Washington State Department of
Labor & Industries
Workers' Compensation Services

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

# Chapter 30: Vocational Services

## Effective October 1, 2020

**Link:** Look for **updates and corrections** to these payment policies at:

https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/policy-2020

**Note:** Vocational services providers must use the codes listed in this chapter to bill for services. Maximum fees apply equally to both State Fund and self-insured vocational services.

## Table of contents

**Page**


Definitions ..... 30-2

**Payment policies**
Billing by referral type ..... 30-3

Fee caps for vocational services ..... 30-9

Job Modification and Pre-Job Accommodation ..... 30-13

Option 2 vocational services ..... 30-18

Special services, non-vocational providers ..... 30-20

Additional requirements for all vocational services providers ..... 30-22

**More info:**
Related topics ..... 30-36


CPT® codes and descriptions only are © 2019 American Medical Association

## Definitions

- **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.


CPT® codes and descriptions only are © 2019 American Medical Association

# Payment policy: Billing by referral type

**Link:** For more detailed information on billing, consult the **Statement for Miscellaneous Services** (F245-072-000).

## Prior authorization

All vocational services require prior authorization.

Vocational services are authorized by referral type. The State Fund uses six referral types:

- Vocational recovery,
- Assessment,
- Plan development,
- Plan implementation,
- Forensic, *and*
- Stand-alone job analysis.

Each referral is a separate authorization for services.

Note: 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.

**Note:** 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.

CPT® codes and descriptions only are © 2019 American Medical Association

## 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) | **$9.70** |
| 0801V | Vocational recovery services (intern) | **$8.27** |
| 0802V | Vocational recovery services extension (VRC) | **$9.70** |
| 0803V | Vocational recovery services extension (intern) | **$8.27** |

### Assessment

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| 0810V | Assessment services (VRC) | **$9.70** |
| 0811V | Assessment services (Intern) | **$8.27** |

### 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) | **$9.70** |
| 0823V | Pre-job or job modification consultation (VRC) | **$9.42** |
| 0824V | Pre-job or job modification consultation (Intern) | **$8.27** |


CPT® codes and descriptions only are © 2019 American Medical Association

### Plan development

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| 0830V | Plan development services (VRC) | **$9.70** |
| 0831V | Plan development services (Intern) | **$8.27** |

### Plan implementation

| Code | Description (1 unit = 6 minutes for all codes) | Max fee per unit |
|---|---|---|
| 0840V | Plan implementation services (VRC) | **$9.70** |
| 0841V | Plan implementation services (Intern) | **$8.27** |

### 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.

**Note: 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) | **$11.60** |

### 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) | **$9.70** |
| 0809V | Stand-alone job analysis (intern) | **$8.27** |
| 0378R | Stand-alone job analysis (non-VRC) | **$9.61** |

CPT® codes and descriptions only are © 2019 American Medical Association

## Payment limits

### Stand-alone job analysis

For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager.

Bills for dates of service beyond the 15th day won't be paid.

### Travel, wait time, and mileage

L&I supports in-person meetings to encourage effective engagement, collaborative problem solving, and delivery of quality vocational services.

The vocational provider may bill, round trip, from their primary branch office to their destination for that referral. The primary branch office is designated by the vocational provider on their Vocational Provider and Firm Application (F252-088-000),

When submitting bills, the vocational provider should:

- Round to the nearest number if necessary.
- Bill all services for the same worker, for the same date of service, on one bill form.

For example:

VRC travels from primary branch office to attending provider's (AP) office to meet with the worker and the AP. VRC will bill the round trip time and miles from their primary branch office to the AP's office.

**Splitting travel when there is more than one claim**

If traveling for more than one claim (per worker or for multiple workers), the vocational provider can bill a round trip from their primary branch to include their destinations for the multiple referrals.

- Split charges equally between all claims, rounding to the nearest number if necessary.
- For two claims, bill half to each claim.
- For three or more claims split the charges accordingly (three claims = by thirds, four claims = by fourths)

For example:

VRC travels from their primary branch office to a meeting with worker on Referral A, then to onsite job analysis meeting on Referral B, then to a meeting at AP's office on Referral


CPT® codes and descriptions only are © 2019 American Medical Association

C, and then back to their primary branch office. VRC will bill a third of the total time and mileage under each referral.

**Note:** For **out of state** cases, VRC may only bill from the branch office nearest the worker.

| Code | Description | Maximum fee |
|---|---|---|
| 0891V | Travel/wait time (VRC or forensic VRC) 1 unit = 6 minutes | **$4.86** |
| 0892V | Travel/wait time (intern) 1 unit = 6 minutes | **$4.86** |
| 0893V | Professional mileage (VRC) 1 unit = 1 mile | **State rate** |
| 0894V | Professional mileage (intern) 1 unit = 1 mile | **State rate** |
| 0895V | Air travel (VRC, Intern, or forensic VRC) | **By report** |
| 0896V | Ferry charges (VRC, intern or forensic VRC) | **By report** |
| 0897V | Hotel charges (VRC, intern or forensic VRC) out-of-state only | **By report** |

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

### 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 |
|---|---|---|
| 0380R | Job modification | **By report** |
| 0385R | Pre-job modification | **By report** |
| 0389R | Pre-job or job modification consultation, 1 unit = 6 minutes | **$11.69** |
| 0390R | Vocational evaluation, 1 unit = 6 minutes | **$9.61** |
| 0391R | Travel/wait (non-VRC), 1 unit = 6 minutes | **$5.29** |
| 0392R | Mileage (non-VRC), one unit = 1 mile | **State rate** |
| 0393R | Ferry charges (non-VRC) (See Note below this table.) | **State rate** |

CPT® codes and descriptions only are © 2019 American Medical Association

**Note:** Code **0393R** requires documentation with a receipt in the case file.

When a worker has two or more open claims requiring time-loss compensation and vocational services, the insurer may make a separate but concurrent vocational referral for each claim. In such cases, vocational evaluators are expected to split the billing equally amongst the referrals. When providing vocational evaluation on multiple referrals and/or claims, follow these instructions:

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims.
- If there are three (or more) claims, the vocational evaluation bills are to be split accordingly (three claims = by thirds, four claims = by fourths), based on the number of concurrent referrals received.


CPT® codes and descriptions only are © 2019 American Medical Association

# Payment policy: Fee caps for vocational services

## Fee cap policy for referrals

Vocational services are subject to fee caps.

The following fee caps are by referral.

**Note:** 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** | **$1,992.73** |
| Assessment referral cap, per referral | **0810V, 0811V** | **$6,960.10** |
| Plan development referral cap, per referral | **0830V, 0831V** | **$6,654.92** |
| Plan implementation referral cap, per referral | **0840V, 0841V** | **$7,544.74** |
| Stand-alone job analysis referral cap, per referral | **0808V, 0809V, 0378R** | **$507.55** |

## Fee cap policy for vocational evaluation services

The fee cap for vocational evaluation services applies to multiple referral types and is allowed once per claim.

For example, if **$698.00** of vocational evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment under another referral type.

CPT® codes and descriptions only are © 2019 American Medical Association

| If the **description** of the service is… | Then the **applicable codes** are: | And the **maximum fee** per claim is: |
|---|---|---|
| Vocational evaluation services | **0821V, 0390R** | **$1,456.27** |

## 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, 2 exception codes are available with an additional fee cap of **$1,942.40.**

| Code | Description | Maximum fee |
|---|---|---|
| **0802V** | Vocational recovery services exception (VRC) | **$9.70** per 6 minutes |
| **0803V** | Vocational recovery services exception (intern) | **$8.27** per 6 minutes |

### AWA referrals

For AWA referrals, 2 exception codes are available with an additional fee cap of **$970.13**.

| Code | Description | Maximum fee |
|---|---|---|
| **0812V** | Assessment services exception (VRC) | **$9.70** per 6 minutes |
| **0813V** | Assessment services exception (intern) | **$8.27** per 6 minutes |


CPT® codes and descriptions only are © 2019 American Medical Association

### Plan implementation referrals

For plan implementation referrals, 2 exception codes are available with an additional fee cap of **$2,242.22**.

| Code | Description | Maximum fee |
|---|---|---|
| 0842V | Plan implementation services exception (VRC) | **$9.70** per 6 minutes |
| 0843V | Plan implementation services exception (intern) | **$8.27** per 6 minutes |

## Fee cap considerations

If at or near 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.

**If both the original fee cap and the fee cap exception are spent,** 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.

**The vocational provider may request a new referral when they are at or near the fee cap exception.**

L&I may close the original referral using the outcome code ADMX and create a new referral. This decision will be made on a case-by-case basis. If a new referral isn't created, the vocational provider must submit a closing report.

- Providers must comply with all requirements in WAC 296-19A when a referral is being closed by L&I, including submitting a closing report.
- Providers won't be able to enter a fee cap reached closure outcome with their closing report. Only L&I can enter this closure code.

CPT® codes and descriptions only are © 2019 American Medical Association

## Flat rate policy for 30-day progress reports

There is a $50 flat rate for each 30-day progress report. Progress report fees do not count toward professional hour fee caps.

| Code | Description | Flat rate |
|---|---|---|
| **0910V** | 30-day progress report (VRC) | **$50.00** per 30-day progress report |
| **0910V** | 30-day progress report (intern) | **$50.00** per 30-day progress report |

**How to submit bills**

- You can only bill one progress report per referral every 30 days.
- To bill for more than one progress report for the same referral on the same invoice, use separate line items of one unit and $50 each for each date of service. If you bill for more than one report on the same line, all but one will be denied.
- If the worker has multiple claims with open referrals, you should bill the progress report under the most recent claim. If time-loss is only involved in one claim, progress reports should be billed under that claim.

**Link:** For more information, see WAC 296-19A.


CPT® codes and descriptions only are © 2019 American Medical Association

# 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.

CPT® codes and descriptions only are © 2019 American Medical Association

## Services that can be billed

In some cases, the department may reimburse for consultation services.

| Code | Description | Activities | Maximum fee |
|---|---|---|---|
| 0823V | **Pre-job or job modification consultation**<br>Vocational Rehabilitation Provider | • Discussing/consulting about modifications to a job. This may include:<br>• Exploring ways a job may be modified within the individual's abilities and the needs of the employer. This may include modifying time, duties, environment, and/or use of alternative equipment.<br>• Discussing available L&I benefits to include stay at work, preferred worker, and job modification with the employer, worker, and/or attending provider.<br>• Communication with others about modifying a job to include the worker, employer, health-care providers, vocational provider, insurer, and/or vendor.<br>• Documenting findings and recommendations,<br>• Instruction in work practices (such as body mechanics, ergonomic principles),<br>• Obtaining bids,<br>• Completing and submitting the Job Modification/Pre-job Assistance Application and any associated follow up, and<br>• Assisting an employer with accessing return to work incentives. | **$9.70** per 6 minutes |
| 0824V | **Pre-job or job modification consultation** | • Same as above | **$8.27** per 6 minutes |


CPT® codes and descriptions only are © 2019 American Medical Association

| Code | Description | Activities | Maximum fee |
|---|---|---|---|
| | Vocational Rehabilitation Provider Intern | | |
| 0389R | **Pre-job or job modification consultation, analysis of physical demands**<br>OT, PT, Ergonomic Specialist | • Same as above<br>• Analyzing job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only). | **$11.69** 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. | **$5.29** per 6 minutes |
| 0392R | **Mileage** (non-VRC), per mile. | Mileage to work/training site or to an equipment vendor to meet with the worker as part of direct consultation services. | **State rate** |
| 0393R | **Ferry charges** (non-VRC). | Ferry travel if required to travel to work/training site as part of direct consultation services. | **State rate** |

CPT® codes and descriptions only are © 2019 American Medical Association

**Authorized equipment vendors**

The following codes can be billed by equipment vendors:

| Billing code | Description | Activities | Maximum fee |
|---|---|---|---|
| 0380R | **Job modification** | Equipment/tools:<br>• Installation,<br>• Set up,<br>• Basic training in use,<br>• Delivery (includes mileage),<br>• Tax,<br>• Custom modification/ fabrication.<br>Work area modification or reconfiguration. | Maximum allowable for 0380R is **$5,000.00** per job or job site. |
| 0385R | **Pre-job accommodation** | Equipment/tools:<br>• Installation,<br>• Set up,<br>• Basic training in use,<br>• Delivery (includes mileage),<br>• Tax,<br>• Custom modification/ fabrication.<br>Work/training area modification or reconfiguration. | Maximum allowable for 0385R is **$5,000.00** per claim.<br>Combined costs of 0380R and 0385R for the same return to work goal can't exceed **$5,000.00**. |

**Note:** 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.

**Link:** Additional information is available at: www.Lni.wa.gov/claims/for-vocational-providers/transitioning-back-to-work/job-modifications and www.Lni.wa.gov/claims/for-vocational-providers/transitioning-back-to-work/pre-job-accommodations.


CPT® codes and descriptions only are © 2019 American Medical Association

## 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.

**Note:** Self-insured employers may pay any pre-job accommodation expenses for injured workers who no longer work for them.

CPT® codes and descriptions only are © 2019 American Medical Association

## 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

### Limits

- Interns can't provide Option 2 vocational services
- Option 2 vocational services must be provided within five years following the date of the department's order confirming the worker's Option 2 election
- Total of all payments for all Option 2 vocational services for a worker won't exceed 10 percent of the worker's maximum Option 2 training fund, nor will the total exceed the remaining balance of the worker's Option 2 training fund at the time payment is made


CPT® codes and descriptions only are © 2019 American Medical Association

- 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.

**Links:**

- State Fund Option 2 Vocational Services Summary (F280-063-000)
- Self-Insured Option 2 Vocational Services Summary (F280-064-000)

### Billing

The VRC can't bill the worker directly for Option 2 vocational services.

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) | **$9.70** |
| R0398 | Option 2 job placement services (VRC) | **$9.70** |

For self-insured claims, contact the self-insured employer or its third-party administrator for billing instructions.

**Note**: The VRC can't bill the insurer for completing the Option 2 vocational services summary form.

**Link:** For more information on Option 2 vocational services, see L&I's website at www.Lni.wa.gov/claims/for-vocational-providers/vocational-services/option-2-vocational-counseling-and-job-placement

CPT® codes and descriptions only are © 2019 American Medical Association

# 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:** For a list of SIE/TPAs, go to: https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/index.

## 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**.

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


CPT® codes and descriptions only are © 2019 American Medical Association

## Requirements for billing

Code **0388R** must be billed by a medical or a miscellaneous non-physician provider on a **Statement for Miscellaneous Services** billing form (F245-072-000). The referral ID and referring vocational provider account number must be included on the bill.

As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you):

- You can't bill as a vocational provider (provider type **68**), *and*
    - You must either use another provider account number that is authorized to bill the ancillary services codes (type **34**, **52**, or **55**), *or*
    - Obtain a miscellaneous services provider account number (type **97**) and bill the appropriate codes for those services.

These providers use the **Statement for Miscellaneous Services** billing form but must include the following specific information to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, *and*
- The service provider ID for the assigned vocational provider in the Name of physician or other referring source box at the top of the form, *and*
- The non-vocational provider's own provider account numbers at the bottom of the form.

**Link:** The **Statement for Miscellaneous Services** billing form is available at: www.Lni.wa.gov/forms-publications/F245-072-000.pdf.

## Payment limits

Code **0388R** can't be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

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

CPT® codes and descriptions only are © 2019 American Medical Association

# Payment policy: Additional requirements for all vocational services providers

## Inappropriate referral: ADMA billing

Vocational providers may use ADMA outcome *VRC or firm declines referral* for up to 14 days after the referral assignment. This outcome is to be used when the referral isn't appropriate. Examples include:

- Conflict of interest, *or*
- Concerns about capacity.

Prior to entering an ADMA outcome, the VRC or firm needs to contact the claim manager to discuss the reasons for declining the referral.

A maximum of three professional hours may be billed for reviewing the file and preparing a brief rationale. The VRC sends the rationale using an EVOC message.

## Preferred worker certification for workers who choose Option 2

Vocational providers must consider assisting a worker in obtaining preferred worker certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining preferred worker certification for up to 14 days after an Option 2 selection has been made.

## Insurer Activity Prescription Form (APF), 1073M

For State Fund claims, healthcare providers won't be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

Employers can obtain physical capacity information by:

- Using completed APFs available on the department's Claim and Account Center, *or*
- Requesting an APF through the claim manager when updated physical capacity information is needed.


CPT® codes and descriptions only are © 2019 American Medical Association

**Link:** Visit L&I's Claim and Account Center at: https://secure.lni.wa.gov/home/default.aspx.

## Other requests for return to work information

Attending providers may respond to requests regarding return to work issues. Examples include:

- Return to work decisions based on a functional capacity evaluation (FCE),
- Request for worker to participate in FCE,
- Job modification or pre-job modification reviews,
- Proposed work hardening program,
- Plan for graduated, transitional, return to work.

## Resume Services (State Fund claims only)

A resume isn't only an important job-seeking tool; it's also an opportunity to engage the worker in thinking about return to work. L&I encourages vocational providers to develop a resume with workers who are in an open vocational referral, within the following parameters:

- Participation of the worker is voluntary.
- The VRC assigned to the referral meets in-person with the worker to develop the resume. If that isn't possible, the assigned VRC may provide resume services telephonically 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.

CPT® codes and descriptions only are © 2019 American Medical Association

  - 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 $321.24 for VRC and/or intern time.

| Code | Description | Maximum fee |
|---|---|---|
| **0844V** | Resume services (VRC) | **$9.70** per 6 minutes |
| **0845V** | Resume services (intern) | **$8.27** per 6 minutes |

## Services that can't be billed

Billable services don't include performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals (except for activities noted in WAC 296-19A-340). Activities associated with reports (other than composing or dictating complete draft of the report) not billable include:

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

Also not billable is time spent on any administrative and clerical activity to include:

- Typing,
- Copying,
- Faxing, mailing, or distributing,
- Filing,
- Payroll,
- Recordkeeping,
- Delivering or picking up mail.


CPT® codes and descriptions only are © 2019 American Medical Association

## 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.

CPT® codes and descriptions only are © 2019 American Medical Association

Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing,
- Interest testing,
- Work samples,
- Academic achievement testing,
- Situational assessment,
- Specific and general aptitude and skill testing.

A provider (vocational or non-vocational) who administers and/or interprets and reports on vocational evaluation and evaluation results must ensure that he or she is qualified to administer and/or interpret and report on the evaluations in regard to the specific instrument(s) being used.

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation, and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational evaluation is not covered during a vocational recovery referral.

**Note:** 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 group testing for three workers, then billing for each worker shouldn't exceed 1.5 hours.

### Vocational providers

Vocational providers (provider type **68**) must use procedure code **0821V** to bill for vocational evaluation services. Use code **0821V** for:

- The formal testing itself, *or*
- A meeting that is directly related to explaining the purposes or findings of testing.


CPT® codes and descriptions only are © 2019 American Medical Association

### Non-vocational providers

Non-vocational providers must use procedure code **0390R**. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, *and*
- Service provider ID for the assigned vocational provider in the Name of the physician or other referring source box at the top, *and*
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form,
- Obtain the vocational referral ID number from the VRC and place on the billing form,
- Obtain the VRC's service provider number and place in the Name of the physician or other referring source box at the top, *and*
- Place the school's provider account number at the bottom of the form.

## Retraining plans that exceed statutory benefit limit

The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit. Additional vocational assistance can only be considered following previous retraining attempts that depleted available money and/or time.

The VSS won't approve a plan with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers may not develop or submit such a plan.

## How to bill when multiple providers work on a single referral

Multiple providers may deliver services on a single referral if they have the same payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where a provider covers the caseload of an ill provider.

When more than one provider works on a referral, each provider must bill separately for services delivered on the referral, and each provider must use:

- His/her individual provider account number, *and*

CPT® codes and descriptions only are © 2019 American Medical Association

- The payee provider account number, *and*
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the assigned provider's performance rating.

## Split billing across multiple referrals

When a worker has two or more open time loss claims, the insurer may make a separate referral for each claim. In cases where the insurer makes two (or more) concurrent referrals for vocational services, vocational providers are expected to split the billing. When providing vocational services on multiple referrals and/or claims, follow these instructions:

- To accurately capture the work done without overbilling, combine billable hours over a larger interval of work (up to the entire billing period) rather than bill for each single activity.

  Examples:

  - A provider has two open referrals for the same worker and the provider bills once per week. They provided a total of 90 minutes during this billing period. They would bill eight units under each claim.
  - A provider has two open referrals for the same worker and the provider bills daily. They provided a total of 40 minutes during this billing period. They would bill four units under each claim.

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims as directed above.
- If there are three (or more) claims requiring time loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (three claims = by thirds, four claims = by fourths), based on the number of concurrent referrals received.

Note: These requirements also apply when billing for testing services.

For example, if provider performs 4.5 hours of testing for a worker with more than one claim and referral, the billing must be split equally among the claims.


CPT® codes and descriptions only are © 2019 American Medical Association

**Note:** Vocational providers must document multiple referrals and split billing for audit purposes.

## Referrals

To receive referrals, the vocational firm owner/manager must have signed L&I's Vocational Firm Best Practices Agreement.

In selecting the VRC who will best support the worker centric work disability prevention approach and other L&I goals, vocational firms should consider:

- VRC availability
- Caseload management and size
- Knowledge of worker's industry
- Skills in work disability prevention and worker centric services
- Other skills specific to the needs of the case

Note: Vocational recovery (VR) referrals must be assigned to a VRC residing in Washington State or a border city. Out-of-state VRCs are only eligible to receive VR referrals for workers who also reside out of state.

**Guidelines for situations involving a VRC leaving a firm or becoming unavailable**:

- Referrals are retained by the firm. The firm is expected to ensure there are no gaps in service.
    - Upon receipt of a vocational provider account application, Private Sector Rehabilitation Services (PSRS) will contact the VRC's current firm owner/manager to inform them of the request.
- The firm is expected to work with L&I to ensure that referrals are successfully re-assigned.
- The firm must notify L&I of VRC and intern personnel changes.

CPT® codes and descriptions only are © 2019 American Medical Association 

**Note:** The VRC assigned to the referral(s) can't contact the claim manager(s) for the purpose of informing them of a change in employment. This would be considered marketing, which is prohibited by department policy.

.

## 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.


CPT® codes and descriptions only are © 2019 American Medical Association

## Submitting a vocational assessment or retraining plan for self-insured claims

**Links:** Answers to the following questions can be found in various WACs (the specific WAC is noted following each question):

- 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

**Note:** Change in status responsibilities apply to both State Fund and Self-Insurance vocational providers.

The insurer must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status includes:

- VRC or intern ends their association with a firm, *or*
- VRC assigned to a referral is no longer available to provide services on the referral(s), *or*
- Firm closes.

CPT® codes and descriptions only are © 2019 American Medical Association

**Link:** These forms may be found at L&I's vocational services website: www.Lni.wa.gov/claims/for-vocational-providers/working-with-li/

**Note:** 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.

**Link:** For more information, see WAC 296-19A-270.

## Approved plan services that occur prior to plan start date

The insurer may cover these are services/fees prior to a plan start date:

- Registration fees billed as retraining tuition (billing code **R0310**), *and*
- Books, supplies, and equipment (billing code **R0312**), *and*
- Rent, food, utilities, and furniture rental. Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, **0301R**, isn't payable prior to a plan start date. Travel that occurs prior to a plan start date is generally:

- To a jobsite to evaluate whether a particular job goal is reasonable, or
- To a school to pay for registration, books or look over the campus.

These types of trips aren't part of a retraining plan and should be billed by the worker under **V0028**. Travel to appointments with the VRC is also billed under **V0028**.

## Selected plan procedure code definitions

L&I has defined the following retraining codes:

- **R0312**, Retraining books, equipment, and supplies are consumable goods such as:


CPT® codes and descriptions only are © 2019 American Medical Association

  - Books,
  - Paper,
  - Pens,
  - CDs,
  - Disposable gloves,
  - Calculator,
  - Software,
  - Survey equipment,
  - Computers,
  - Welding gloves & hood,
  - Professional uniforms, including shoes,
  - Bicycle repair kits,
  - Mechanics tools.
- **R0390,** Retraining childcare. Providers must be licensed. If a worker is unable to attend training without the use of training funds to pay child care, all anticipated childcare needs must be identified by the VRC in the proposed retraining plan. The total cost of the identified childcare, in addition to other allowable costs, must fit within the statutory retraining benefit limit.

The insurer doesn't have the authority to purchase:

- Glasses,
- Hearing aids,
- Dental work,
- Clothes for interviews,
- Other items as a way to remove barriers during retraining.

## Reimbursement for food

The insurer reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan with authorized board and lodging.

CPT® codes and descriptions only are © 2019 American Medical Association

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).

**Link:** 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.


CPT® codes and descriptions only are © 2019 American Medical Association

**Note:** Questions regarding completion of the Plan Time/Cost/Travel Encumbrance form (F245-454-000) should be referred to the VSS.

CPT® codes and descriptions only are © 2019 American Medical Association

# Links: Related topics

| If you're looking for more information about… | Then go here: |
|---|---|
| **Administrative rules** for corrective action for failure to notify about changes in status | Washington Administrative Code (WAC)<br>WAC 296-19A-270:<br>http://apps.leg.wa.gov/WAC/default.aspx?cite=296-19A-270 |
| **Administrative rules** for fee caps on vocational services | Washington Administrative Code (WAC) 296-19A:<br>http://apps.leg.wa.gov/WAC/default.aspx?cite=296-19A |
| **Becoming an L&I provider** | L&I's website:<br>www.Lni.wa.gov/claims/for-vocational-providers/working-with-li/ |
| **Billing** instructions and forms | Chapter 2:<br>Information for All Providers |
| **Fee schedules** for all healthcare and vocational services | L&I's website:<br>www.Lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/ |
| **Job modifications and pre-job accommodations policies** | L&I's website:<br>www.Lni.wa.gov/claims/for-vocational-providers/transitioning-back-to-work/job-modifications<br>and<br>www.Lni.wa.gov/claims/for-vocational-providers/transitioning-back-to-work/pre-job-accommodations |
| **L&I's Claim and Account Center** | L&I's website:<br>https://secure.lni.wa.gov/home/default.aspx |
| **Statement for Miscellaneous Services** | L&I's website:<br>www.Lni.wa.gov/forms-publications/F245-072-000.pdf |


CPT® codes and descriptions only are © 2019 American Medical Association

| If you're looking for more information about… | Then go here: |
|---|---|
| **Option 2 Vocational Services** | Washington Administrative Code (WAC) 296-19A-631, 633, 635, 637<br>L&I's website:<br>www.Lni.wa.gov/claims/for-vocational-providers/vocational-services/option-2-vocational-counseling-and-job-placement<br>Self-Insured Option 2 Vocational Services Summary:<br>www.Lni.wa.gov/forms-publications/F280-064-000.pdf<br>State Fund Option 2 Vocational Services Summary:<br>www.Lni.wa.gov/forms-publications/F280-063-000.pdf |
| **Services that aren't covered** | WAC 296-19A-340:<br>https://app.leg.wa.gov/wac/default.aspx?cite=296-19A-340 |
| **Statement for Retraining and Job Modification Services** form | L&I's website:<br>www.Lni.wa.gov/forms-publications/F245-030-000.pdf |
| **Notify L&I of changes in status** | Email Private Sector Rehab Services PSRS@LNI.WA.GOV |
| **Vocational Provider and Firm Application** | L&I's website:<br>www.Lni.wa.gov/forms-publications/F252-088-000.pdf |

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**

CPT® codes and descriptions only are © 2019 American Medical Association