

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

Chapter 36: Nursing Home and Other Residential Care Services

Effective July 1, 2021



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

<https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/policy-2021>



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Payment policy: All residential care services

▶ When residential services are covered

The insurer covers:

- Proper and necessary residential care services that require **twenty-four hour institutional care** to meet the worker's needs, abilities, and safety, *and*
- Medically necessary **hospice care**, comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Services must be:

- Proper and necessary,
- Required due to an industrial injury or occupational disease,
- Requested by the attending physician, *and*
- Authorized by an L&I ONC (occupational nurse consultant) or self-insured employer before care begins.



Note: Services provided in adult day care center facilities aren't covered by the insurer.

▶ Prior authorization and reauthorization

Initial admission

Residential care services require prior authorization. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator.



Link: For authorization procedures on a self-insured claim, contact the self-insurer. Contact information is available at: <https://lni.wa.gov/insurance/self-insurance/look-up-self-insured-employers-tpas/index>.

When care needs change

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for reauthorization of the workers care.

▶ Who must provide these services to qualify for payment

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for twenty-four hour institutional care including:

- Skilled Nursing Facilities (SNF),
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital,
- Critical Access Hospitals (CAHs) licensed by DOH and Veterans Hospitals using swing beds to provide long term care or sub-acute care,
- Adult Family Homes,
- Assisted Living Facilities,
- Secure Residential Facilities,
- Boarding Homes, *and*
- Hospice care providers.

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.



Note: TCUs must obtain a separate provider number from L&I.

▶ Services that aren't covered

Adult day care center facilities or assisted living facilities performing adult day care services

Services provided in adult day care center facilities aren't covered by the insurer.

Pharmaceuticals and durable medical equipment (DME)

Residential facilities can't bill for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed by a pharmacy or DME supplier.



Note: Inappropriate use of CPT[®] and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

▶ Requirements for billing

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this chapter.



Link: The primary billing procedures applicable to residential facility providers can be found in [WAC 296-20-125](#) (see Billing procedures).

All residential care services should be billed on form [F245-072-000](#) (Statement for Miscellaneous Services).

▶ **Additional information: Negotiated payment arrangements**

Insurers with existing negotiated arrangements made **prior to January 1, 2005** may continue their current arrangements and continue to use billing code **8902H** until the worker's need for services no longer exists or the worker is transferred to a new facility. L&I won't negotiate payment arrangements for admissions after January 1, 2005.



Note: Billing code **8902H** (Negotiated payment arrangements) is a code that pays by report.

▶ **Additional information: Residential services review, periodic independent nursing evaluations**

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to:

- Onsite review of the worker, *and*
- Review of medical records.

All services rendered to workers are subject to audit by L&I.



Link: For more information, see [RCW 51.36.100](#) and [RCW 51.36.110](#).



Payment policy: Residential services, including boarding homes, assisted living facilities, and adult family homes

▶ **Requirements for the Residential Care Assessment Tool**

At the insurers’ request, a Residential Care Assessment Tool (form [F245-377-000](#)) must be completed by an independent Registered Nurse (RN) or an L&I ONC based in the field:

- Within 30 days of admission, *and*
- At least once per year after the initial assessment.

The tool determines the appropriate L&I payment grouping.

▶ **Services that can be billed**

The numeric score determined by the Residential Care Assessment Tool will determine which billing code to use. The three levels of care will be applied to all nonskilled nursing facility types. The payment rates are daily payment rates (see table below).



Note: Don’t bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

If the assessment score is...	Then the appropriate billing code is:	Which has this description :
6 – 20 Basic level	8893H	L&I RF Low
21 – 36 Intermediate level	8894H	L&I RF Medium
37 – 57 Advanced/Special level	8895H	L&I RF High



Link: For maximum fees (Daily Rates) see the Residential Facility Rates, L&I Payment Group #13 – Boarding Homes, Assisted Living Facilities and Adult Family Homes, on the L&I fee schedule page at:

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



Payment policy: Critical Access Hospitals (CAHs) and Veterans Administration Hospitals using swing beds for sub-acute care

▶ Payment methods

Critical Access Hospitals and Veterans Administration Hospitals will be paid for sub-acute care (swing bed services) utilizing a hospital specific POAC rate.

▶ Prior authorization

You must contact an ONC for approval.



Link: To obtain information about contacting an ONC, call L&I's Provider Hotline at **1-800-831-5227**.

▶ Requirements for billing

Upon approval from a Labor and Industries ONC, CAHs and Veterans Administration Hospitals should bill their usual and customary charge for sub-acute care (swing bed use) on the **UB-04** billing form.

Identify these services in the Type of Bill field (Form Locator 04) with the 018x series (hospital swing beds).



Link: To view the UB-04 form, see:

https://lni.wa.gov/forms-publications/search?group-translations=true&index=Forms_Pubs&pg=1&limit=20&query=UB04

▶ Does this policy apply to self-insured employers?

No. Self-insured employers' payment formula for hospital inpatient services and non-fee schedule hospital outpatient services = *the hospital specific POAC factor x Allowed charges*. Contact your insurer for correct form and payment procedures.



Payment policy: Hospice care

► Requirements for billing

Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Hospice programs must bill the following HCPCS codes:

If the hospice care is provided in...	Then bill for services using HCPCS code:	Which has a maximum fee of:
Nursing long term care facility	Q5003	By report
Skilled nursing facility	Q5004	By report
Inpatient hospital	Q5005	By report
Inpatient hospice facility	Q5006	By report
Long term care facility	Q5007	By report
Inpatient psychiatric facility	Q5008	By report
Place NOS	Q5009	By report

► Payment limits

Hospice claims are paid on a by report basis (see table above).

Occupational, physical, and speech therapies are included in the daily rate and aren't separately payable.



Payment policy: Skilled nursing facilities

► Requirements for the Minimum Data Set Basic Assessment Tracking Form

Within 30 working days of admission, nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker. The completed MDS must be sent to the ONC or SIE/TPA for authorization of the appropriate billing code.



Link: The form is available from CMS at: www.cms.gov/NursingHomeQualityInits/.

This form or similar instrument will also determine the appropriate L&I payment. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment code to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.



Payment policy: Skilled nursing facility and transitional care unit beds

▶ Payment methods

L&I uses a modified version of the Patient Driven Payment Model (PDP) through the use of Health Insurance Prospective Payment System (HIPPS) skilled nursing facility (SNF) codes for developing nursing home payment rates.

The fee schedule for SNF and transitional care unit (TCU) beds is a series of HIPPS codes tied to a series of 11 local codes. The items covered include :

- Room rates,
- Therapies, *and*
- Nursing components depending on the needs of the worker.



Note: Medications aren't included in the L&I rate.

▶ Prior authorization

A HIPPS code must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code.

▶ Additional information: Fee schedule

For a listing of HIPPS and local code combinations, see L&I's fee schedule page at:

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



Link: For maximum fees see Nursing Facility Rates, HIPPS codes, L&I payment Groups 1 through 11, on the fee schedule page at:

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



Note: L&I won't pay nursing homes or other residential care when the injured worker isn't present, such as when hospitalized or on vacation. L&I won't pay bed hold fees.



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
Becoming an L&I provider	L&I's website: https://lni.wa.gov/patient-care/provider-accounts/become-a-provider/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services	L&I's website: https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/
Minimum Data Set (MDS) Basic Assessment Tracking Form	Medicare's (CMS's) website: www.cms.gov/NursingHomeQualityInits

Payment policies for durable medical equipment (DME)	Chapter 9: Durable Medical Equipment
Statement for Miscellaneous Services form	L&I's website: https://lni.wa.gov/forms-publications/search?group-translations=true&index=Forms_Pubs&pg=1&limit=20&query=F245-072-000
Washington revised code (state laws) regarding audits of healthcare providers	Revised Code of Washington (RCW) 51.36.100: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.100 RCW 51.36.110: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.110

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811** or email PHL@lni.wa.gov