, schools must:

- Have an admission policy allowing all qualified members of the general population to be candidates for admission, *and*
- Maintain documentation on **student** completion and placement rates, *and*
- Maintain credentials. Accredited or licensed training providers must maintain their accreditation or licensure status per [WAC 296-19A-590](#). Non-accredited or unlicensed training providers must reapply every two years per [WAC 296-19A-550](#). Failure to maintain credentials may result in termination of the provider number (WAC [296-19A](#)), *and*
- Comply with all federal, state, and local regulations, and other requirements governing their education and business operations, *and*
- Ensure services provided are respectful, equitable, and responsive to diverse cultural beliefs, practices, preferred languages, and communication needs, *and*
- Ensure access to spoken and sign language according to [Title VI of the Civil Rights Act of 1964](#) and the [Americans with Disabilities Act \(ADA\)](#). Interpretation services for an injured **worker** or a crime victim are covered by L&I and don't require prior authorization. For further details, see [Chapter 2: Information for All Providers](#).

For additional guidance, see [Schools and Training Programs \(wa.gov\)](#).



Note: To become an approved L&I training provider, schools must submit an application and be accredited, licensed, or otherwise meet L&I provider requirements. To apply for an L&I provider account, see [Become a Training Provider](#).

Changes to a billing address, tax ID, etc. could require a different L&I provider number and could cause bills to be delayed or denied. See [Become a Training Provider](#) or contact SchoolOversightProgram@Lni.Wa.Gov for assistance.

Services that can be billed

With documentation and prior authorization, the insurer covers the following codes:

- Fees for **student** applications and placement tests (**0388R**). This code can be authorized before the training plan has been approved.

Under an approved training plan, the insurer covers the following codes:

- Tuition and fees (training, exams, licensing) (**R0310**)
- Books, supplies, and equipment (**R0312**)



Note: Childcare providers must be licensed.

When to bill the insurer

Billing must fall within the date spans and allowed amounts as listed in the approved training plan (either the Encumbrance form or the Option 2 Authorization Letter).

Tuition must be billed by quarter or semester. For schools without quarters or semesters, billing can't exceed 90-day increments.

Example

A \$6,000 training plan starting 9/5/2023 and ending 1/1/2024 should be billed as follows:

- 9/5/2023 – 11/20/2023: \$3,000
- 11/21/2023 – 1/1/2024: \$3,000

Make sure your billing dates are within the approved plan dates, or it may cause payment delays or denials.

For additional billing guidance, see [Resources for Training Providers](#).

Refund requirements

At a minimum, schools must use the refund and cancellation policies outlined below unless the school is governed by a higher statutory authority. For example, community and technical colleges are governed by different laws and also defer to federal laws regarding financial aid. The insurer may approve refund policies whose terms are more favorable to **students** than the following established minimums.

The process

Refunds must be calculated using the official date of **withdrawal or termination**.

Refunds require the L&I claim number, the billing codes, dates of service, the original bill ICN, and the refund amount. For details, see [Getting a Payment Adjusted](#) and complete the Refunding Money form ([F245-043-000](#)).

Refunds are only payable for bills submitted to the insurer.

Refunds must be submitted within thirty calendar days of the **student's** official date of **withdrawal or termination**. See [RCW 51.48.260](#) and [WAC 296-19A-390](#).

If training ends before a student begins classes

If the applicant isn't accepted, the school may keep money billed for applications and placement tests under code **0388R**. The school must refund all money billed under codes **R0310** and **R0312**.

If the school cancels a class before it starts, the school must refund all money billed for the class under codes **R0310** and **R0312**.

If a training is terminated after signing the enrollment contract and before the **student** begins classes, the school may retain an established **registration fee** equal to 10% of the total tuition cost, or \$100, whichever is less.

If training ends after the student begins classes

The school may retain the **registration fee**, plus a percentage of the total tuition as described in the table below.

The percentage will be applied within the date span that includes the official date of **withdrawal or termination**. Authorized dates are listed on the Encumbrance Form or Authorization Letter.

For example, if a student completes 4 weeks within a 10-week date span (40% of the scheduled training), the school may bill no more than 50% of the tuition for that date span.

When the student completes this amount of training...	Then the school may retain no more than this percentage of tuition:
1 week or up to 10%, whichever is less	10%
More than 1 week but less than 25%	25%
25% up to 50%	50%
More than 50%	100%

Services that aren't covered

The following services aren't covered:

- Schools using a monthly subscription service, *or*
- Hourly tutoring.

Requirements for billing

The insurer will only pay bills that fall within the dollar limits and date spans identified in the approved training plan. For further assistance, see [Resources for Training Providers](#).

All charges for tuition must be submitted to the insurer.

Schools can't charge **workers** or VRCs for tuition. Bills must be submitted to the insurer.

Documentation

L&I may request records regarding the **worker's** training. Records may include a course catalog with prices and policies, signed enrollment agreement, documentation of a **student's** attendance dates, or other information needed to evaluate the **student's** progress or attendance.

Upon request, schools are required to submit records or information on the **student's** progress to L&I or vocational counselors at no cost.

Payment limits

Schools must bill the insurer based on their usual and customary fees.

When questions arise about the cost of training (such as tuition, fees, supplies, etc.), L&I will base decisions on the catalog relevant when the plan was approved. This catalog must include total cost of the program including tuition, fees, supplies, etc. Licensed schools must maintain a current catalog with costs on file with the school's credentialing body.

Schools can't:

- Bill the worker more than any other **student** for the same program, *or*
- Charge **workers** or VRCs directly for tuition, *or*
- Bill the **worker** or VRC for amounts above the approved training plan cost. See [RCW 51.04.030\(2\)](#) and [WAC 296-20-020](#).



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 vocational provider's L&I provider account number 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

For code **0388R**, there is a limit of 1 unit per day, per claim.



Payment policy: Travel, wait time, and mileage

General information

L&I supports in-person meetings to encourage effective engagement, collaborative problem solving, and delivery of quality vocational services. Travel, wait time, and mileage charges aren't included in the fee cap for any referral type.

The vocational provider may bill mileage, round trip, from their primary branch office to their in-state or border city 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 1 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 1 claim

If traveling for more than 1 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.

- Split charges equally between all claims, rounding to the nearest number if necessary.
- For 2 claims, bill half to each claim.
- For 3 or more claims split the charges accordingly (3 claims = by thirds, 4 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.

Prior authorization

Reimbursement for lodging and airfare requires prior authorization from L&I. The VRC is responsible for obtaining authorization from the Vocational Services Specialist (VSS) for their travel in advance.

Extension of stay

If the stay is extended for the VRC referral needs, L&I will reimburse for the additional lodging provided prior authorization has been obtained. It is the VRC's responsibility to contact the VSS to request authorization to extend the stay.

Services that can be billed

Code	Description	Maximum fee
0891V	Travel/wait time (VRC or forensic VRC) 1 unit = 6 minutes Includes time spent driving, waiting for appointments, or other similar circumstances.	\$5.29 per 6 minutes
0892V	Travel/wait time (intern) 1 unit = 6 minutes Includes time spent driving, waiting for appointments, or other similar circumstances.	\$5.29 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) Requires documentation with a receipt in case file.	By Report
0897V	Hotel charges (VRC, intern or forensic VRC)	State rate

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
0391R	Travel/wait (non-VRC), 1 unit = 6 minutes	\$5.76 per 6 minutes
0392R	Mileage (non-VRC), 1 unit = 1 mile	State rate
0393R	Ferry charges (non-VRC) Requires documentation with a receipt in case file.	State rate

Services that aren't covered

L&I won't reimburse for the following:

- Meals, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Cancellations made by the **lodging provider**, *or*
- Lodging and/or fees outside the authorized period.

Documentation requirements

Documentation must be submitted separately from bills. Please include the phrase "**index: VOC**" in the bottom right corner of each page to ensure documentation is entered properly in L&I's systems.

Please submit a copy of the hotel invoice and airfare receipt for documentation. L&I will reimburse up to the [US General Services Administration](#) rates for out of state travel, and up to the [Office of Financial Management](#) travel reimbursement for in-state travel.

Documentation must contain:

- A copy of the itemized receipt, *and*
- The travel date span, *and*
- The claimant's name, *and*
- L&I claim number(s), *and*
- Total charge for the date span, *and*
- Number of units (nights) stayed.



Payment policy: Additional requirements for all vocational services providers

Documentation requirements

For bills submitted to the department, see [WAC 296-19A-360](#) for documentation requirements.

Inappropriate referral: ADMA billing

Vocational firms must assign a referral to a vocational counselor within 24 hours. After the assignment is made, the counselor may have reason to decline. The use of the ADMA outcome, *firm declines referral*, should be rare and determined as quickly as possible within 14 days of the referral assignment.

Examples of when a firm may need to use the ADMA outcome code include:

- Conflict of interest, or
- Higher level of specialization is necessary.

A maximum of 3 professional hours may be billed for reviewing the file and preparing a brief rationale after the referral is assigned to a counselor. The counselor assignment is critical to avoiding delays in payment

Prior to entering an ADMA outcome, the firm needs to call the unit vocational services specialist to discuss the reasons for declining the referral. If the ADMA code is still appropriate, the firm must enter the outcome code and send the rationale using an EVOC message.

The ADMA outcome code shouldn't be used by firms to selectively decline referrals in favor of less complicated cases or to manage capacity. Firms must be proactive in managing counselor caseload and notify L&I if the volume of referrals needs to be adjusted.

Preferred worker certification for workers who choose Option 2

Vocational providers must consider assisting a worker covered by the State Fund 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 granted by legal order.

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 accommodation reviews,
- Proposed work rehabilitation 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 **\$342.55** for VRC and/or intern time.

Code	Description	Maximum fee
0844V	Resume services (VRC)	\$10.55 per 6 minutes
0845V	Resume services (intern)	\$8.99 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) that aren't billable include:

- Editing, revising, or typing,
- Filing,
- Distributing or mailing.

Time spent on any administrative and clerical activity also isn't billable including:

- 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 isn't 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 3 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*
- The vocational provider's L&I provider number 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 L&I 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 an initial plan on a claim with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers shouldn't 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 another provider.

When more than 1 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.

Split billing across multiple referrals

When a worker has 2 or more open time loss claims, the insurer may make a separate referral for each claim. In cases where the insurer makes 2 (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 2 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 8 units under each claim.
- A provider has 2 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 4 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 3 (or more) claims requiring time loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 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 1 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 L&I provider number (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:

- Tuition and fees (training, exams, licensing) (billing code **R0310**), *and*
- Books, equipment, supplies, other (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 may reimburse 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](#).



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 Pre-job accommodations on L&I's website
L&I's Claim and Account Center	Claim and Account Center
Quality assurance by vocational firms	Quality Assurance by Vocational Firms
Schools and training programs	Resources for Training Providers on L&I's website
Statement for Miscellaneous Services	F245-072-000 on L&I's website
Option 2 Vocational Services	WAC 296-19A-631, 633, 635, 637 Option 2 details on L&I's website Self-Insured Option 2 Vocational Services Summary 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?

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.