Washington State Department of Labor & Industries
Workers' Compensation Services

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

Chapter 11: Home Health Services

Effective July 1, 2019

Link: Look for possible **updates and corrections** to these payment policies at www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2019/

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Definitions

- **Attendant care home health services:** Attendant services support personal care or assist with activities of daily living of a medically stable worker with physical or cognitive impairments. Attendant care home health is provided in the workers' home.

- **Bundled:** A bundled procedure code isn't payable separately because its value is accounted for and included in the payment for other services. Bundled codes are identified in the fee schedules.

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

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

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

- **Chore services:** Housecleaning, laundry, shopping, meal planning and preparation, transportation of the injured worker, errands for the injured worker, recreational activities, yard work, and child care.

Note: Chore services aren't a covered benefit. See:
WAC 296-23-246: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-246

- **Home health services:** Multidisciplinary (PT, OT, speech, nursing, aide) interventions for short-term rehabilitative therapy, nursing supervision, home safety, equipment and physical assessments.

- **Home infusion services:** Services to provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home, along with nursing services. Home infusion services can be authorized independently or in conjunction with home health services.

- **Personal care:** May include, but isn't limited to administration of medication, bathing, personal hygiene and skin care, bowel and bladder incontinence, feeding assistance, mobility assistance, turning and positioning, transfers or walking, supervision due to cognitive impairment, behavior, or blindness, range of motion exercises, or ostomy care.

Payment policy: Home health services

Links: For additional information on home health services, see WAC 296-20-03001(8) and WAC 296-23-246.

When services become proper and necessary to treat a worker's accepted condition, the insurer will pay for aide, RN/LPN, physical therapy (PT), occupational therapy (OT), and speech therapy services provided by a licensed home health agency.

Most home health services are interventions to improve function and safety between hospital care and outpatient care and therapy. These services aren't intended for attendant care delivered in the home. The expectation of home health services is to enable the worker to receive outpatient, rehabilitative or medical services.

Home health therapies can be approved for the following types of needs:

- Post injury or post-surgical activity restrictions, restrictions on the ability to use 2 or more extremities, bilateral non-weight bearing restriction, or post-operative infection requiring IV antibiotics;
- Inability to ambulate or inability to maneuver a wheelchair;
- Inability to transfer in or out of a vehicle with or without assistance;
- Inability to safely negotiate ingress or egress of residence;
- Unable to sit (supported or unsupported) or alternate between sitting and standing for up to 2 hours;
- Inability to bathe or dress themselves if they live alone.
- No available transportation service exists due to rural setting; or
- No outpatient facilities are available to provide medically necessary care.

Prior authorization

All home health services require prior authorization.

The insurer will determine maximum hours and type of authorized home health care based on a nursing assessment of the worker's personal care needs that are proper and necessary and related to the worker's industrial injury.

All home health services must be requested by a physician. The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

Home health services may be terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

Home health agency requirements

Home Health Agencies: Home health agencies provide skilled nursing and therapy related services. They must be licensed as a home health agency.

Services for which home health agencies may bill include:

- Nursing
- Home health aide
- Physical therapy
- Occupational therapy
- Speech therapy

Home health care provider requirements

Aide, RN, LPN, physical therapy (PT), occupational therapy (OT), and speech therapy (ST).

Requirements for billing

Services that can be billed

HCPCS code	Description and notes	Max fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day	**$40.52**
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day	**$42.02**
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day	**$42.02**
G0159	Plan of care established by Physical Therapist in the home, 15 min units	**$42.02**
G0160	Plan of care established by Occupational Therapist in the home, 15 min units	**$42.02**
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units	**$42.02**
G0299	Services of skilled nurse RN in the home. 15 min units	**$42.02**
G0300	Services of skilled nurse LPN in the home. 15 min units	**$38.47**
8970H	Home Health Aide Service up to 2 hours	**$60.40**
8971H	Home Health Aide Services each additional 15 minutes	**$7.55**

Payment limits

- Home Health Aide Service codes 8970H and 8971H can only be billed when there is RN oversight.
- Base Rate Code 8970H is billable once per day and covers up to 2 hours.
- Add-on Code 8971H is only billable with Base Rate Code 8970H. Each unit of 8971H equals 15 minutes. Up to 8 units per day are billable.
- For 8970H and 8971H the insurer follows the timed code policies established by CMS in section 20.2 (reporting of service units with HCPCS), chapter 5 of the Medicare Claims Processing Manual (Internet-Only Manual 100-04).

Documentation

The following documentation is required to be submitted by the home health care provider within 15 days of beginning the services:

- Attending provider's treatment plan and/or orders by the attending provider,
- An initial evaluation by the RN or PT/OT (bill using G0159, G0160, and G0162 see table above), *and*
- A treatment plan.

Updated plans must be submitted every 30 days thereafter for authorization periods greater than 30 days.

Providers must submit documentation to the insurer to support each day billed that includes:

- Begin and end time of each caregiver's shift,
- Name, initials, and title of each caregiver, *and*
- Specific care provided and who provided the care.

Authorization for continued treatment requires:

- Documentation of the worker's needs and progress, *and*
- Renewed authorization at the end of an approved treatment period.

Durable medical equipment (DME)

Durable medical equipment may require specific authorization prior to purchase or rental.

Link: To see which codes require prior authorization, see the HCPCS fee schedule at http://www.lni.wa.gov/apps/FeeSchedules/

Codes that require prior authorization are noted with a **Y** in the "PRIOR AUTH" column.

Note: See definition of **Bundled** in Definitions at the beginning of this chapter.

Worker responsibilities

The worker is expected to be present and ready for scheduled home health nurse or therapist treatment. The insurer may terminate services if the work is not present, refuses treatment or assessment.

Payment policy: Attendant care home health services

Attendant services support personal care or assist with activities of daily living of a medically stable worker with physical or cognitive impairments. Attendant care home health is provided in the workers' home.

Prior authorization

- All attendant care services require prior authorization.
- The insurer will determine maximum hours and type of authorized attendant care based on a nursing assessment of the worker's personal care needs.
- Services must be proper and necessary and related to the worker's industrial injury or covered under a department medical treatment order.

Note: For a definition of **personal care**, see Definitions at the beginning of this chapter.

Attendant care services may be **terminated or not authorized** if:

- Behavior of worker or others at the place of residence is threatening or abusive,
- Worker is engaged in criminal or illegal activities,
- Worker doesn't have the cognitive ability to direct the care provided by the attendant and there isn't an adult family member or guardian available to supervise the attendant,

- Residence is unsafe or unsanitary and places the attendant or worker at risk, *or*
- Worker is left unattended during approved service hours by the approved provider.

The insurer will notify the provider in writing when current approved hours are modified or changed.

Attendant care agency requirements

Attendant care services may be provided by a *home health licensed* agency or a *home care licensed* agency. The agency providing services must be able to provide the type of care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

Attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services.

The agency can bill workers for hours that aren't approved by the insurer if the worker is notified in advance that they are responsible for payment.

Home Health Agencies

Home health agencies provide skilled nursing and therapy related services. Home health agencies must have registered nurse (RN) supervision of caregivers providing care to a worker.

Examples of services include:

- Nursing
- Home health aide

Home Care Agencies

Home care agencies provide non-medical services to people with functional limitations.

Examples of non-medical services include:

- Activities of daily living, such as assistance with ambulation, transferring, bathing, dressing, eating, toileting, and personal hygiene to facilitate self-care.

Attendant care provider requirements

Caregivers and services provided are dependent on the type of agency license providing the services and the needs of the worker.

Payment limits

- Reimbursement for attendant care services includes supervision and training and is not billed separately(This does not include nurse delegation).
- Attendant care providers can't bill for services the attendant performs in the home while the worker is away from the home.
- The insurer won't pay services for more than 12 hours per day for any one caregiver, unless specifically authorized.
- The insurer won't pay for care during the time the caregiver is sleeping.

Requirements for billing

Services that can be billed

HCPCS code	Description	Max fee
S9122	Attendant in the home provided by a home health aide certified or certified nurse assistant per hour	**$28.25**
S9123	Attendant in the home provided by a registered nurse per hour	**$61.44**
S9124	Attendant in the home provided by licensed practical nurse per hour	**$44.83**

Link: To see which codes require prior authorization, see the HCPCS fee schedule at http://www.lni.wa.gov/apps/FeeSchedules/

Documentation

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift,
- Printed name of caregiver, initials, signature and title of each caregiver, and
- Specific care provided and who provided the care.

Special considerations

Chore services

Chore services and other services that are only needed to meet the worker's environmental needs aren't covered.

Note: Chore services aren't a covered benefit, see WAC 296-23-246**.** See definition of **Chore services** in Definitions at the beginning of this chapter.

Attendant care services in hospitals or nursing facilities

Attendant care services won't be covered when a worker is in the hospital or a nursing facility **unless**:

- The worker's industrial injury causes a special need that the hospital or nursing facility can't provide, *and*
- Attendant care is authorized specifically to be provided in the hospital or nursing facility.

Independent nurse evaluation reports

All RN evaluation reports must be submitted to the insurer:

- Within 15 days of the initial evaluation, *and then*
- Annually, *or*
- When requested, *or*
- When the worker's condition changes and necessitates a new evaluation.
- If a current nursing assessment is unavailable, a nursing evaluation will be conducted to determine the level of care and the maximum hours of personal care needs the worker requires.

An independent nurse evaluation requested by the insurer, may be billed under Nurse Case Manager or Home Health Agency RN codes, using their respective codes. (See more information about these reports under Requirements for billing, below.)

Wound care

When attendant care agencies are providing care to a worker with an infectious wound, prior authorization and prescription from the treating physician are required.

In addition to prior authorization, when caregivers are providing wound care a prescription from the treating provider is required to bill for infection control supplies (HCPCS code **S8301**).

An invoice for the supplies must be submitted with the bill.

Note: See legal definition of **Bundled** in Definitions at the beginning of this chapter.

Worker travel

Workers who qualify for attendant care and are planning a long-distance trip must inform the insurer of their plans and request specific authorization for coverage during the trip.

The insurer won't cover travel expenses of the attendant or authorize additional care hours.

Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

The worker must coordinate the trip with the appropriate attendant care agencies.

Temporary or respite care

If in-home attendant care can't be provided by an agency, the insurer can approve a temporary stay in a residential care facility or skilled nursing facility.

Temporary or respite care requires prior authorization. The agency providing respite care must meet L&I criteria as a provider of home health services.

The insurer can approve services for a spouse or family member who provides either paid or unpaid attendant care when respite (relief) is required.

Note: Spouses won't be paid for respite care.

Spouse attendant care

Spouses may continue to bill for spouse attendant care if they:

- Aren't employed by an agency, *and*
- Provided insurer approved attendant services to the worker prior to October 1, 2001, *and*
- Met criteria in the year 2002.

Link: For more information on laws about spouse attendant care, see WAC 296-23-246.

Spouse attendants may bill up to 70 hours per week. Also:

- Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation, which must be performed yearly, and
- If the worker requires more than 70 hours per week of attendant care the insurer can approve a qualified agency to provide the additional hours of care, and
- The insurer will determine the maximum amount of additional care based on an RN evaluation.
- Spouse attendants won't be paid during sleeping time.

Services that can be billed:

HCPCS code	Description	Max fee
8901H	Spouse attendant in the home per hour	**$13.87**

Documentation

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of caregiver's shift,
- Printed name of caregiver, initials, signature of caregiver, and
- Specific care provided.

Payment policy: Home infusion services

Home infusion services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home, along with nursing services. Home infusion services can be authorized independently or in conjunction with home health services.

Prior authorization

- Prior authorization is required for all home infusion services including nurse services, drugs, and supplies.
- The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.
- Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition.

Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy, as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

Services that can be billed

Services that can be billed

CPT® code	Description and notes	Max fee
99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit	**$162.15**
99602	Skilled RN visit for each additional hour per visit	**$68.19**

Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound

Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.

Supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes

Payment policy: In-home hospice services

Prior authorization

In-home hospice services must be preauthorized and may include chore services. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Requirements for billing

Services that can be billed:

HCPCS code	Description and notes	Max fee
Q5001	Hospice care, in the home, per diem. Applies to in-home hospice care.	By report

Note: See legal definition of **by report** in Definitions at the beginning of this chapter.

Social work and **chore services** aren't covered, ***except*** as part of home hospice care.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for home health services	Washington Administrative Code (WAC) 296-20-03001(8): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03001 WAC 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102 WAC 296-23-246: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-246
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including home health)	L&I's website: http://www.lni.wa.gov/apps/FeeSchedules/
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **hospice services performed in a facility**	Chapter 36: Nursing Home and Other Residential Care Services
Payment policies for **physical therapy and occupational therapy**	Chapter 24: Physical Medicine Services
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services

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