Washington State Department of
Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 1: Introduction

Effective July 1, 2024

Table of Contents

General information: About MARFS and this manual

What is MARFS?

The Medical Aid Rules and Fee Schedules (MARFS) is a package of information about how workers' compensation insurers in Washington State pay for healthcare and vocational services provided to injured workers and crime victims.

MARFS encompasses three things:

- **Medical aid rules** published in the Washington Administrative Codes (WACs) for industrial insurance (workers' compensation),
- **Fee schedules** for healthcare and vocational professional provider and facility services, *and*
- This **payment policies manual**.

What is in this manual?

This manual contains 36 chapters of payment policies for healthcare and vocational services provided by individual professional providers or facilities.

A payment policy for a specific service may include information about:

- Prior authorization,
- Who must perform specific services to qualify for payment,
- Services that can be billed or that aren't covered,
- Requirements for billing,
- Documentation requirements,
- Payment limits, *and/or*
- Other information, such as payment methods, background information on coverage decisions, unique requirements, and examples to illustrate billing procedures.

Note: Not every payment policy includes all of these elements. See the fee schedules for prior authorization requirements.

Beyond this introductory chapter, in this manual you will find:

- One chapter on **general policies and information** for all providers,
- Twenty-nine chapters for **professional services**, which contain payment policies for individual professional healthcare and vocational providers, and interpreters, and
- Five chapters for **facility services**, which contain payment policies for healthcare facilities.

Note: Within each of the services sections, the chapters appear alphabetically.

What part of MARFS isn't in this manual?

This manual doesn't include:

- Fee schedules, which contain the maximum fees (payment amounts) for the authorized billing codes providers use to bill for services,
- The field key, which explains the column headings and abbreviations that appear in the fee schedules,
- Medical aid rules, which are L&I-specific WACs, *and*
- Updates and Corrections, which contain any changes to policies and fees that occur between annual publications of this manual.

Link: Medical Aid Rules are available in Title 296 WAC on the Washington State Legislature's website.

How do I know if a policy is current?

The policies in this manual are updated and published at the start of each fiscal year (June 1), and are effective for services provided from July 1 until the next publication of this manual.

Sometimes changes do occur between publications of this manual. Such changes are communicated to providers through L&I's Medical Provider News email listserv and are also documented on an Updates & Corrections page on L&I's website.

Link: For information about how to join the email listserv, see the "General information: All payment policies and fee schedules" section of Chapter 2: Information for All Providers.

General information: About the layout and design

How is each chapter organized?

Payment policies for general types of services are organized into individual chapters. Each chapter contains:

- A title page with a **Table of Contents** for the chapter,
- Followed by **payment policies** for specific services, or **general information**, *and*
- At the end of the chapter, a table with links to **related topics**.

Some chapters also include **definitions** of key terms, including descriptions of billing code **modifiers**. When a chapter does contain definitions, they appear immediately following the Table of Contents.

Visual cues

Visual cues and icons appear consistently throughout the payment policies manual. The following is a list of these icons and visual cues, with descriptions of how they are used:

Bulleting

Bullet lists are used to:

- organize complex information, *and*
- break it up into manageable pieces.

Link 

Direct links to related information that may be of interest and assistance are provided. These include links to other chapters within the payment policies manual, helpful websites, forms and documents, or specific WACs and RCWs.

Note 

Notes appear throughout the manual to draw attention to useful information.

Table of Contents 

The same icon always appears next to the Table of Contents.

Definitions, Modifiers, or general policy information 

The same icon always appears next to Definitions, Modifiers, or general policies that aren't payment policies.

Payment policy 

The same icon always appears next to each payment policy.

Sample pages

Below are illustrations of actual chapter content to show how information appears throughout.

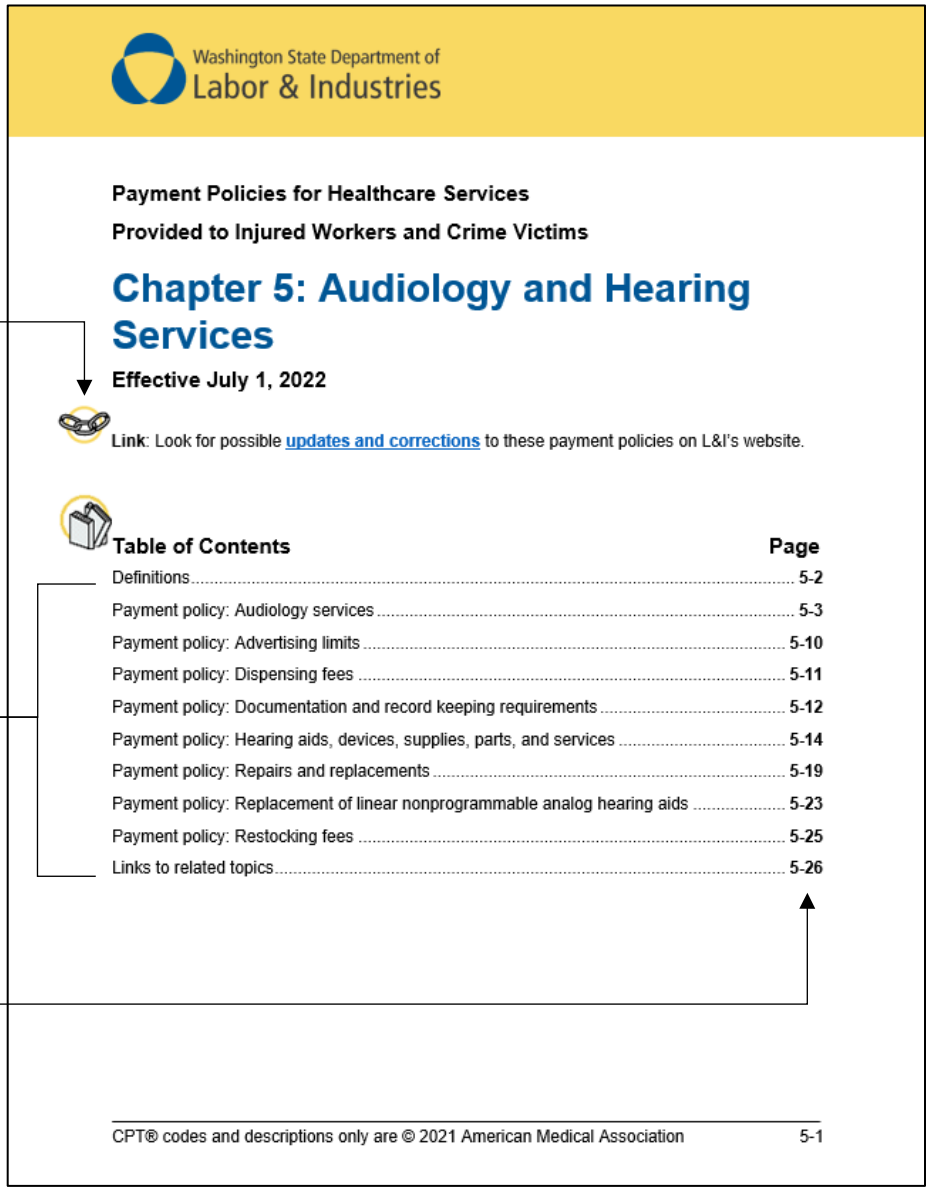
Sample title page

Each state fiscal year (which begins July 1), L&I publishes updated policies.

Sometimes updates or corrections occur between annual publications. The Link on the title page will bring you to the website that lists such changes.

The Payment policies appear in alphabetical order.

To jump to a specific page, click on a page number.



Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 5: Audiology and Hearing Services

Effective July 1, 2022

Link: Look for possible updates and corrections to these payment policies on L&I's website.

Table of Contents **Page**

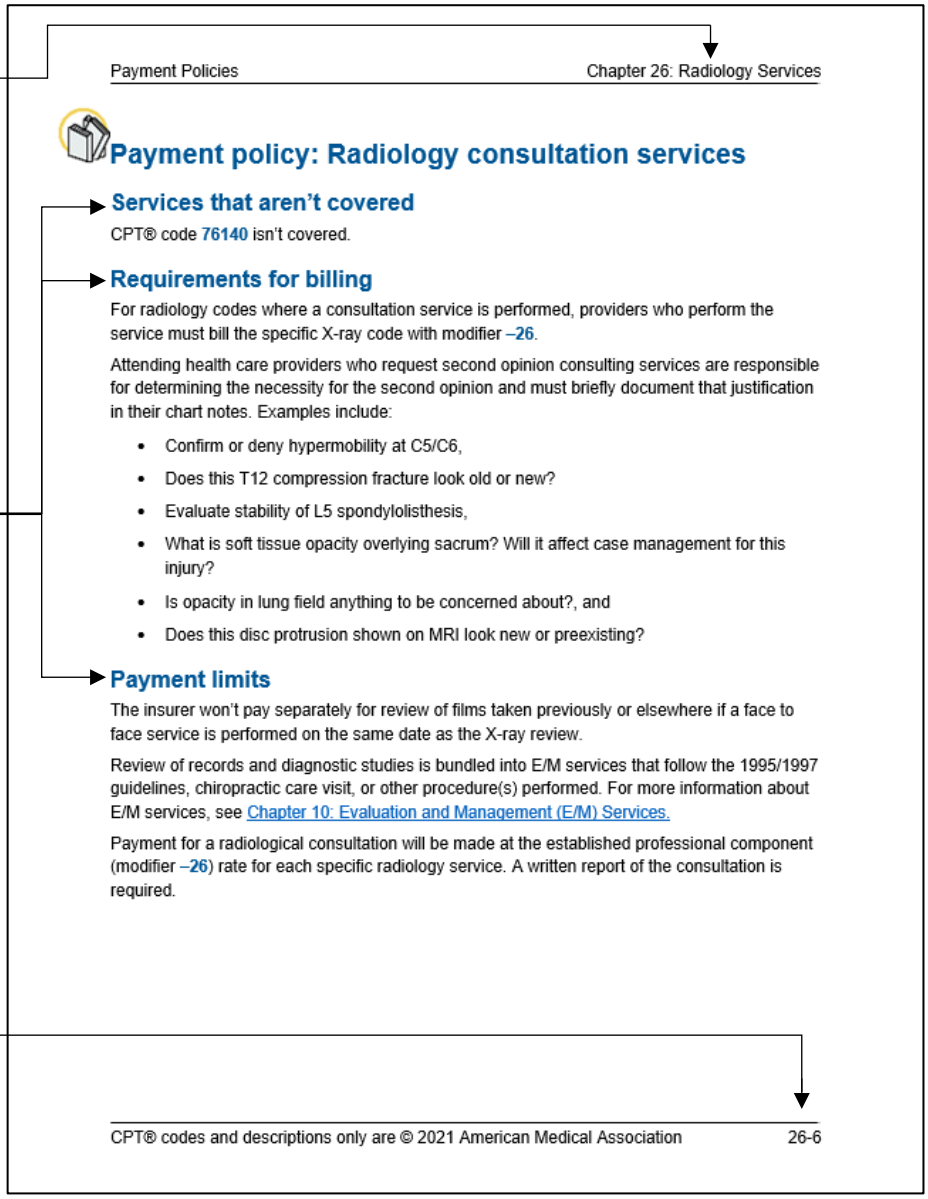
 5-1

Sample payment policy page

On every page, the printable version tells you what chapter you're reading.

To help you track down the specific information you need more quickly, each policy topic stands out in large, bold-faced type.

Pages are identified by the chapter number, then the page number within that chapter.



Payment Policies Chapter 26: Radiology Services

Payment policy: Radiology consultation services

Services that aren't covered

CPT® code 76140 isn't covered.

Requirements for billing

For radiology codes where a consultation service is performed, providers who perform the service must bill the specific X-ray code with modifier –26.

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6,
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis,
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?, and
- Does this disc protrusion shown on MRI look new or preexisting?

Payment limits

The insurer won't pay separately for review of films taken previously or elsewhere if a face to face service is performed on the same date as the X-ray review.

Review of records and diagnostic studies is bundled into E/M services that follow the 1995/1997 guidelines, chiropractic care visit, or other procedure(s) performed. For more information about E/M services, see Chapter 10: Evaluation and Management (E/M) Services.

Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the consultation is required.

CPT® codes and descriptions only are © 2021 American Medical Association 26-6

General information: Highlights of policy changes since July 1, 2023

These highlights are intended for general reference. This isn't a comprehensive list of all the changes in the payment policies or fee schedules.

For complete code descriptions and lists of new, deleted, or revised codes, refer to the 2023 CPT© and HCPCS coding books.

Washington Administrative Code (WAC) and payment changes

The following changes to WACs and payment rates occurred:

- Cost of living adjustments were applied to RBRVS and anesthesia services and/or local codes,
- WAC 296-20-135 increases the anesthesia conversion factor to **$3.89** per minute (**$58.35** per 15 minutes) and the RBRVS conversion factor increases to **$59.98**,
- WAC 296-23-220 and WAC 296-23-230 increases the maximum daily cap for physical and occupational therapy services to **$147.97**, and
- WAC 296-23-250 set a daily cap for massage therapy of 75% of the daily cap for PT/OT services. The rate for July 1, 2024 is **$110.98**.

Policy & fee schedule additions, changes, and clarifications

Professional services chapters

Chapter 2: Information for All Providers now includes information for providers who have a dual license. There is a new section on the timeline for adjustments and rebills and clarifies provider requirements for billing corrections.

Chapter 3: Ambulance, Taxi, and Other Transportation Services includes a new billing code for taxi no-shows related to insurer arranged Independent Medical Exams (IMEs) or insurer arranged consultations.

Chapter 9: Durable Medical Equipment is restructured to improve clarity and ease-of-use, and contains a new standalone policy for Negative Pressure Wound Therapy.

Chapter 14: Language Access Services for Spoken Languages is restructured to improve clarity and ease-of-use, and reflects changes to interpretation services. Sign language services are now in Chapter 22: Other Services.

Chapter 17: Mental Health Services clarifies the differences between neuropsychological testing and psychological testing.

Chapter 19: Naturopathic Physicians and Acupuncture Services underwent a complete overhaul and now allows naturopaths to bill CPT® for office visits and treatment. A reorganized acupuncture policy provides further clarity.

Chapter 22: Other Services includes several new policies, including a policy specifically for lodging providers, an updated Behavioral Health and Interventions policy, and an update for the Surgical Quality Care Program. Masters Level Therapists are now part of the L&I provider network. Sign language services now reside in this chapter.

Chapter 25: Physical Medicine Services clarifies Functional Capacity Exam billing limits. A new policy was added for Work Rehabilitation.

Chapter 27: Reports and Forms now clarifies when 60-day reports are required.

Chapter 30: Vocational Services includes a vocational school refund policy and revamped policies for travel and remote services.

Facility services chapters

In the facility services chapters, fees including Hospital rates have been updated.

The insurer is continuing to update the outpatient code editor (OCE). Notices of future updates will be posted on the Updates & Corrections page on L&I's website.

Fee schedules

With the exception of the comma-delimited files, the Field Keys are integrated into the fee schedules.

The following fee schedules, factors, and rates have been updated:

- Ambulatory surgery center (ASC) fees,
- Dental fees,
- Durable medical equipment fees,
- Hospital ambulatory payment classification (APC) rates,
- Hospital percent of allowed charge (POAC) factors,
- Hospital rates,
- Interpreter fees,
- Laboratory fees,
- Pharmacy fees,
- Professional fees,
- Prosthetics and orthotics fees, *and*
- Residential fees.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for industrial insurance (workers' compensation)	Washington Administrative Code (WAC) Title 296
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services	Fee schedules on L&I's website

Need more help?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.