Washington State Department of
Labor & Industries
Workers' Compensation Services

General Provider Billing Manual

F245-432-000 (07-2021)

General Provider Billing Manual: Table of Contents

About Billing Instructions

Where can you find help with L&I billing procedures?

Labor & Industries (L&I) provides resources to help you understand and comply with the Industrial Insurance laws in the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC).

L&I publishes the Medical Aid Rules and Fee Schedule (MARFS) which has the payment policies and fee schedule. You can find MARFS online on the L&I Website.

In addition, L&I publishes a general billing manual. This manual includes the following information:

- Information about Industrial Insurance and Crime Victims.
- Electronic and paper billing information.
- How to complete the bill forms.
- Where to send bill forms.
- Billing examples.
- Links to billing forms.

About Labor & Industries (L&I) Industrial Insurance

As administrator of Washington State's workers' compensation system, L&I is similar to a large insurance company that provides claim-related coverage to workers who suffer job-related injuries and illnesses.

Two programs cover Washington's workers' compensation claimants: the Washington State Fund (SF) and the Self Insured Employer Program (SIE). Both programs are governed by the Revised Code of Washington (RCWs) and the Washington Administrative Code (WACs).

State Fund Industrial Insurance

The Washington State Fund is financed by premiums from employers, workers, and income from investments. L&I claim managers oversee State Fund benefits to workers who are injured or become ill on the job. The State Fund covers all employers in the state who are not self-insured or covered by the U.S. Department of Labor.

State Fund claim numbers begin with one letter (B, C, F, G, H, J, K, L, M, N, P, X, Y, or Z) followed by 6 numbers or two letters (AA, AB) followed by 5 numbers. Example state fund claim numbers include: B123456 or AM95370.

Additional information about billing State Fund can be found in this manual or online at the L&I website. You can also call the Provider Hotline at 800-848-0811 or send a secure email to PHL@Lni.wa.gov.

Self-Insured Employer Program

L&I regulates about 365 large, self-insured employers (SIE) who have qualified to provide their own workers' compensation insurance. Every SIE must authorize medical treatment and pay bills in

accordance with Title 51 RCW and the Medical Aid Rules and Fee Schedules of the State of Washington per WAC 296-15-330(1).

Self-Insured claim numbers all start with S, T, or W followed by 6 numbers or 2 letters followed by 5 numbers. Example self-insured claim numbers include T123456 or SG12345.

Billing Self-Insurers

You must submit your bills on L&I or self-insured approved forms (WAC 296-20-125(1)).

Mail your bills directly to the SIE or third-party administrators (TPA). For a list of SIE/TPAs and their contact information, please visit https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/.

Additional information about billing for self-insured claims can be found at https://lni.wa.gov/insurance/self-insurance/providers.

Getting Paid for Services Provided to Washington Workers

Every provider who treats workers' compensation claimants must have an active provider account with L&I to be eligible for payment (WAC 296-20-015). Please visit L&I's website for detailed information about becoming an L&I provider on the L&I website.

If you practice in Washington State and are one of the following provider types, you must be in our network to care for injured workers beyond the initial office or emergency-room visit. This includes treatment for workers of business covered by L&I as well as those employed by self-insured employers:

- Physician (MD & DO)
- Advanced Registered Nurse Practitioner
- Chiropractor
- Dentist
- Naturopathic Physician
- Optometrist
- Physician Assistant
- Podiatric Physician

State Fund Electronic Billing

L&I offers free electronic billing through Provider Express Billing (PEB). PEB saves time and money, allows for greater control over the billing process, eliminates entry time, and allows bills to process faster than paper billing. PEB reduces keying errors and decreases bill processing costs.

You can find detailed PEB information on our website at www.Lni.wa.gov/ElectronicBilling.
There are 3 ways to bill electronically for state fund claims:

1. Direct Entry through PEB using a free online form. Note: This does not include hospital/inpatient/outpatient bills.

2. Upload billing files using your own software. (Please contact electronic billing at EBULNI@LNI.wa.gov if you would like to be set up for file upload.)

3. Submit bills through a clearinghouse/intermediary.

Self-Insurance Electronic Billing

Please contact the employer or their third party administrator (TPA) for billing information.

State Fund Paper Billing

The type of service you provide determines which billing form you need to use. See a list of all bill requirements for each provider type in the General Provider Billing Manual – page 6.

You must submit your bill on an L&I approved form. **L&I does not accept faxed bills**, **and will only accept mailed bills**. Mail your bills to the address below:

Department of Labor & Industries
PO Box 44269
Olympia WA 98504-4269

Crime Victims Compensation Program

The Crime Victims Compensation Program is a secondary insurance program that provides financial, medical, and mental health benefits to victims of crimes.

Crime Victims claim numbers begin with the letter V, followed by 6 digits or a 2 letters, such as VA, followed by 5 digits.

Additional information about the Crime Victims Compensation Program can be found on the L&I website, or by calling the Crime Victims Compensation Program at 360-902-5377 or 800-762-3716.

Getting Paid for Services Provided to Crime Victims

You can find Crime Victims billing forms on the L&I website.

Please ***don't fax*** your bills to Crime Victims Compensation Program. Mail your bills to:

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

Split Billing – Treating Two Separate Conditions

If the worker is treated for two separate conditions at the same visit, the charge for the service must be divided equally between the payers.

If evaluation and treatment of the two injuries increases the "complexity" of the visit:

- A higher level Evaluation and Management (E/M) code might be billed, *and*

- If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed.

Separate chart notes and reports must be submitted when there are two different claims.

Note: The claims may be from injuries sustained while working for two different employers and the employers only have the right to information about injuries they are responsible for.

For State Fund claims, when submitting:

- **Paper bills** to L&I, list all workers' compensation claims treated in Box 11 and 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.

Note: L&I will divide the 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 and the SIE and the other payer based on the level of service provided during the visit, *and*

- In this case, separate chart notes for the accepted condition should be sent to the insurer.

Vocational Service Providers

How should a vocational service provider bill when rendering services to two or more State Fund claims?

The vocational service provider must submit separate bills for each claim number to which services were rendered. The units of service and provider fee must be appropriated between the claim numbers.

What billing form do I use?

The type of service you provide determines which billing form to use. Find your provider type below.

- **Practitioners** (including physicians, osteopathic physicians, radiologists, podiatrists, chiropractors, psychologists, physical therapists, Certified Registered Nurse Anesthetist, Resident Assistant, Advanced Registered Nurse Practitioner, Physician Assistant, occupational therapists, optometrists, opticians, laboratories, hospital ER/professional services, panel examiners, and naturopaths) must complete the nationally accepted **CMS 1500** form (F245-127-000).

- **Ambulatory Surgery Centers** must complete the nationally accepted **CMS 1500** form (F245-127-000).

- **Interpreters** must submit charges on the **Statement for Miscellaneous Services** form (F245-072-000).

- **Miscellaneous Services** (including dental services, durable medical equipment and supplies, dietitians, home health care, nursing homes, adult family homes, boarding homes, assisted living facilities, ambulance companies, placement agencies, audiology, prescribed drugs that do not have national drug codes, prosthetics/orthotics, transportation (such as cabulance, taxi, etc.) massage therapists, repair or replacement glasses, or vocational rehabilitation services) are submitted on the **Statement for Miscellaneous Services** form (F245-072-000).

- **Pharmacy** charges (which include prescription drugs or over the counter drugs that have national drug codes) are submitted on the **Statement for Pharmacy Services** form (F245-100-000). Medical equipment and supplies and over the counter drugs that do not have national drug codes must be billed on the Statement for Miscellaneous Services form (F245-072-000).
- **Compound Prescriptions** (a combination of two or more ingredients to make one prescription) must be submitted on the **Statement for Compound Prescription** form (F245-010-000).

- **Hospitals** must submit bills on the nationally recognized **UB04 HCFA 1450** form (F245-367-000).

- **Retraining and Job Modification Services** (including job modifications, pre-job accommodations, and retraining expenses) are submitted on the **Statement for Retraining and Job Modification Services** form (F245-030-000). Submit retraining travel for workers on the **Travel Reimbursement Request** form (F245-145-000).

- **Vocational Services**. Submit vocational rehabilitation charges on the **Statement for Miscellaneous Service** form (F245-072-000).

Medical Aid Rules and Fee Schedules

The files of an accident report or the rendering of treatment to a worker who comes under the department's or self-insurer's jurisdiction, constitutes acceptance of the department's medical aid rules and compliance with its rules and fees (WAC 296-20-020). Doctors outside of the State of Washington should refer to WAC 296-20-022, "Payment of out-of-state providers."

Payment policies, reimbursement amounts, and payment indicators are listed in the Medical Aid Rules and Fee Schedules online at www.Lni.wa.gov/FeeSchedules.

The Medical Aid Rules, WAC 296-20-010, states in part:

> (2) The fee schedules are intended to cover all services for accepted industrial insurance claims. All fees listed are the maximum fee allowable. Practitioners shall bill their usual and customary fee for services. **If a usual and customary fee for any particular service is lower to the general public than listed in the fee schedule, the practitioner shall bill the department or self-insurer at the lower rate.** The department or self-insurer will pay the lesser of the billed charge or the fee schedules' maximum allowable.
>
> (5) No fee is payable for missed appointments unless the appointment is for an examination arranged by the department or self-insurer.

(6) When a claim has been accepted by the department or self-insurer, no provider or his/her representative may bill the worker for the difference between the allowable fee and the usual and customary charge. Nor can the worker be charged a fee, either for interest or completion of forms, related to services rendered for the industrial injury or condition Refer to Chapter 51.04 RCW.

Reports and Documentation

The department or self-insurer requires documentation or report to approve treatment, pay benefits to the worker, and process the payment of bills. The documentation or reports provide information to adequately manage workers' compensation claims. See WAC 296-20-06101 for specifics. L&I requires that certain documentation or reports be provided within specific time frames. Failure to provide complete reports can significantly delay bill payment and delivery of benefits to your patients. Also see RCW 51.36.060 and WAC 296-20-01002.

Report Type	Due
Report of Accident (ROA)	Within 5 days of first visit (2 days for best practice)
Progress Report	Every 30 — 60 days (Monthly or every 12th visit for PT/OT visits)
Chart Note/Office Note	When service is billed
Supplement/Special Reports	Immediately upon request
Consultation Reports	Within 15 days of the consultation
IME Reports	Within 14 days of the IME or receipt of special test or study results
Extended Service Reports	When service is billed
Activity Prescription Form	With ROA/PIR and when worker restrictions change. See limits: www.Lni.wa.gov/ActivityRx

Put the worker's name and claim number on all pages of your reports.

How should providers document services?

For charting progress and ongoing care, use the standard **SOAP-ER** (Subjective, Objective, Assessment, Plan and progress, Employment issues, Restrictions to recovery) format. In workers' compensation, there is a unique need for work status information.

SOAP-ER Charting Format

Office/chart/progress notes and 60-day narrative reports should include the SOAP-ER contents:

S Worker's Subjective Complaints

What the worker states about the illness or injury. Refer to WAC 296-20-220 (j).

O Objective Findings

What is directly observed and noticeable by the medical provider. This includes factual information. For example: physical exam — skin is red and edematous; lab test — positive for opiates; X-rays — no fracture. Refer to WAC 296-20-220 (i).

A Assessment

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

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

The assessment 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 likelihood of recovery from a disease and/or injury.

P Plan and Progress

What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment, and the plan must state how long the treatment will be administered.

E Employment Issues

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

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?

Clearly state the treatment performed and the treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to claimants. Refer to WAC 296-20-010 (7) and WAC 296-20-01002 (Chart notes).

You may avoid unnecessary requests for claim information from vocational counselors and others by providing the information above in every chart note. If there have been no changes in employment or restrictions since your patient's last visit, state this in your chart notes, since this information may be critical for the vocational counselor to proceed with vocational services.

The 60-Day Report

If you are treating a worker for an extended period, you must mail or fax a report to the claim manager or SIE/TPA every 60 days (WAC 296-20-06101). Legible, comprehensive chart notes may be submitted in lieu of a 60-day narrative report *PROVIDED* the chart notes include all the information required. Be sure to identify the report as the "60-Day Report". In addition to the SOAP-ER information above, it should contain the following information:

1. The condition(s) diagnosed with ICD-10-CM codes.
2. The condition's relationship to the industrial injury/illness, if any.

3. The probability, if any, of permanent partial disability (PPD).
4. **If you feel the patient is not able to return to work, please explain why the worker is still disabled.**

Documentation to Support Billing

Providers must maintain documentation in workers' individual records to verify the level, type, and extent of services provided to workers.

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

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

The insurer may deny or reduce a provider's level of payment for:

- A specific visit or service if the required documentation isn't provided *and/or*
- The level of service doesn't match the procedure code billed.

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

Important Tips:

- Make chart notes legible.
- Submit chart notes for all visits, include substantiation for the level and type of service provided.
- Remember that chart notes are acceptable in lieu of requested narrative reports.
- Also see Submitting Bills & Reports at https://lni.wa.gov/patient-care/billing-payments/billing-li/.

For a complete list of items to include in chart notes and 60-Day Reports, see the Medical Aid Rules and Fee Schedules (www.Lni.wa.gov/FeeSchedules) under Charting Format section, and/or in WAC 296-20-01002 (Chart Notes).

Put the worker's name and claim number on all pages of your reports.

Where do I send reports and chart notes?

State Fund Claims:

Fax: 360-902-4567 (Please note claim number on each page – No cover sheet needed)

Mail to: Department of Labor & Industries
PO Box 44291
Olympia WA 98504-4291

Crime Victim Claims:

Fax: 360-902-5333 (Please note claim number on cover sheet and each page)

Mail to: Crime Victims Compensation Program
Department of Labor & Industries
PO Box 44520
Olympia WA 98504-4520

Self-Insured Claims:

Send self-insured reports and chart notes directly to the SIE/TPA.

For a list of SIE/TPAs and their contact information, go to: www.Lni.wa.gov/SelfInsured.

State Fund Remittance Advice Overview

The State Fund remittance advice provides a detailed report of all bill activity at two-week intervals. If you are due a payment per the remittance advice, you will also receive a warrant/direct deposit (payment).

Page one of the provider's remittance advice is the "Newsletter". The free form text relays information about the payment cycle, future warrants, billing instructions, rule changes, fee schedule changes, future workshops, etc. Please review this page carefully.

Page two of the remittance advice is a Legal Notice informing you of your right to request reconsideration or appeal any payment determination in the remittance advice and the maximum time you have for such an appeal/reconsideration.

Page(s) three through the last page inform the provider or worker which bills are being paid in the warrant, which bills are denied, and which bills are pending. At the very end of this section, it will list all explanation of benefit (EOB) codes used in the remittance.

After you have reviewed your remittance advice, if you disagree with the amount paid, please submit a "Provider's Request for Adjustment" form and reference the *original ICN and rendering provider number*.

Remittance Advice Detail

Page Header	**Detail**
Remittance Advice Number	Sequence number in this warrant register
Warrant Register Number	Number assigned to log all warrants for this payment cycle
Payee Provider Number	Provider's L&I payee account number
Payee Provider Name	Provider's L&I payee name
Column Heading	**Detail**
Service Provider Name	Rendering provider's name
Service Provider Number	Rendering provider's L&I provider account number and NPI
Claim Number	Injured worker's L&I claim number
Name	Injured worker's last name and initial of first name

Patient Account/Prescription Number	Account number or prescription number assigned by the provider or pharmacy to identify the injured worker, bill, or prescription
ICN	(Internal Control Number) Assigned by L&I to permanently identify this bill
Service Dates From	The date of service or the beginning date of a service period.
Service Dates To	The date of service or the ending date of a service period.
Unit of Service	The number days/visits/time units/miles.
PI – Price Indicator	Payment methodology (**I**npatient % of charge, **D**RG per case rate, DRG **P**er Diem)
REV	The Medical Aid Fee Schedule procedure code that was used to determine payment. NUBC (Inpatient and Outpatient).
Procedure	HCPCS Level 1, 2, or 3 (Outpatient)
M1, M2, M3, M4	Level 1, 2, 3, or 4 Modifier (Outpatient)
APC	Ambulatory Payment Classification (Outpatient)
DRG/MDC	Diagnosis Related Group/Major Diagnosis Category (Inpatient)
NDC	National Drug Classification
Column Heading	**Detail**
Billed Charges	Amount the provider billed
Allowed	The amount payable
Tax or Non-Covered Charges	The amount of sales tax or the amount of hospital charges not payable
EOB Codes (Explanation of Benefits)	The explanation of benefit reason code for the amount being paid or not paid. These codes can be applicable to the total bill or to specific line charges.
Summary	**Detail**
Paid Bills	The bills and types of bills being paid in this warrant in line-item detail
Denied Bills	The bill and types of bill forms that are being denied in this remittance

Bill in Process	The bills that have been received and keyed into MIPS, but have not cleared all adjudication edits in time for this payment cycle's cutoff date.
Adjustment Bills	To protest or make changes to the original processed bill
Credit Balance Bills (CRE)	The bills that are being held in abeyance until a credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. This is money owed to L&I.
Bill Returned	Resubmit original returned bill with the information requested.
Paid Bills – Gross Adjustment	The bills and types of bills being paid in this warrant in summary detail only.
Denied Bills – Gross Adjustment	The bills and types of bills being denied in this remittance in summary detail only.
Bills Paid MTD	The total number of bills paid this month to date.
Amount Paid MTD	The total dollar amount paid this month to date.
Amount Paid YTD	The total dollar amount paid this year to date.
Bills Denied/Returned MTD	The total number of bills denied and/or returned this month to date.
Bills Denied/Returned YTD	The total number of bills denied and/or returned this year to date.
EOB Explanation	The narrative explanation of the EOB codes appearing on this remittance advice.

STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO BOX 44322
OLYMPIA, WA 98504-4263

BLMC8000-R001
REPORT DATE: XX/XX/XXXX
PAGE 1
REMITTANCE ADVICE: 000000
WARRANT REGISTER: 00000
INVOICE DATE: XX/XX/XXXX
PAYEE NAME: XXXXXXXXXXXXXXX
PAYEE NUMBER: 0000000

THE PROVIDERS ADDRESS
INFORMATION WILL GO
IN THIS AREA OF THE COVER PAGE.

- NEWSLETTER UPDATE -
ELECTRONIC PDF VERSION OF PROVIDER'S REMITTANCE ADVICE.

BEGINNING MARCH 15, 2010 THE DEPARTMENT WILL MAKE AVAILABLE A COPY OF YOUR PAPER REMITTANCE ADVICE (RA) FOR DOWNLOAD AS A PDF FILE. THE PDF VERSION OF THE REMITTANCE ADVICE WILL BE AV AVAILABLE FOR 90 DAYS AFTER ITS CREATION DATE. AFTER 90 DAYS, THE PDF VERSION WILL BE ARCHIVED BUT MAY BE RESTORED FOR DOWNLOAD BY CONTACTING THE DEPARTMENT'S ELECTRONIC BILLING UNIT (EBU).

THE PDF VERSION OF THE REMITTANCE ADVICE IS AN EXACT COPY OF THE PAPER RA IN AN ELECTRONIC FORMAT AND IS IN ADDITION TO THE EDI 835 RA AND PROPRIETARY RA FILES AVAILABLE TO PROVIDERS ON REQUEST.

ALL ELECTRONIC VERSIONS OF THE REMITTANCE ADVICE CAN BE ACCESSED USING THE DEPARTMENT'S PROVIDER EXPRESS BILLING (PEB) WEBSITE.

IF YOU ARE NOT A CURRENT USER OF PEB, YOU WILL NEED TO REGISTER WITH PEB TO HAVE ACCESS TO THE PDF VERSION OF THE REMITTANCE ADVICE. TO REGISTER, DO THE FOLLOWING:

GO TO SECUREACCESS WASHINGTON (SAW) HTTP://SECUREACCESS.WA.GOV/ AND REGISTER BY CREATING AN ACCOUNT. ONCE REGISTERED WITH SAW, LOGIN TO YOUR SAW ACCOUNT AND DO THE FOLLOWING: ADD SERVICES. SELECT AGENCY-DEPT OF LABOR AND INDUSTRIES. SELECT APPLY FOR PROVIDER EXPRESS BILLING. SELECT I AM A FIRST TIME VISITOR AND CONTINUE. ENTER YOUR CONTACT INFO AND CONTINUE. READ/ACCEPT ACCESS AGREEMENT AND CONTINUE. SELECT RELATIONSHIP OF PEB PROVIDER. ENTER YOUR PROVIDER ACCOUNT NUMBER FOR REQUEST ACCESS BY PROVIDER ID. READ/ACCEPT ACCESS MANAGER ROLE FOR YOUR ORGANIZATION. AN ACCESS ACTIVATION CODE WILL BE GENERATED. CONTACT THE EBU AT 360-902-6511 OR EBULIN@LNI.WA.GOV FOR YOUR ACTIVATION CODE OR IF YOU NEED ASSISTANCE.

******* REMITTANCE ADVICE LEGAL NOTICE *******

INITIAL PAYMENTS OR ADJUSTMENTS RESULTING IN INCREASED PAYMENTS MADE ON THIS REMITTANCE ADVICE WILL BECOME FINAL SIXTY (60) DAYS AFTER RECEIPT UNLESS: 1) A WRITTEN REQUEST FOR RECONSIDERATION IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 3) AN APPEAL IS FILED WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA, WITHIN THAT TIME.

ADJUSTMENTS MADE TO PREVIOUS PAYMENTS ON THIS REMITTANCE ADVICE RESULTING IN DECREASED PAYMENTS WILL BECOME FINAL TWENTY (20) DAYS AFTER RECEIPT UNLESS: 1) A WRITTEN REQUEST FOR RECONSIDERATION IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 3) AN APPEAL IS FILED WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA, WITHIN THAT TIME.

ADJUSTMENT AND/OR RECONSIDERATION REQUESTS MUST BE SENT TO THE DEPARTMENT OF LABOR AND INDUSTRIES, PO BOX 44291, OLYMPIA, WA 98504-4291

APPEALS MUST BE SENT TO THE BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, OLYMPIA, WA 98504-2401 OR SUBMITTED ON AN ELECTRONIC FORM FOUND AT HTTP://WWW.BIIA.WA.GOV/.

Medical Information and Payment System
Remittance Advice Detail

PAYEE NUMBER: 0000000 NPI 0000000000
PAYEE NAME:xxxxxxxxxxx

INSTRUCTIONS:
1: FOR INFORMATION ON BILLS IN PROCESS: CALL 1-800-831-5227 2: FOR INFORMATION ON FINALIZED BILLS: CALL 1-800-848-0811

CLAIM NUMBER	NAME	I	SERVICE DATES FROM	TO	UNIT OF SERVICE	P I	REV DRG/MDC	PROC NDC	M1	M2	M3	M4	APC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES
SERVICE PROVIDER NAME	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX																	
SERVICE PROVIDER NUMBER	XXXXXXX **NPI** XXXXXXXXXX																	
BILLS-IN-PROCESS – INPATIENT BILL																		
AA11111 XXXXXXXXXX		X	000000	000000		D	000/00							0000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898	**ICN-** 99999999999999999 *****BILL TOTAL . . .**													0000.00	0.00	0.00	0.00	559
AA11111 XXXXXXXXXX		X	000000	000000		D	000/00							00000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898	**ICN-** 99999999999999999 *****BILL TOTAL . . .**													00000.00	0.00	0.00	0.00	559
****BILLS PENDING TOTALS – INPATIENT BILL**	*****NUMBER OF BILLS-** 2													00000.00	0.00	0.00	0.00	
DENIED BILLS – OUTPATIENT BILLS																		
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PAT ACCT/RX NUM- TEST SR 2500-209898	**ICN-** 99999999999999999 *****BILL TOTAL . . .**													000.00	0.00	0.00	0.00	280
****DENIED BILL TOTALS – OUTPATIENT BILL**	*****NUMBER OF BILLS-** 1													000.00	0.00	0.00	0.00	
BILLS-IN-PROCESS – OUTPATIENT BILL																		
AA11111 XXXXXXXXXX		X	000000	000000	1	D	0000	11111						000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898	**ICN-** 99999999999999999 *****BILL TOTAL . . .**													000.00	0.00	0.00	0.00	H16
AA11111 XXXXXXXXXX		X	000000	000000	20		0000	11111						000.00	0.00	0.00	0.00	
			000000	000000	1		0000	22222					00617	000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898	**ICN-** 99999999999999999 *****BILL TOTAL . . .**													000.00	0.00	0.00	0.00	559
****BILLS PENDING TOTALS – OUTPATIENT BILL**	*****NUMBER OF BILLS-** 2													00000.00	0.00	0.00	0.00	
****TOTAL FOR SERVICE PROVIDER NUMBER XXXXXXX NPI XXXXXXXXXX**														**XXXXXXX.XX**	**XXXXX.XX**	**XXXXXX.XX**	**XXXXXX.XX**	
SERVICE PROVIDER NAME	**XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX**																	
SERVICE PROVIDER NUMBER	**XXXXXXX NPI XXXXXXXXXX**																	
BILLS-IN-PROCESS – OUTPATIENT BILL																		

PAYMENTS AND PAYMENT DENIALS RECEIVED HERE BECOME FINAL IN SIXTY DAYS, OR , PROVIDER REPAYMENTS ORDERED HERE BECOME FINAL IN TWENTY DAYS, UNLESS: (1) YOU FILE A WRITTEN REQUEST FOR RECONSIDERATION WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR (2) YOU FILE AN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA WITHIN THAT TIME.

INSTRUCTIONS:
1: FOR INFORMATION ON BILLS IN PROCESS: CALL 1-800-831-5227 2: FOR INFORMATION ON FINALIZED BILLS: CALL 1-800-848-0811

CLAIM NUMBER / NAME	I	SERVICE DATES FROM	TO	UNIT OF SERVICE	P I	REV DRG/MDC	PROC NDC	M1	M2	M3	M4	APC	BILLED CHARGES	TAX OR NON-COVD ALLOWED	NON-COVD CHARGES	PAYABLE	EOB CODES
SERVICE PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX																	
SERVICE PROVIDER NUMBER XXXXXXX **NPI** XXXXXXXXXX																	
BILLS-IN-PROCESS – INPATIENT BILL																	
AA11111 XXXXXXXXXX	X	000000	000000		D	000/00							0000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898 **ICN-** 99999999999999999 *****BILL TOTAL . . .**													0000.00	0.00	0.00	0.00	559
AA11111 XXXXXXXXXX	X	000000	000000		D	000/00							00000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898 **ICN-** 99999999999999999 *****BILL TOTAL . . .**													00000.00	0.00	0.00	0.00	559
****BILLS PENDING TOTALS – INPATIENT BILL ***NUMBER OF BILLS-** 2													00000.00	0.00	0.00	0.00	
DENIED BILLS – OUTPATIENT BILLS																	
AA11111 XXXXXXXXXX	X	000000	000000	1	D	0000	11111						000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898 **ICN-** 99999999999999999 *****BILL TOTAL . . .**													000.00	0.00	0.00	0.00	280
****DENIED BILL TOTALS – OUTPATIENT BILL ***NUMBER OF BILLS-** 1													000.00	0.00	0.00	0.00	
BILLS-IN-PROCESS – OUTPATIENT BILL																	
AA11111 XXXXXXXXXX	X	000000	000000	1	D	0000	11111						000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898 **ICN-** 99999999999999999 *****BILL TOTAL . . .**													000.00	0.00	0.00	0.00	H16
AA11111 XXXXXXXXXX	X	000000	000000	20		0000	11111						000.00	0.00	0.00	0.00	
		000000	000000	1		0000	22222					00617	000.00	0.00	0.00	0.00	
PAT ACCT/RX NUM- TEST SR 2500-209898 **ICN-** 99999999999999999 *****BILL TOTAL . . .**													000.00	0.00	0.00	0.00	559
****BILLS PENDING TOTALS – OUTPATIENT BILL ***NUMBER OF BILLS-** 2													00000.00	0.00	0.00	0.00	
****TOTAL FOR SERVICE PROVIDER NUMBER XXXXXXX NPI XXXXXXXXXX**													**XXXXXXX.XX**	**XXXXX.XX**	**XXXXXX.XX**	**XXXXXX.XX**	
SERVICE PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX																	
SERVICE PROVIDER NUMBER XXXXXXX NPI XXXXXXXXXX																	

INSTRUCTIONS:
1: FOR INFORMATION ON BILLS IN PROCESS: CALL 1-800-831-5227 2: FOR INFORMATION ON FINALIZED BILLS: CALL 1-800-848-0811

CLAIM NUMBER	NAME	I	FROM	TO	SERVICE	I	DRG/MDC	NDC	M1	M2	M3	M4	APC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES

BILLS SUMMARY FOR ALL SERVICE PROVIDERS

**PAID BILL TOTALS – XXXXXXXXXXX	***NUMBER OF BILLS-	333	55555.00	55555.00	0.00	55555.00
**DENIED BILL TOTALS – OUTPATIENT BILL	***NUMBER OF BILLS-	333	55555.00	0.00	0.00	0.00
**BILLS PENDING TOTALS – INPATIENT BILL	***NUMBER OF BILLS-	333	55555.00	0.00	0.00	0.00
**RETURNED BILL TOTALS – XXXXXXXXXXX	***NUMBER OF BILLS-	333	55555.00	0.00	0.00	0.00
**BILLS PENDING TOTALS – OUTPATIENT BILL	***NUMBER OF BILLS-	333	55555.00	0.00	0.00	0.00

TOTAL WARRANT AMOUNT 55555.00

*** BILLS PAID MTD 000 *** AMOUNT PAID MTD 00,000.00 *** BILLS PAID YTD 000 ** AMOUNT PAID YTD 00,000.00
*** BILLS DENIED MTD 00 *** BILLS DENIED YTD 00

**********THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE: **********

280 DENIED. CLAIM ID BILLED IS NOT ACTIVE. CALL 1-800-831-5227 TO CONFIRM THE ID BEFORE REBILLING.

559 ACTIONS IS BEING TAKEN. DO NOT SEND REBILL, ADJUSTMENT OR APPEAL UNTIL YOU RECEIVE NOTICE OF PAYMENT DECISION. AFTER 60 DAYS CALL L&I 800-848-0811.

H16 SUSPENDED. CLAIM NUMBER IS MISSING OR INVALID ON BILL. CALL 1-800-831-5227 TO CONFIRM CLAIM NUMBER BEFORE REBILLING.

SEE PAGE 2 FOR MORE DETAILS.

Glossary

Abeyance
The condition of being temporarily put on hold. An order placing a previous order on hold pending the receipt of further information and issuance of another order.

Bundled
When a bundled service is covered, payment for that item or service is incorporated into the payment for the codes or services to which they are incidental. (For example, when a surgery is performed, a surgical tray is bundled. This service is not separately payable because it is included in the payment for other services.) Bundled codes and services are identified in the fee schedule.

Concurrent Care
In some cases, treatment by more than one practitioner may be allowed. The department or self-insurer will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system and/or require specialty or multi-disciplinary care.

Doctor
A person licensed to practice one or more of the following professions: medicine and surgery, osteopathic medicine and surgery, chiropractic, drugless therapeutics, podiatry, dentistry, optometry.

Fee Schedule A list of the maximum amounts Labor and Industries or a self-insured employer pays providers for authorized medical services and equipment. (WAC 296-20-020)

Fixed and Stable
The point reached when a condition is unlikely to be significantly improved by further medical treatment and the worker has reached a stable plateau from which further recovery is not reasonably expected.

Light Duty
Temporary or permanent work that is less vigorous or less physically taxing than that which the worker performed before the industrial injury or illness.

Medical Aid Rules
Rules explaining what providers must do to comply with industrial insurance laws and the level of reimbursement allowed for medical services.

Medically Necessary
Those health services are medically necessary which, in the opinion of the director or his or her designee, are:

(a) Proper and necessary for the diagnosis and curative or rehabilitative treatment of an accepted condition; and (b) Reflective of accepted standards of good practice within the scope of the provider's license or certification; and (c) Not delivered primarily for the convenience of the claimant, the claimant's attendant, doctor, or any other provider; and (d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered medically necessary. Services which are controversial, obsolete, experimental, or investigational are presumed not to be medically necessary, and shall be authorized only as provided in WAC 296-20-03002 (6).

Parameter
Different limits for different services, see fee schedule.

Protest
First level of assertion of a position disagreeing with a claim action.

Protest of claim decisions or protest of a department decision by either employer or employee should, be made by letter as promptly as possible, within 60 days, including specific reasons for the disagreement. A protest may result in a decision being either changed or affirmed. If a decision is affirmed, the protesting party may appeal in writing to the Board of Industrial Insurance Appeals, PO Box 42401, Olympia, WA 98504-2401, or submit on electronic form via the BIIA website http://www.biia.wa.gov/h.

Provider
Any authorized vendor whose services are provided to a worker and are payable by the department. Providers range from physicians to hospitals to taxi cab companies and more.

Rejected Claim
A claim which either does not meet the criteria for a valid claim or is a duplicate of a previously filed claim.

Revised Code of Washington (RCW)
Laws adopted by the legislature to govern the conduct of employers, employees, state agencies, etc. Changing an RCW requires the passage of a bill through the House and Senate. Those statutes covering industrial insurance (workers' compensation) laws fall under title 51.

Unit of Service
The sum total of services provided for day, unit, etc.

Washington Administrative Codes (WACs)
Department regulations, authorized by statute and holding the force of law, adopted to support the RCWs. WAC rules must go through a public hearing process before they are approved.

RCW References

RCW 51.36.080
Payment of fees and medical charges by department –
Interest –
Cost-effective payment methods -- Audits.

(1) All fees and medical charges under this title shall conform to the fee schedule established by the director and shall be paid within sixty days of receipt by the department of a proper billing in the form prescribed by department rule or sixty days after the claim is allowed by final order or judgment, if an otherwise proper billing is received by the department prior to final adjudication of claim allowance. The department shall pay interest at the rate of one percent per month, but at least one dollar per month, whenever the payment period exceeds the applicable sixty-day period on all proper fees and medical charges.

Beginning in fiscal year 1987, interest payments under this subsection may be paid only from funds appropriated to the department for administrative purposes.

Nothing in this section may be construed to require the payment of interest on any billing, fee, or charge if the industrial insurance claim on which the billing, fee, or charge is predicated is ultimately rejected or the billing, fee, or charge is otherwise not allowable.

In establishing fees for medical and other health care services, the director shall consider the director's duty to purchase health care in a prudent, cost-effective manner without unduly restricting access to necessary care by persons entitled to the care. With respect to workers admitted as hospital inpatients on or after July 1, 1987, the director shall pay for inpatient hospital services on the basis of diagnosis-related groups, contracting for services, or other prudent, cost-effective payment method, which the director shall establish by rules adopted in accordance with chapter 34.05 RCW.

(2) The director may establish procedures for selectively or randomly auditing the accuracy of fees and medical billings submitted to the department under this title. [1998 c 245 § 104; 1993 c 159 § 2; 1987 c 470 § 1; 1985 c 368 § 2; 1985 c 338 § 1; 1971 ex.s. c 289 § 55.]

NOTES:
Effective date -- 1987 c 470 § 1: "Section 1 of this act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect on July 1, 1987." [1987 c 470 § 4.]
Effective date -- 1985 c 368 § 2: "Section 2 of this act shall take effect July 1, 1987." [1985 c 368 § 7.]

Legislative findings – 1985 c 368:
"The legislature finds that:
(1) The governor's steering committee on the six-year state health care purchasing plan has estimated that health care expenditures by the department of labor and industries will rise from $172.5 million in fiscal year 1985 to $581.5 million in fiscal year 1991, an increase of two hundred thirty-seven percent in six years, while the number of persons receiving the care will rise only fifteen percent in the same period;

(2) The growing cost of health care for covered workers is a major cause of recent industrial insurance premium increases, adversely affecting both employers and employees;

(3) The department of labor and industries has not developed adequate means of controlling the costs of health care services to which covered workers are entitled by law;

(4) There is a need for all agencies of the state to act as
prudent buyers in purchasing health care." [1985 c 368 § 1.]
Effective dates – Severability -- 1971 ex.s. c 289: See **RCW 51.98.060 and 51.98.070**.

RCW 51.04.060
No evasion of benefits or burdens.

No employer or worker shall exempt himself or herself from the burden or waive the benefits of this title by any contract, agreement, rule or regulation, and any such contract, agreement, rule or regulation shall be pro tanto void.
[1977 ex.s. c 350 § 3; 1961 c 23 § 51.04.060. Prior: 1911 c 74 § 11; RRS § 7685.]

RCW 51.48.025
Retaliation by employer prohibited -- Investigation -- Remedies.

(1) No employer may discharge or in any manner discriminate against any employee because such employee has filed or communicated to the employer an intent to file a claim for compensation or exercises any rights provided under this title. However, nothing in this section prevents an employer from taking any action against a worker for other reasons including, but not limited to, the worker's failure to observe health or safety standards adopted by the employer, or the frequency or nature of the worker's job-related accidents.

(2) Any employee who believes that he or she has been discharged or otherwise discriminated against by an employer in violation of this section may file a complaint with the director alleging discrimination within ninety days of the date of the alleged violation. Upon receipt of such complaint, the director shall cause an investigation to be made as the director deems appropriate. Within ninety days of the receipt of a complaint filed under this section, the director shall notify the complainant of his or her determination. If upon such investigation, it is determined that this section has been violated, the director shall bring an action in the superior court of the county in which the violation is alleged to have occurred.

(3) If the director determines that this section has not been violated, the employee may institute the action on his or her own behalf.

(4) In any action brought under this section, the superior court shall have jurisdiction, for cause shown, to restrain violations of subsection (1) of this section and to order all appropriate relief including rehiring or reinstatement of the employee with back pay.
[1985 c 347 § 8.]

RCW 51.48.060
Physician or licensed advanced registered nurse practitioner **-- Failure to report or comply.**

Any physician or licensed advanced registered nurse practitioner who fails, neglects or refuses to file a report with the director, as required by this title, within five days of the date of treatment, showing the condition of the injured worker at the time of treatment, a description of the treatment given, and an estimate of the probable duration of the injury, or who fails or refuses to render all necessary

assistance to the injured worker, as required by this title, shall be subject to a civil penalty determined by the director but not to exceed two hundred fifty dollars.
[2004 c 65 § 14; 1985 c 347 § 6; 1977 ex.s. c 350 § 71; 1971 ex.s. c 289 § 20; 1961 c 23 § 51.48.060. Prior: 1927 c 310 § 6(e), part; 1921 c 182 § 7, part; 1911 c 74 § 12, part; RRS § 7686(e), part.]

NOTES:
Report to legislature -- Effective date -- Severability -- 2004 c 65:
See notes following RCW 51.04.030.
Effective dates -- Severability -- 1971 ex.s. c 289: See **RCW 51.98.060** and 51.98.070.

Directory

Field Service Offices

You may find a list of locations and contact information for L&I's many field offices online at www.Lni.wa.gov/Offices.

State Fund Mailing Addresses

Send Report of Industrial Injury or Occupational Disease by fax to 360-902-6690 or 1-800-941-2976, or mail to the following address:

Department of Labor & Industries
PO Box 44299
Olympia WA 98504-4299

Send correspondence for a State Fund claim by fax to 360-902-4567, or mail to the following address:

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

See page 8 for information on submitting bills.

Additional information on submitting bills, reports, and forms can be found at:
https://lni.wa.gov/patient-care/billing-payments/billing-li/

Self-Insurance Website:

https://lni.wa.gov/insurance/self-insurance/providers

Crime Victims Provider Resources:

Crime Victims Compensation Program

Telephone Numbers

For **provider account number** information	360-902-5140

For Automated Claim Information	800-831-5227
(Call for claim #'s, status info., diagnosis codes, procedure codes, drug restrictions, workers, providers & employers) For most claim and billing questions, your first stop should be the Automated Claim Information Message System. Use your provider account number and a touch-tone telephone to access information on the status of State Fund claims, allowed/denied diagnosis and procedure codes, current bill status and the name of claim managers and their phone numbers. The Automated Claim information line is available weekdays between 6 a.m. and 7 p.m.	

For **Provider Hotline**	800-848-0811 PHL@Lni.wa.gov
(Call for billing or remittance advice problems, authorization other than inpatient, and verify diagnosis/procedure codes). Medical treatment adjudicators staffing the Provider Hotline can answer your questions on bill payment or denials, provider bulletins and updates, the Medical Aid Rules and Fee Schedule, and applicable sections of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW). The Provider Hotline operates from 8 a.m. to 5 p.m. weekdays. When utilization review is not required, Provider Hotline staff may authorize radiology services and diagnostic testing such as arthrograms, myelograms, bone scans, CT scans, EMGs and NCVs. Hotline staff may also assist you in authorizing medical services such as outpatient, non-selected surgeries; consultations; orthotics; prosthetics; durable medical equipment; hearing aid services; physical therapy; and massage therapy. See next page for Provider Hotline tips.	

For **inpatient or select outpatient authorizations**	800-541-2894
Requests for review of inpatient procedures and targeted outpatient procedures as outlined at www.Lni.wa.gov/ClaimsIns/Providers/AuthRef/UtilReview/default.asp should be initiated through our UR contractor, Comagine. Fax: 1-877-665-0383	

For **Electronic Billing Unit**	360-902-6511

For questions regarding **Self-Insurance Claims**	360-902-6901

For **workers' concerns or questions, direct them to**	800-LISTENS 800-547-8367
Questions from workers should be directed to the Automated Claim Information Line (formerly IVR line) at 1-800-831-5227, the Office of Information and Assistance (OIA) at this line, or the worker's claim manager.	

For questions regarding **Crime Victims Claims**	800-762-3716
Questions about crime victims claims should be directed to the Crime Victims Compensation program at Labor & Industries.	

For **Federal Claims** please visit www.dol.gov/owcp/index.htm or call	866-692-7487 206-470-3100
Questions about federal claims should be directed to the U.S. Department of Labor.	

Tips for Top Service from the Provider Hotline (800-848-0811 or PHL@Lni.wa.gov)

- If you are calling for authorization, please be ready with your provider number, the claim number, procedure codes, dates of service, referring physician, and basis for the request.

- Remittance advices are viewable for one year after the date of issue on our Provider Express Billing Portal. For remittance older than one year, please contact the Electronic Billing email at EBULNI@Lni.wa.gov.

- If you are calling about a specific bill, the remittance advice information and total bill charge will help us locate the bill more quickly. Please refer to your "Remittance Advice" or call the Automated Claim Information line for information on bills submitted within the last 60 days. Remember that L&I is unable to process bills with dates of service more than a year old, unless timely filing is proven.

- Any corrections to your remittance advice need to be brought to L&I's attention within 60 days after you receive it or the payment becomes final and binding. The remittance advice outlines your protest rights.

- Provider Hotline staff request that you limit your inquiries to *five or fewer claims* to allow other callers access to the available staff.