Washington State Department of
Labor & Industries

Medical Aid Rules and Fee Schedules (MARFS)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2024

This document can be found on the department's website at https://lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/.

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.

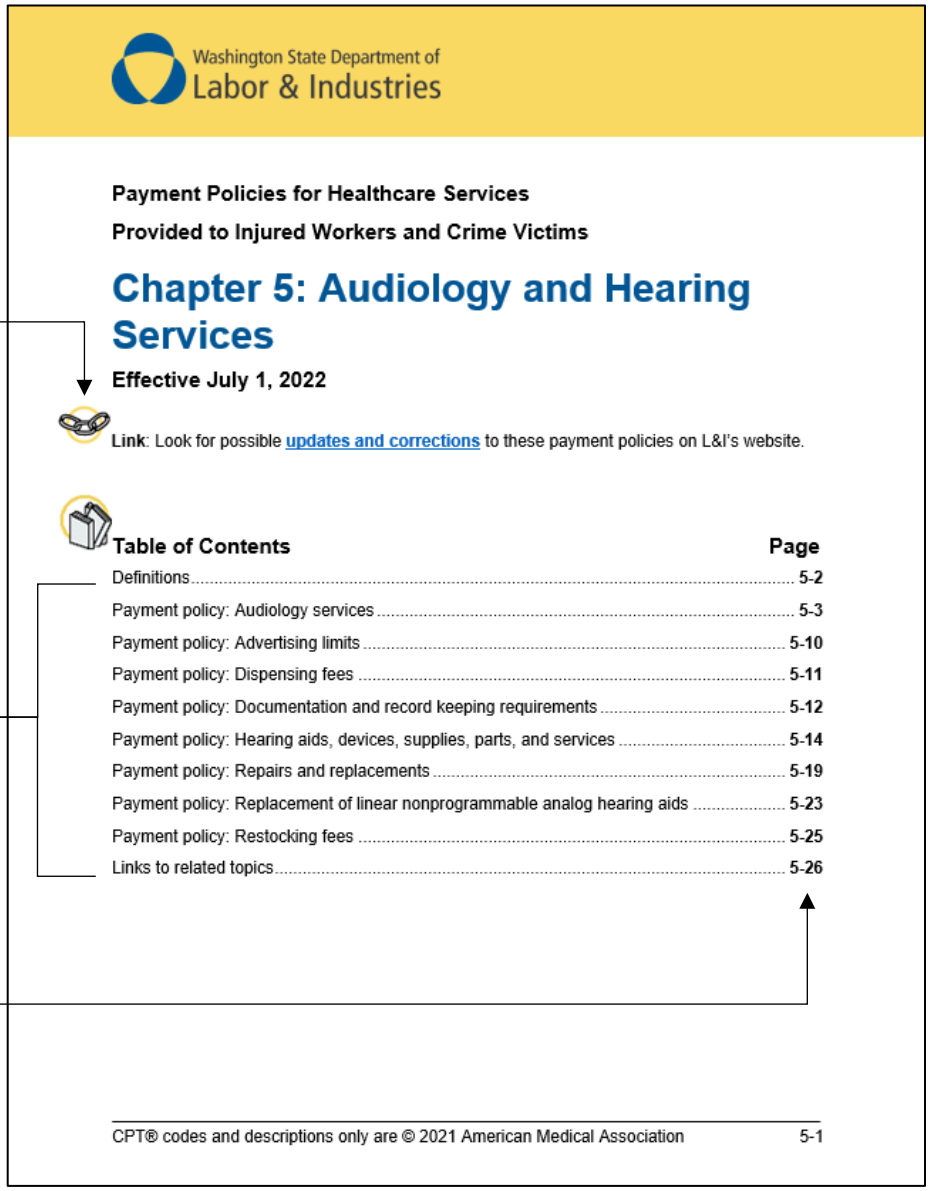
Sample title page

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**

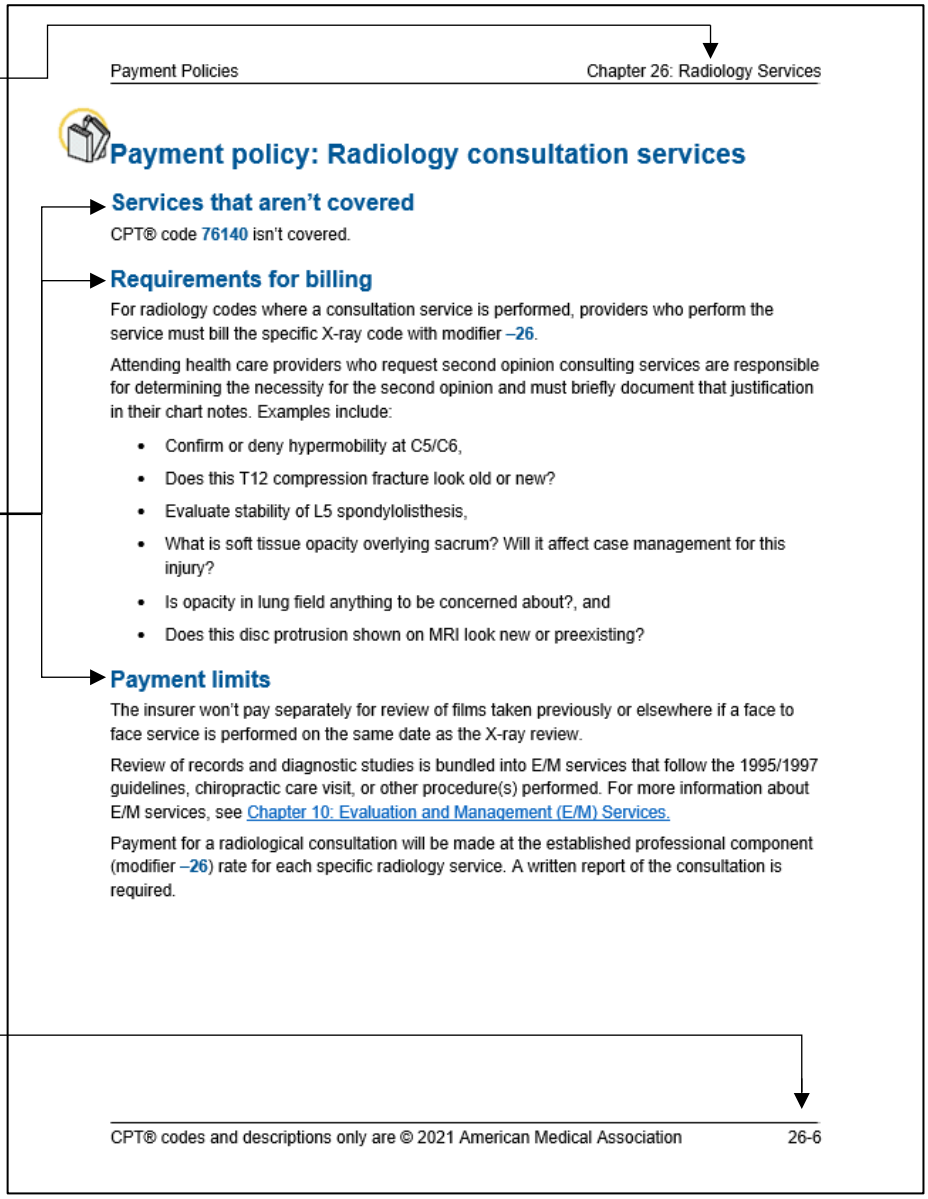
 5-1

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 2: Information for All Providers

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Attending Provider (AP): A person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry; and advanced registered nurse practitioner. An Attending Provider actively treats an injured or ill worker. Typically, this is the primary care provider for a worker, although the worker may elect to change their attending provider and select another attending provider of their choosing. At times, the Attending Provider may be a concurrent care provider instead of the primary care provider. References throughout MARFS apply to Attending Provider types and not solely the attending provider on the claim.

Link: For the legal definition of AP, see WAC 296-20-01002. For information on transferring care between APs, see WAC 296-20-065.

Bundled codes: Procedure codes that aren't separately payable because they are accounted for and included in the payment of other procedure codes and services.

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

By report: A code listed in the fee schedule as "By Report" which 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.

Certified or accredited facility or office: L&I defines a certified or accredited facility or office that has certification or accreditation from 1 of the following organizations:

- Medicare (CMS – Centers for Medicare and Medicaid Services),
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
- Accreditation Association for Ambulatory Health Care (AAAHC),
- American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF),
- American Osteopathic Association (AOA),
- Commission on Accreditation of Rehabilitation Facilities (CARF).

When services are performed in a facility setting, the insurer makes 2 payments:

- One to the professional provider, and
- One to the facility.

Payment to the facility includes resource costs, such as:

- Labor,
- Medical supplies, and
- Medical equipment.

Clinic or non-facility: Procedures performed in a provider's office that are paid at non-facility rates includes office expenses. When services are provided in non-facility settings, the professional provider typically bears the costs of:

- Labor,
- Medical supplies, *and*
- Medical equipment.

Separate payment isn't made to a facility when services are provided in a non-facility setting.

Initial visit: The first visit to a healthcare provider during which the Report of Accident (Workplace Injury, Accident or Occupational Disease) is completed and the worker files a claim for workers' compensation.

Local code modifiers: In addition to the modifiers found CPT® or HCPCS, the insurer uses a series of additional local code modifiers. These modifiers are developed specifically for L&I claims.

Medical records: Includes all documentation to support the services billed, including but not limited to: chart notes, office notes, reports, forms, and flow sheets.

Link: For more information, see WAC 296-20-01002, WAC 296-20-015, WAC 296-20-025, WAC 296-20-12401, and WAC 296 -20-065.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Type of Service: List of codes used for types of service when billing. These codes are based on the provider account type.

- 3 Medical
- 4 Dental
- 9 Miscellaneous services and therapy
- C Chiropractic
- D Naturopathic
- N Nursing
- P Physical therapy
- V Vocational services
- X Outpatient hospital

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–FR (Direct supervision via interactive audio and video telecommunications system)	
Use this modifier to indicate when direct supervision is provided via telehealth.	This type of supervision isn't covered by the insurer. Payment for the service will be denied.
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

General information: All payment policies and fee schedules

Effective date of these policies and fee schedules

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2024.

Who these rules, decisions, and policies apply to and when

Providers

All providers must follow the administrative rules, medical coverage decisions, and payment policies contained within MARFS when providing services to injured workers, and when submitting bills to either State Fund, self-insurers, or Crime Victims Compensation Program. The filing of an accident report or rendering treatment to an injured worker constitutes acceptance of the department's policies, rules, and fees.

Link: For more information, see WAC 296-20-020.

Conflicting policies in CPT®, HCPCS, or CDT®

If there are any services, procedures, or text contained in the physicians' Current Procedural Terminology (CPT®), federal Healthcare Common Procedure Coding System (HCPCS), or Dental Procedure Codes (CDT®) coding books that are in conflict with MARFS, the Department of Labor and Industries' (L&I) rules and policies take precedence.

Link: For more information, see WAC 296-20-010.

Claimants

All policies in this manual apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program, and self-insurers unless otherwise noted. The term claimants is used interchangeably with the term worker.

Links: For more information on L&I WACs, see WAC 296.

For more information on the Revised Code of Washington (RCW), see https://leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx.

Questions may be directed to the:

- Provider Hotline at **1-800-848-0811** or PHL@lni.wa.gov, or
- Crime Victims Compensation Program at **1-800-762-3716**, or
- Self-Insurance Section at **360-902-6901**.

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

MARFS updates and corrections

On occasion, between annual publications, updates and corrections are made to either the policies or the fee schedules. L&I publishes such updates and corrections on their website.

L&I Medical Provider News email listserv

To receive notices about payment policy and fee schedule updates and corrections, you can join the L&I Medical Provider News email listserv. Via email, listserv participants will receive:

- Updates and changes to the Medical Aid Rules and Fee Schedules, *and*
- Notices about courses, seminars, and new information available on L&I's website.

How state agencies develop fee schedules and payment policies

To be as consistent as possible in developing billing and payment requirements for healthcare providers, Washington State government payers coordinate the development of their respective fee schedules and payment policies. The state government payers are:

- The Washington State Fund Workers' Compensation Program (administered by L&I), *and*
- The State Medicaid Program (administered by the Health Care Authority), *and*
- The Public Employees Benefits Board (administered by the Health Care Authority), *and*
- The Department of Corrections.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own funding source, benefit contracts, rates, and conversion factors.

Maximum fees, not minimum fees

L&I establishes maximum fees for services; it doesn't establish minimum fees.

RCW 51.04.030(1) states that L&I shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule.

WAC 296-20-010(2) reaffirms that the fees listed in the fee schedule are maximum fees. Practitioners shall bill their usual and customary fees. The department or self-insurer will pay the lesser of the billed charge or the fee schedules' maximum allowable. Further, no provider may bill the worker for the difference between the allowable fee and usual and customary charge.

Payment review (audits)

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

Links: For more information, see RCW 51.36.100 and RCW 51.36.110.

Workers' choice of healthcare provider

Workers are responsible for choosing their healthcare providers. If provider network requirements apply, the worker may choose any network provider.

In most cases, the provider must be an approved network provider to be eligible for payment of services beyond the **initial visit**.

At the same time, the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow L&I and self-insured employers (collectively known as the insurer) to recommend particular providers or to contract for services:

- RCW 51.04.030(1) allows the insurer to recommend to the worker particular healthcare services or providers where specialized or cost effective treatment can be obtained; however,
- RCW 51.28.020 and RCW 51.36.010 stipulate that workers are to receive proper and necessary medical and surgical care from licensed providers of their choice.

General information: Becoming a provider

Provider Accounts and Credentialing

General information

All providers must have an active L&I provider account to bill for services, including Locum Tenens. Providers must apply through ProviderOne, unless exempt. Visit the Become a Provider webpage for the most up to date information.

Note: L&I isn't using ProviderOne for billing. Use ProviderOne for enrollment and credentialing only.

Medical Provider Network (MPN)

As part of Workers' Compensation Reform laws passed by the 2011 Washington Legislature, L&I created a statewide workers' compensation MPN. Network requirements apply to care delivered in Washington State. Network requirements don't apply to Crime Victim services.

Providers practicing in Washington State must be in the MPN to care for injured workers beyond the initial office or emergency-room visit. This includes treatment for workers of businesses covered by L&I as well as those employed by self-insured employers. The following provider types must enroll in the MPN:

- Medical physicians and surgeons;
- Osteopathic physicians and surgeons;
- Chiropractic physicians;
- Naturopathic physicians;
- Podiatric physicians and surgeons;
- Dentists;
- Optometrists;
- Advanced registered nurse practitioners; and
- Physician assistants.

Note: All out-of-state providers and facilities are exempt and may continue to treat injured workers without joining the network. They must have a provider number and abide by the insurer's fee schedules and payment policies.

Links: For more information on the MPN, see:

RCW 51.36.010, which establishes the legal framework of the network, *and*

WAC 296-20-01010, which establishes the scope of the network, *and*

WAC 296-20-01020 through WAC 296-20-01090, available in WAC 296-20, *and*

The Become a Provider webpage, which includes application materials as well as current information for affected providers, *and*

The Provider Network and COHE Expansion webpage, which includes complete information on the network and the new standards.

Treating Washington injured workers

A provider must have an active L&I provider account number to treat Washington's injured workers and receive payment for medical services. This includes all types of providers, regardless of whether they are required to join the network. For State Fund claims, this proprietary account number is necessary for L&I to accurately set up its automated billing systems.

The federally issued National Provider Identifier (NPI) must be registered with L&I before billing or sending correspondence to the insurer.

Applying for provider account numbers

Groups or facilities, agencies, organizations or institutions must have a Federal Tax Identification Number before submitting an application in ProviderOne.

Providers apply for an L&I account through ProviderOne, unless exempt.

- If you or your organization are new to L&I and new to ProviderOne, apply here.
- If you or your organization are currently using ProviderOne, login, add L&I as an agency, complete any required steps, and submit your enrollment.

Find out if you're exempt at the Become a Provider webpage. If you are an exempt provider, submit the application on the Exempt Provider Application tab.

Out of Country providers see Become an Out of Country Provider.

The following providers have additional application requirements. To fulfill those requirements, visit:

- Chiropractic consultant
- Independent medical examiner
- Interpreter
- Masters Level Therapists (MLTs)
- PGAP® Activity Coach
- Vocational provider
- Work rehabilitation provider

HIPAA covered entity health care providers will need a NPI to apply.

Links: To learn more on how to apply or make changes to your provider account, see Become a Provider.

See more details about the provider account application process in WAC 296-20-12401.

Providers can apply for NPIs online.

Requirements of providers

All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure they are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

Dual licensures or additional certifications

Providers who are also licensed in another discipline (dual-licensed) must have a separate L&I provider account number to perform and bill for those services.

Providers who hold an additional certification for services outside their typical scope of practice must ensure they've uploaded their certification information into their ProviderOne domain in order to perform and bill for services related to that certification.

Providers are expected to bill their services under the correct provider number appropriately, based on the licensure scope of practice, and the location where services are rendered at time of service.

APs must communicate with vocational rehabilitation counselors (VRCs)

All L&I **APs** must abide by WAC 296-19A-030 in the following areas by:

- Maintaining open communication with the worker's assigned vocational rehabilitation provider and referral source,
- Responding to all request for information necessary to evaluate a worker's ability to work, need for vocational services, and ability to participate in a vocational retraining plan, *and*
- Doing all that is possible to expedite the vocational rehabilitation process.

Review Chapter 27: Reports and Forms for VRC-specific forms that may be requested.

Access, Equity, and Respect

Providers must ensure they provide services that are respectful, equitable, and responsive to diverse cultural beliefs, practices, preferred languages, and communication needs.

Providers are required to ensure spoken and sign language access according to Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA). Interpreting for an injured worker or a crime victim is covered by L&I and doesn't require prior authorization. For further details, see Language Access Services.

Billing for services

Once the L&I provider account number is established, and the federally issued NPI is registered with L&I, either number can be used on bills submitted to L&I.

For State Fund providers with multiple accounts under the same tax ID, include the individual account number for the location billing in box 24J of the CMS 1500. This reduces payment delays.

L&I isn't using ProviderOne for billing.

Link: For additional information on electronic billing:

Go to L&I's Provider Express Billing website, or

Contact the Electronic Billing Unit at:

Phone: 360-902-6511
Fax: 360-902-6192

Email: ebulni@Lni.wa.gov

Find a Doctor (FAD) website

If you have an active L&I provider account number, you may opt to join the searchable, online FAD database.

Keep your provider account up-to-date

To prevent payment delays, keep your account up to date in ProviderOne.

Exempt providers are required to complete a Provider Account Change Form (F245-365-000).

Accurate information helps ensure smooth communication between:

- Providers,
- L&I,
- Workers, and
- Employers.

Self-insured employer accounts

For information about setting up provider account(s) to bill for treating self-insured injured workers, see the "General information: Self-insured employers (SIEs)" section of this chapter, below.

Crime Victims Compensation Program accounts

Healthcare providers can use the same L&I provider number to bill for treating State Fund injured workers and crime victims.

Crime Victims providers are exempt from the provider network. Counselors that treat crime victims, but can't treat injured workers, must obtain a provider number through the Crime Victims Compensation program.

New providers can sign up for both programs at the same time using 1 provider application.

Links: You can contact the Crime Victims Compensation Program at **1-800-762-3716**, or email: CrimeVictimsProgram@Lni.wa.gov, or

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

Provider resources for the Crime Victims Compensation Program are available on L&I's website.

General information: Charting format

Required format: SOAP-ER

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, and Plan and progress) format (see below). In workers' compensation, there is a unique need for work status information. To meet this need, the insurer requires the addition of **ER** (Employment and Restrictions) to the SOAP format, and that chart notes document the worker's status at the time of each visit. Chart notes must document:

S - Subjective complaints

- What the worker states about the illness or injury.
- Those symptoms perceived only by the senses and feelings of the person examined, which can't be independently proven or established.

Link: For more information, refer to WAC 296-20-220(1)(j).

O - Objective findings

- What is directly observed and noticeable by the medical provider.
- This includes factual information, for example, "physical exam – skin on right knee is red and edematous", "lab tests – positive for opiates", "X-rays – no fracture".
- Essential elements of the injured worker's medical history, physical examination and test results that support the **AP's** diagnosis, the treatment plan and the level of impairment.
- Those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examining physicians.

Link: For more information, refer to WAC 296-20-220(1)(i).

A - Assessment

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

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

This can also include the:

- Etiology (ET), defined as the origin of the diagnosis, and/or
- Prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P - Plan and Progress

- The provider must recommend a plan of treatment. This is a goal directed plan based on the assessment. The goal must state the expected outcome from the prescribed treatment, and the plan must state how long the treatment will be administered.
- Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to workers.

E - Employment issues

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

R - Restrictions to recovery

- Describe the physical limitations (temporary and permanent) that prevent or limit return to work.
- What other limitations, including unrelated conditions, are preventing return to work?
- Are any unrelated condition(s) impeding recovery?
- Can the worker perform modified work or different duties while recovering (including transitional, part time, or graduated hours)?
- Is there a need for return to work assistance?

Office notes/chart notes, progress notes, and 60-day reports should include the SOAPER contents.

The insurer has additional reporting and documentation requirements which are described in WAC 296-20-06101. Additional documentation requirements are described in the individual payment policy chapters of this document (MARFS), which are broken out by provider or service type. These are in addition to the general documentation requirements that must be followed by all providers per the next policy.

Link: For more information, refer to WAC 296-20-010(8), WAC 296-20-06101, and WAC 296-20-01002 (Chart notes).

General information: Documentation requirements; how improper documentation could impact payment for services

Documentation of services

Providers are required to submit all **medical records** (such as chart notes) that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation must contain the pertinent history and the pertinent findings found during an exam. Clinical staff may review quality of care provided. Providers must maintain documentation in workers' individual records to verify the level, type, and extent of services provided to workers, including that care is proper and necessary.

Chart notes:

- Must be written for a single date of service, *and*
- Must include a full description of treatment rendered as well as documentation of the area of the body treated.

Documentation must include the actual amount of time spent performing each time-based service when:

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

All documentation to support the service billed must be received by the insurer prior to submitting your bill or within 30 days of the date of service, whichever comes first. The insurer may recoup, deny or reduce a provider's level of payment for a specific visit or service if the required documentation isn't provided, the level, type or extent of service doesn't match the procedure code billed, or is not proper and necessary. Refer to WAC 296-20-015.

For documentation best practices, see Practice Resources for Attending Providers.

Limitations

Chart notes must be submitted for each individual date of service and by each individual provider. Joint chart notes of any kind aren't acceptable.

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

Documenting a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

Required content

The insurer won't pay for services unless the documentation includes the name and title of the person performing the service.

Providers can submit forms with a signature stamp or an electronic signature.

Links: For the legal definition of chart notes, see WAC 296-20-01002.

Requirements in addition to CPT®

In addition to the coding guidelines published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. Additional documentation requirements are described in the individual payment policy chapters of this document (MARFS), which are broken out by provider or service type and/or in WAC 296-20-06101.

The insurer may pay separately for specialized reports or forms required for claims management.

"Narrative report" merely signifies the absence of a specific form.

Level of service depends on the CPT® coding requirements.

Medical records are expected to be legible and in the SOAP-ER format.

Links: For more information, see WAC 296-20-06101.

Changes to medical records

Changes made to **medical records** **after bill submission** won't be accepted for determining appropriate payment. If a change to the medical record is made after bill submission, only the original record will be considered in determining appropriate payment of services billed to the insurer.

Changes to the **medical records** amended **prior to bill submission** may be considered in determining the validity of the services billed. All changes to **medical records** must be made according to the rules below. This policy is based on American Health Information Management Association (AHIMA) and Centers for Medicare & Medicaid Services (CMS) guidelines.

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of services. A late entry, addendum, or correction to the medical record must:

- Note the current date of that entry, *and*
- Be signed by the person making the addition or change.

Late entries

A late entry may be necessary to supply additional information that was omitted from the original entry or to provide additional documentation to supplement entries previously written. The late entry must:

- Note the current date,
- Be added as soon as possible, *and*
- Be written by the provider who performed the original service and only if the provider has total recall of the omitted information.

To document a late entry:

- Identify the new entry as a "late entry," *and*
- Enter the current date and time – don't try to give the appearance that the entry was made on a previous date or an earlier time, *and*
- Identify or refer to the date and incident for which the late entry is written, *and*
- If the late entry is used to document an omission, validate the source of additional documentation as much as possible.

Addendums

An addendum is used to provide information that wasn't available at the time of the original entry.

To document an addendum:

- Identify the entry as an "addendum" and state the reason for the addendum referring back to the original entry, *and*
- Document the current date and time, *and*
- Identify any sources of information used to support the addendum.

Corrections

A correction to the medical record requires that these proper error correction procedures are followed:

- Draw a line through the entry, making sure the inaccurate information is still legible, *and*
- Initial and date the entry, *and*
- State the reason for the error, *and*
- Document the correct information.

Falsified documentation

Deliberately falsifying **medical records** is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creating new records at the time records are requested, *or*
- Backdating entries, *or*
- Postdating entries, *or*
- Predating entries, *or*
- Writing over, *or*
- Adding to existing documentation (except as described in late entries, addendums, and corrections, above).

Links: For more information, see RCW 51.48.270, RCW 51.48.290 and RCW 51.48.250.

Documentation requirements when referring worker for care outside of the local community

Whenever it is necessary to refer an injured worker for specialty care or for services outside of the local community, include in the medical notes:

- The medical reason for the referral, *and*
- A statement of why it is reasonable or necessary to refer outside of the community.

Special reports and documentation for industrial insurance claims

In addition to the documentation requirements published by the American Medical Association in the Current Procedural Terminology (CPT®) book, L&I or the self-insurer has additional reporting and documentation requirements to adequately manage industrial insurance claims. These requirements are described in the individual payment policy chapters of this document (MARFS), which are broken out by provider or service type. and in WAC 296-20-06101.

See Chapter 27: Reports and Forms for a list of reports and forms that may be requested by the insurer. L&I's Report of Accident or the self-insurer's Provider's Initial Report are separately payable.

Links: For more information about the SOAP-ER format, see General information: Charting format.

General information: Interpretive Services

How providers arrange for interpretive services

Under the Civil Rights Act of 1964, the healthcare or vocational provider will determine whether effective communication is occurring. The insurer covers the cost of an interpreter for all visits, even if a worker's claim is rejected, up until the date of rejection. The healthcare or vocational provider will determine, with the worker, if the assistance of an interpreter is needed for effective communication to occur.

You may choose to use any of the following interpretation options for covered, billable treatment or services provided to the worker:

- In-person interpretation,
- Over the phone interpretation,
- Video remote interpretation.

For all spoken language interpreter services, the healthcare or vocational provider will schedule an interpreter to provide medical interpretation during an appointment using SOSi (SOS International LLC). The healthcare or vocational provider may not select the same interpreter for every appointment scheduled by the worker, unless there are extenuating circumstances. For in-person interpretation, all scheduled parties must be in person during an encounter with a scheduled interpreter.

The following people aren't covered when providing interpretation:

- Family members, including anyone under 18 years old, *or*
- Friends of the worker, *or*
- Providers or their employees who provide their own interpretation services, *or*
- Interpreters who are not part of L&I's scheduling system or who don't have an L&I provider account number.

Out-of-state interpreters and sign language providers are exempt from the scheduling system and must have their own L&I provider account number to provide services for L&I workers.

Providers must write in their chart notes the reason why an interpreter was used and include the booking ID for any cancelled/unfulfilled interpreter appointment. Include the name of the interpreter and the language. If necessary, sign the Interpreter Services Appointment Record (ISAR).

Interpreter services aren't covered for administrative purposes, such as scheduling or rescheduling an appointment.

For over the phone interpretation or video remote interpretation, the healthcare or vocational provider will use the insurer's contracted vendor SOSi.

International Calls

Providers may access over the phone interpreter services for international calls. The provider, interpreter, and client will have access to a Zoom meeting, which can be joined using a link or by calling in with a phone number. The interpreter will have the ability to call the client from the Zoom meeting if needed.

Links: For more information on interpreter services see:

Chapter 14: Language Access Services.

Chapter 22: Other Services

How providers arrange interpretive services.

Interpreter Lookup Service online tool to help identify interpreters for out-of-state services or for sign interpretation.

For prescheduled appointments, use L&I's vendor SOSi.

General information: Penalties for failing to comply with RCW 51.48.060

The penalty for failing to comply with RCW 51.48.060 is **$580**. For more information, see RCW 51.48.060 and RCW 51.48.095.

The provider penalty for willfully obtaining or attempting to obtain erroneous payments or benefits is **$1161** or 3 times the amount of such excess benefits or payments per occurrence. For more information, see RCW 51.48.080, RCW 51.48.250, and RCW 51.48.095.

General information: Recordkeeping requirements

Which records a provider must keep

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. In the records you keep for each worker, you must include:

- Subjective and objective findings,
- Records of clinical assessment (diagnoses),
- Reports,
- Interpretations of X-rays,
- Laboratory studies,
- Other key clinical information in patient charts, *and*
- Any other information to support the level, type and extent of services provided.

How long a provider must keep records

All records

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years.

L&I may request records before, during or after the delivery of services to ensure workers receive proper and necessary medical care and to ensure provider compliance with the department's MARFS. The provider must submit the requested records within 30 calendar days from receipt of the request. Failure to do so may result in denial or recoupment of bill payment(s).

Link: For more information, see WAC 296-20-02005 and WAC 296-20-02010.

X-rays

Providers are required to keep all X-rays for a minimum of 10 years.

Link: For more information, see WAC 296-20-121 and WAC 296-23-140.

General information: Self-insured employers (SIEs)

How Self-Insurance works in Washington

SIEs or their third party administrators (TPA) administer their own claims instead of paying premiums to the State Fund.

SIEs must authorize treatment and pay bills according to Title 51 RCW and the Medical Aid Rules (WACs) and Fee Schedules of the state of Washington (WAC 296-15-330(1)), including the payment policies described in this manual.

For SIE claims, healthcare providers should send their bills, reports, requests for authorization, and other correspondence directly to the SIE/TPA.

Links: A list of SIE/TPAs is available online.

SIE/TPA provider identification numbers

To bill SIE/TPAs for workers' compensation claims, contact the individual insurer directly for their provider identification number requirements.

Medical Provider Network providers should use their individual NPI in Box 24J of the CMS 1500 form to facilitate prompt payment.

Special SIE claim forms

Self-Insurer Accident Report (SIF-2)

SIEs use the SIF-2 to establish a new claim and assign a claim number.

Only the SIE and the worker complete the SIF-2.

Provider's Initial Report (PIR)

PIR forms are supplied to providers to assist self-insured injured workers in filing claims. The PIR is used in the same way the Report of Accident (ROA) form is used for State Fund covered workers.

Only the provider and the worker complete the PIR.

Providers may bill for interest on medical bills for self-insured claims only

Providers are entitled to bill interest for late payment of any proper medical bills on self-insured claims (RCW 51.36.085).

- Use Local Code **1159M** to bill for interest.
- Use the Self-Insurance Medical Bill Interest Calculator to calculate the correct interest due. Call (360) 902-6938 with questions.

Disputes between providers and SIEs

The Self-Insurance (SI) Program of L&I regulates the SIEs for compliance with RCW, WAC, policies, and fee schedules.

If a dispute arises between a provider and an SIE, the provider may ask the SI program to intervene and help resolve the dispute. For disputes related to:

- **Treatment authorization or nonpayment of bills**, the SI Claims Adjudicator assigned to the claim will handle the dispute. Call the Self-Insurance Program's receptionist at 360-902-6901 to be directed to the appropriate claim adjudicator.
- **Underpayments of bills**, the SI section medical compliance consultant will handle the dispute. Complete and submit Self-Insurance Medical Provider Billing Dispute form (F207-207-000). Call 360-902-6938 with questions.

General information: Submitting claim documents to the State Fund

How to submit

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. The imaging system can't read some types of paper and has difficulty passing other types through automated machinery.

Bills should never be faxed to the department.

Documents faxed to the department are automatically routed to the claim file; paper documents are manually scanned and routed to the claim file.

Do this

When submitting documents:

- Do submit documents on white 8 ½ x 11-inch paper (1 side only), *and*
- Do leave ½ inch at the top of the page blank, *and*
- Do put the patient's name and claim number in the upper right hand corner of each page, *and*
- Do, if there is no claim number available, substitute the patient's social security number, *and*
- Do reference only 1 worker/patient in a report or letter, *and*
- Do submit together all documents pertaining to 1 claim, *and*
- Do emphasize text using asterisks or underlines, *and*
- Do include a key to any abbreviations used, *and*
- Do submit legible information.

Don’t do this

When submitting documents:

- Don’t use colored paper, especially hot or intense colors, *and*
- Don’t use thick or textured paper, *and*
- Don’t send carbonless paper, *and*
- Don’t use any highlighter markings, *and*
- Don’t place information within shaded areas, *and*
- Don’t use italicized text, *and*
- Don’t use paper with black or dark borders, especially on the top border, *and*
- Don’t submit documents for different workers/patients together.

Where to submit

Submitting State Fund bills, reports, and correspondence to the correct addresses or fax numbers:

- Helps L&I process your documents promptly and accurately,
- Can prevent significant delays in claim management,
- Can help you avoid repeated requests for information you have already submitted, *and*
- Helps L&I pay you promptly.

Link: **Attending providers** have the ability to send secure messages through the Claim and Account Center.

The following table shows where you may fax or send correspondence and reports.

If you are **submitting**…	Then you can **fax** to:	Or send to this **State Fund mailing address**:
Report of Accident (ROA) Workplace Injury or Occupational Disease (also known as "Accident Report" or "ROA") (F242-130-000)	**360-902-6690** or **800-941-2976** Hot ROA Fax for hospital admissions **360-902-4980** **These fax numbers are for ROAs only!**	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, Activity Prescription Forms (**APFs**), **Reports and chart notes** for State Fund Claims, and **Claim related documents** other than bills.	**360-902-4567**	Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291 **Reports and chart notes must be submitted separately from bills.**
Provider Account information **updates**	**360-902-4484**	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261

If you are **submitting**…	Then you can **fax** to:	Or send to this **State Fund mailing address**:
Bills, including: • UB-04 forms, • CMS 1500 forms, • Retraining & job modification bills, • Home nursing bills, • Miscellaneous bills, • Pharmacy bills, • Compound prescription bills, and • Requests for adjustment.	**Don't fax bills!**	Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund **refunds** (attach copy of remittance advice) (F245-043-000)	N/A	Management Services Cashier – MIPS Deposit Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835

Link: These and other forms are available at L&I's Billing Forms and Publications website .

General information: Telehealth

Several of the chapters include details pertaining to the delivery of services through **telehealth**. No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person in the applicable chapters for additional information.

A Report of Accident (ROA/PIR) may **only** be filed as part of an in-person physical examination of the injured worker. This service may **not** be done via **telehealth**, except for mental health only claims.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

The department requires use of modifier **–GT** for most **telehealth** services. See the applicable chapter for more details.

For further details regarding **telehealth** service requirements, see:

- Chapter 7: Chiropractic Services
- Chapter 10: Evaluation and Management Services
- Chapter 17: Mental Health Services
- Chapter 19: Naturopathic and Acupuncture Services
- Chapter 20: Nurse Case Management
- Chapter 22: Other Services
- Chapter 25: Physical Medicine Services
- Chapter 30: Vocational Services
- Chapter 33: Brain Injury Rehabilitation Services
- Chapter 34: Chronic Pain Management

Payment policy: All professional services

Coverage of procedures

Medical coverage decisions

To ensure quality of care and prompt treatment of workers, L&I makes general policy decisions, called “medical coverage decisions”. Medical coverage decisions include or exclude a specific healthcare service as a covered benefit.

Procedure codes that aren’t covered

Procedure codes listed as “not covered” in the fee schedules aren’t covered for the following reasons:

- The treatment isn’t safe or effective, or is controversial, obsolete, investigational, or experimental, *or*
- The procedure or service is generally not used to treat industrial injuries or occupational diseases, *or*
- The procedure or service is payable under another code.

On a case-by-case basis, the insurer may pay for procedures in the first two categories above. To be paid, the healthcare provider must:

- Submit a written request, *and*
- Obtain approval from the insurer prior to performing any procedure in these categories.

The request must contain:

- The reason,
- The potential risks and expected benefits,
- The relationship to the accepted condition, *and*
- Any additional information about the procedure that may be requested by the insurer.

Links: For more information on coverage decisions and covered services, refer to WAC 296-20-01505, WAC 296-20-02700 through -02850 available in WAC 296-20, WAC 296-20-030 through -03002 available in WAC 296-20, and WAC 296-20-1102.

Requirements for billing

Unlisted procedure codes

Some covered procedures don't have a specific code or payment level listed in the fee schedule. When reporting such a service, the appropriate unlisted procedure code must be billed. Within the chart notes or surgical report, supporting documentation including a full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using the established procedure codes. Modifiers must be included. **The provider also must list the most similar procedure code or codes to the services performed including units of service.**

No additional payment is made for the supporting documentation.

Links: For more information, refer to WAC 296-20-01002 and to the fee schedules.

For more information about licensed nursing services and payment, see WAC 296-23-245.

Physician Assistants (PA)

To be paid for services, PAs must:

- Have a valid individual L&I provider account numbers referencing their supervising physician, *and*
- Bill for services using their provider account numbers, *and*
- Use the appropriate billing modifiers.

Note: Services performed by a PA and co-signed by the supervising physician must be submitted under the PA's individual L&I provider account number.

Payment limits

Providers may not charge workers for copayments or deductibles. The worker may not be balance billed for any services that are claim related. See RCW 51.04.030(2) and WAC 296-20-020.

Administrative billing

Providers may not charge workers or the insurer for administrative activities, including but not limited to:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine communications related to appointments (including, but not limited to, requests and reminders),
- Ordering prescriptions, including requests for refills,
- Test results that are informational only, *or*
- Communications with office staff.

Don't bill the worker for services not covered by the insurer for treatment related to the industrial injury unless an agreement is reached by the worker and the provider. Wellness plans or programs designed to improve overall health and fitness aren't covered.

Physician Assistants (PAs)

Physician Assistant services must be billed under their own provider number but are paid to the supervising physician or employer up to a maximum of 90% of the allowed fee. The fee schedules for DME, supplies, and materials applies equally to all providers. There is no reduction for these supplies and equipment if prescribed by a PA.

PAs may sign any documentation required by the department for services they provide.

Consultations and impairment rating services related to workers' compensation benefit determinations aren't payable to physician assistants.

Links: For more information about physician assistant services and payment, see WAC 296-20-12501, RCW 51.28.100, and WAC 296-20-01501.

Units of service

Payment for billing codes that don't specify a time increment or unit of measure are limited to 1 unit per day. For example, only 1 unit is payable for CPT® code **97022** regardless of how long the therapy lasts.

Payment policy: Attending Providers (APs)

General information

APs are a key resource for workers. Responsibilities include:

- Initiating workers' compensation benefits by completing the report of accident,
- Educating workers on their benefits,
- Reporting worker progress,
- Helping workers' return to a productive work life,
- Rating impairments when conditions have reached maximum medical improvement,
- Accepting and abiding by the Medical Aid Rules and Fee Schedules, *and*
- Reporting suspected fraud, claim suppression, and unsafe working conditions.

Workers have the right to select their **Attending Provider**. The worker may transfer that responsibility to another provider. See WAC 296-20-065 for details.

Who must perform these services to qualify for payment

A worker's attending provider is the provider who directs their treatment. Only the following provider types may be an **AP**:

- Licensed practitioners of medicine, osteopathic medicine and surgery, chiropractic, dentistry, podiatry, optometry, or naturopathy,
- Advanced Registered Nurse Practitioner, *or*
- Physician assistants.

An active **provider account** number is required prior to treating a worker, except for initial office or emergency visits per WAC 296-20-015.

Providers who can be an **AP** aren't necessarily always the attending provider on a worker's claim. Only one provider on a claim may hold this role at a time. All other providers who are treating the worker and aren't the **AP** are considered concurrent care providers.

Further resources are available on our website.

Prior authorization

Prior authorization for conservative care is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker

Link: For more information, see WAC 296-20-030(1).

Certain services require prior authorization. See the fee schedule for details. Certain services may require utilization review by the state fund's contract manager. See Professional provider payment methods for details.

Services that can be billed

Attending Providers may bill for services within their scope of practice and that adhere to the department's rules and policies. For more information, including service and documentation requirements and payment limits, see the appropriate MARFS policy chapter for the services being provided. See the professional fee schedule and the All professional services section in this chapter for additional coverage information.

Services that aren't covered

Certain services aren't covered by the insurer. See the professional fee schedule, WAC 296-20, medical coverage decisions, and our website for details.

Payment policy: Billing codes and modifiers

Procedure codes used in the fee schedules

L&I's fee schedules use the federal CPT®, CDT, HCPCS and agency unique local codes (see more information, below).

Procedure codes

The descriptions and complete coding information are found in the current CDT®, CPT®, or HCPCS manuals.

The fee schedule lists all covered codes (including **bundled**, **By Report** and the maximum fee) and some non-covered codes. If a code isn't listed in the fee schedule, it isn't covered.

Link: For more information, please see our complete fee schedule.

Code description limits

Due to space limitations, only partial descriptions of HCPCS or CDT® codes appear in the fee schedules.

Due to copyright restrictions, there aren't descriptions for CPT® codes in the fee schedules.

Providers' responsibility when billing

Providers must bill according to the full text descriptions published in the CDT®, CPT®, and HCPCS books. These books can be purchased from private sources.

Link: For more information, refer to WAC 296-20-010(1).

CPT® codes (HCPCS Level I codes)

Codes

HCPCS (commonly pronounced “hick picks”) Level I codes are the CPT® codes developed, updated, and copyrighted annually by the American Medical Association (AMA). There are three categories of CPT® codes:

- **CPT® Category I codes** are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, and don’t include newly emerging technologies. The codes consist of five numbers (for example, **99202**), and
- **CPT® Category II codes** are optional and used to facilitate data collection for tracking performance measurement. The codes consist of four numbers followed by an F (for example, **0001F**), and
- **CPT® Category III codes** are temporary and used to identify new and emerging technologies. The codes consist of four numbers followed by a T (for example, **0001T**).

Modifiers

HCPCS Level I modifiers are the CPT® modifiers developed, updated, and copyrighted by the AMA. These modifiers are used to indicate that a procedure or service has been altered without changing its definition.

These modifiers consist of two numbers (for example, **–22**).

Note: L&I doesn’t accept the five digit modifiers.

HCPCS Level II codes and modifiers

Codes

HCPCS Level II codes (usually referred to simply as “HCPCS codes”) are updated by the Center for Medicare & Medicaid Services (CMS). HCPCS codes are used to identify:

- Miscellaneous services,
- Supplies,
- Materials,
- Drugs, and
- Professional services.

These codes begin with 1 letter, followed by four numbers (for example, **K0007**).

Codes beginning with D are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3®).

Modifiers

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered. These modifiers consist of either:

- Two letters (for example, **–AA**), *or*
- 1 letter and 1 number (for example, **–E1**).

Local codes and modifiers

Codes

Local codes are used to identify unique services or supplies.

These codes consist of four numbers followed by 1 letter (except F and T). For example, **1040M**, which must be used to code completion of the State Fund’s Report of Accident and Self-Insurer’s Provider’s Initial Report forms.

L&I may modify local code use as national codes become available.

Modifiers

Local code modifiers are used to identify modifications to services.

These modifiers consist of 1 number and 1 letter (for example, **–1S**).

L&I may modify local modifier use as national modifiers become available.

Local modifiers for contracted services are only listed in the specific contract.

Quick reference guide for all billing codes and modifiers

If the **billing code type** is…	Then the **purpose** of the code is:	And the **code format** is:	And the **modifier format** is:	And the **source** of the code is:
HCPCS Level I: **CPT® Category I**	Professional services, pathology and laboratory tests.	5 numbers	2 numbers	AMA / CMS
HCPCS Level I: **CPT® Category II**	Tracking codes, to help collect data for tracking performance measurement.	4 numbers followed by F	N/A	AMA / CMS
HCPCS Level I: **CPT® Category III**	Temporary codes for new and emerging technologies.	4 numbers followed by T	N/A	AMA / CMS
HCPCS Level II (HCPCS code)	Miscellaneous services, supplies, materials, drugs, and professional services.	1 letter followed by 4 numbers	2 letters, or 1 letter followed by 1 number	AMA / CMS
Local code (unique to L&I)	L&I unique services, materials, and supplies.	4 numbers followed by 1 letter (but not F or T)	1 number followed by 1 letter	L&I

Modifier use throughout MARFS

The modifier section at the beginning of each chapter includes only modifiers mentioned in the text. Refer to current CPT® and HCPCS books for a complete list of modifiers, with their descriptions and instructions for use.

Link: See the L&I Professional Services Fee Schedules for modifier and procedure code details.

Local code modifiers

The following is a complete list of local code modifiers:

Use	Payment Information
–1S (Surgical dressings for home use)	
Use this modifier to indicate when surgical dressing supplies are dispensed for home use. Bill with the appropriate HCPCS code for each dressing item.	Services with this modifier may be bundled, based on who is providing the dressings. If not bundled, payment is made at **100%** of the fee schedule level or billed charge, whichever is less.
–7N (Services in conjunction with an IME)	
Use this modifier to indicate when services are requested for an IME.	This modifier doesn't affect payment but is necessary to describe the service performed.
–8R (COHE modifier for case management codes and consultations)	
Use this modifier to indicate when the billing provider is part of a Centers of Occupational Health & Education (COHE) program.	Payment is made at **110%** of the fee schedule level or billed charge, whichever is less.
–8S (Health/Surgical health services coordination by a Health Services Coordinator)	
Use this modifier to indicate when a second billable HSC case note on the same day, for the same claimant, under the same claim. Bill each case note on separate lines and apply this modifier to the second line.	Payment for the second case note is made at **50%** of the fee schedule level or billed charge, whichever is less.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Billing instructions and forms

Who to bill (which insurer)

Each insurer uses a unique format for claim numbers. This will help you identify which insurer to bill for a specific claim:

State Fund claims either begin with:

- The letters A, B, C, F, G, H, J, K, L, M, N, P, X, Y or Z followed by six digits, *or*
- Double alpha letters (example AA) followed by five digits.

Self-insured claims either begin with:

- S, T, or W followed by six digits, *or*
- Double alpha letters (example SA) followed by five digits.

Crime Victims claims either begin with:

- V followed by six digits, or
- Double alpha letters (example VA) followed by five digits.

Special cases

Claims for contractors hired to clean up the Hanford Nuclear Reservation for the Department of Energy (US) are self-insured.

Federal claims begin with A13 or A14.

Link: Questions and billing information about federal claims should be directed to the U.S. Department of Labor at **202-693-0036**, **206-470-3100**, or **866-692-7487** (Northwest district) or their website.

Workers covered by Medicare

If a worker has an allowable workers' compensation injury or illness, workers' compensation is always the sole insurer for the injury or illness.

- Medicare is never a secondary payer for workers' compensation claims. The workers' compensation insurer's payment is the full payment.
- Medicare can't be billed for allowed workers' compensation claims.
- If Medicare is incorrectly billed for a workers' compensation claim, the provider is required to reimburse all payments made by Medicare. Covered services provided to injured workers may only be billed to L&I or the self-insurer.

Report of Accident (ROA/PIR) requirements

A Report of Accident (ROA/PIR) may **only** be filed as part of an in-person physical examination of the injured worker. This service may **not** be done via **telehealth**, except for mental health only claims.

Telehealth services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

All information voluntarily provided by the worker in the Worker and Employer sections of the Report of Accident (ROA) must be included in electronic data submissions. All fields in the Provider section of the ROA must be completed and must be included in electronic data submissions. These requirements must be met to qualify for the $10 financial incentive for electronic submission of ROAs.

Providers now have the option to file State Fund ROAs online via FileFast or through Health Information Exchange (HIE).

Online filing of the State Fund accident report reduces delays in claim management. Benefits of filing a ROA online include:

- Immediate confirmation of receipt.
- Faster authorization for treatment and prescription refills.
- Increased accuracy (reduces common mistakes).
- The provider is instantly assigned to the claim.
- Pharmacists can fill additional prescriptions.
- Quick access to the claim.
- $10 additional reimbursement for online filing (code **1040M**).

ROAs/PIRs submitted within 5 business days after an injured worker's **initial visit** are paid at a higher rate than ROAs/PIRs submitted after 5 business days. The insurer pays for completion of ROAs/PIRs on a graduated scale based on when they are received by the insurer following the "Initial visit"/"This exam date" (box 15b on the paper ROA form, and box 3 on the PIR form).

	Within 5 days	6-8 days	9 days or more
Max fee via paper or fax	**$46.01**	**$36.01**	**$26.01**
Max fee via FileFast/HIE – State Fund only (additional $10 incentive; add to your bill when submitting)	**$56.01**	**$46.01**	**$36.01**

Note: When filing State Fund ROAs via FileFast make sure to add the $10 web incentive to your bill.

Link: Information about online filing options is available on our FileFast website or by calling **877-561-3453**.

Information is available online about filing through the Health Information Exchange (HIE).

Payment incentives on State Fund claims

Providers must bill their usual and customary charges. For ROAs received more than 5 business days from “This exam date” (box 15b on paper ROA), L&I’s payment system automatically reduces the ROA payment.

Payments are increased for participation in the Centers of Occupational Health and Education (COHE) or for online claim filing (FileFast).

Who may be paid for completion of the ROA/ Providers Initial Report (PIR)

A provider with a valid provider account number may be paid for completing an ROA or PIR if they are licensed as 1 of the following:

- Advanced Registered Nurse Practitioner (ARNP)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Medical Doctor (MD)
- Naturopathic Doctor (ND)
- Doctor of Optometry (OD)
- Physician Assistant Certified (PA-C) / Physician Assistant (PA)

Billing requirements

Bill only 1 ROA or PIR per claim, using local code **1040M**.

Submit the ROA or PIR to the insurer immediately following the “Initial visit” (which the ROA and PIR calls “This exam date”).

Complete the ROA F242-130-000 (English) using the instructions on the form.

Complete the PIR using instructions on the back of form F207-028-000. If you need additional space, attach the information to the application, and include the claim number at the top of the page.

Reimbursement amount is based on the date the healthcare provider includes in box 15b of the paper ROA, and in box 3 of the PIR, Attending Health Care Provider section, (This exam date). If that box is blank, the department’s payment system will look at box 16 of the paper ROA (Signature of the health care provider) and the self-insurer will look at box 13, (Date) in the Attending Health Care Provider section. To ensure correct payment, make sure the ROA/PIR is filled out completely.

Billing procedures

Information on billing procedures is outlined in WAC 296-20-125.

Billing manuals and billing instructions

The General Provider Billing Manual (F245-432-000) and L&I's provider specific billing instructions contain:

- Billing guidelines,
- Reporting and documentation requirements,
- Resource lists, and
- Contact information.

Additional billing manuals:

- CMS 1500 Billing Manual (F245-423-000)
- Crime Victims Direct Entry Billing Manual (F800-118-000)
- Direct Entry Billing Manual (F245-437-000)
- Home Health Services Billing Manual (F245-424-000)
- Hospital Services Billing Manual (F245-425-000)
- Mental Health Fee Schedule and Billing Guidelines (F800-105-000) (For the Crime Victims Program)
- Miscellaneous Services Billing Manual (F245-431-000)
- Pharmacy Billing Manual (F245-433-000)
- Retraining and Job Modification Billing Manual (F245-427-000)

Billing workshops

L&I offers providers free billing workshops to help you save time and money by:

- Learning to bill L&I correctly,
- Getting new tools for doing business with L&I, *and*
- Meeting your Provider Support and Outreach Representatives.

Electronic billing for State Fund bills

Electronic billing is available to all providers of services to injured workers covered by the State Fund. Electronic billing is helpful because it:

- Allows greater control over the payment process,
- Eliminates entry time,
- Allows L&I to process payments faster than paper billing,
- Reduces billing errors, *and*
- Decreases the costs of bill processing.

Your correspondence and reports may be faxed to L&I, but **bills can't be faxed**. There are three secure ways providers can bill L&I electronically:

- Free online billing form with Direct Entry submission through Provider Express Billing (PEB) (no specific software/clearinghouse required), *or*
- Upload bills using your software (the department doesn't supply billing software for electronic billing), *or*
- Use an intermediary/clearinghouse.

Note: Don't fax bills to L&I.

Where to find electronic billing information

Fax numbers can be found in the "Submitting claim documents to the State Fund" payment policy section (earlier in this chapter) or on L&I's website.

For additional information on electronic billing, go to our Provider Express Billing website or contact the Electronic Billing Unit at:

Phone: **360-902-6511**

Fax: **360-902-6192**

Email: ebulni@Lni.wa.gov

Information on Crime Victims compensation is available on L&I's website.

Billing forms

Providers must use L&I's current billing forms. **Using out-of-date billing forms may result in delayed payment.**

Links: Medical provider forms can be found on L&I's website.

Rebills, Adjustments and Refunds – When to submit a billing adjustment vs. a new bill to the State Fund

If a provider identifies an overpayment or underpayment, an adjustment or refund is required. Per WAC 296-20-02015, if the provider receives payment they're not entitled to, the provider must repay the excess payment (plus accrued interest).

Type of submission	Scenario	How to Submit	Notes
Rebill (resubmission) Rebills refers to the submission of an exact duplicate of the original bill: same charges, codes and billing date.	**Entire bill was previously denied** due to claim closure or rejection, which has subsequently been reopened or is now allowed. Disagreements regarding bills denied for all other reasons, see Billing Limitations, Appeals & Protests.	Submit an exact duplicate of the denied bill via: • Direct entry, *or* • Electronically using your own billing software, *or* • Electronically through your clearinghouse, *or* • Other approved form.	Please indicate "rebill" on the new bill. Must be received within 1 year from the date of the reopening order.

Type of submission	Scenario	How to Submit	Notes
Adjustment (correction) An adjustment refers to a request to correct or alter a previously paid or partially paid bill.	**Correct** a previously paid or partially paid bill, due to a billing error that resulted in an: • **Underpayment**, *or* • **Partial overpayment**. If an entire bill or service was billed correctly and denied in error, a protest is required. Do not submit an adjustment.	• Complete the Provider's Request for Adjustment form and send it to the address on the form, *or* • Direct entry, *or* • Electronically using the provider's own billing software, *or* Electronically through clearinghouse.	Must be received within 90 days from the date of payment, with the exception of providers who are under review by the department and are asked to submit adjustments as part of that review. Once processed, any under or overpayments will be added to or taken out of your next remittance advice.
Refund	Repay the department for an entire bill or line item identified as an **overpayment**.	• Refund Notification form. Complete and return, along with payment, to the address on the form.	Please include a copy of the remittance advice (RA).

Note: If billing is infrequent, it's recommended to submit a refund instead of an adjustment to ensure your account is not placed in a negative status, which may incur interest charges. Do not submit both an adjustment and a refund.

Link: Additional information on adjustments is available on our Getting a payment adjusted webpage and in Billing Limitations, Appeals & Protests in this chapter.

Billing for missed appointments

Workers are expected to attend scheduled appointments.

WAC 296-20-010(5) states: L&I or self-insurers won't pay for a missed appointment unless the appointment is for an examination arranged by L&I or the self-insurer.

A provider may bill a worker for a missed appointment per WAC 296-20-010(6) if the provider:

- Has a missed appointment policy that applies to all patients regardless of payer, *and*
- Routinely notifies all patients of the missed appointment policy.

Providers must notify the claim manager immediately when an injured worker misses an appointment.

The insurer isn't responsible or involved in the implementation and/or enforcement of any provider's missed appointment policy.

Payment Policy: Billing Limitations, Appeals & Protests

Billing Limitations

- **Timely filing:** Bills must be submitted within 1 year from the date of service to be considered for payment per WAC 296-20-125.
- **Denied bills**
    - If the bill was denied due to claim closure or rejection, which has been subsequently reopened or are now allowed, the provider can be rebill. Rebills should be identical to the original bill; same charges, codes and billing date and must be received within 1 year of the date of the reopening order.
    - If the bill was denied due to lack of authorization, refer to the Explanation of Benefit (EOB) code on the remittance advice (RA) for how to seek authorization or see Retrospective Authorization for more information.
    - If the bill was denied for any other reason and the provider disagrees, they can submit a formal protest to L&I or an appeal to BIIA within 60 days of receipt of the remittance advice or notice showing the denial to reconsider payment.
- **Adjustments:** Requests to correct a previously paid or partially paid bill, due to a billing error, must be received within 90 days from the date of payment, with the exception of providers who are under review by the department and are asked to submit adjustments as part of that review.

Failure to submit within limitations noted above will result in the department's payment, non-payment and/or decision being final.

Link: See WAC 296-20-125, RCW 51.52.060, Rebills, Adjustments and Refunds in this chapter, Getting a payment adjusted or Retrospective authorization for more information.

Protests and Appeals

Limitations

In accordance with RCW 51.52.060, if a provider disagrees with a denied bill or service, a formal protest to L&I or appeal to the Board of Industrial Insurance Appeals (BIIA) is required upon receipt of remittance advice, order and notice or award within the following timeframes:

- 60 days for a claim or payment decision, or
- 20 days for a billing decision that reduces the amount paid or demands repayment by the insurer.

If the insurer or BIIA does not receive a written protest or appeal by this time, the decision is final.

Vocational disputes should be received by the department within 15 days of receipt of notification per WAC 296-19A-450.

Note: Processed adjustments – as in adjustments the insurer has returned to the provider following processing – that result in no change or increase in payment are subject to the 60-day limitation, while any reduction in payment is subject to the 20-day limitation. Payment is considered final after these timeframes have passed.

Submitting a protest or appeal

To submit a protest or appeal for an L&I decision either:

- Protest directly to L&I for reconsideration of the decision, or
- Appeal directly to the Board of Industrial Insurance Appeals (BIIA). Once the appeal is received by the BIIA, they will notify the department and give L&I an opportunity to reconsider the original decision. If L&I doesn't reconsider the decision, the BIIA will notify the provider about the status of the appeal.

If a provider disagrees with a decision made by a self-insured employer, the provider must file a protest directly to L&I.

Protests to L&I

To protest a decision directly to L&I for reconsideration, provider should submit a written protest to the Claim Manager that includes:

- Worker's name and L&I claim number (include on every page),
- Claim Manager (CM) name,
- Description and date of L&I decision,
- Why you disagree with the decision, and
- If protesting a closed claim, an outline of worker's current condition and a description of the worker's treatment and current prognosis.

If the protest is timely, L&I will issue another decision that modifies, reverses or reaffirms the original decision. If there is disagreement with the decision, the provider may appeal to BIIA.

For protests related to an audit, please submit a written request for reconsideration as directed on the order.

Appeals to the Board of Industrial Insurance Appeals (BIIA)

A written appeal to BIIA should include the following:

- Name and address of the injured worker,
- Name and address of the employer,
- L&I claim number,
- Date of injury or occupational disease,
- Date of the L&I decision being appealed,
- County in which you would like proceedings to be held, and
- What you are asking for.

For appeals related to an audit or eligibility, see Provider appeal on the BIIA website.

Link: See RCW 51.52, Protesting an L&I Claim Decision, and BIIA Workers' Compensation Appeals for more information.

For disputes related to vocational services see RCW 51.32.095 and Vocational Dispute Resolution.

Payment policy: Current coverage decisions for medical technologies and procedures

Coverage decisions for medical technologies and procedures

Before providing services to injured workers, please review L&I's published coverage decisions to determine whether the treatment or medical technology is covered and if there are any specific restrictions or conditions.

Payment policy: Overview of payment methods

Ambulatory Surgery Center (ASC) payment methods

ASC rate calculations

Insurers use a modified version of the ASC payment system developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC.

Links: For more information on this payment method, see Chapter 32: Ambulatory Surgery Centers (ASCs) or refer to WAC 296-23B.

By report

Insurers pay for some covered services on a **By Report** basis. Fees for **By Report** services may be based on the value of the service as determined by the report.

Maximum fees

For services covered in ASCs that aren't priced with other payment methods, L&I establishes maximum fees.

Hospital inpatient payment methods

The following is an overview of the hospital inpatient payment methods. For more information, see Chapter 35: Hospitals or refer to WAC 296-23A.

Self-insurers

Self-insurers use Percent of Allowed Charges (POAC) to pay for all hospital inpatient services.

Link: For more information, see WAC 296-23A-0210.

All Patient Refined Diagnosis Related Groups (APR DRG)

State Fund uses All Patient Refined Diagnosis Related Groups (APR DRGs) to pay for most inpatient hospital services.

Link: For more information, see WAC 296-23A-0200.

Per Diem

Hospitals paid using the APR DRG method are paid per diem rates for APR DRGs designated as low volume.

State Fund low volume APR DRG categories include:

- Chemical dependency,
- Psychiatric,
- Rehabilitation,
- Medical, and
- Surgical.

Percent of Allowed Charges (POAC)

State Fund uses a POAC payment method:

- For some hospitals exempt from the APR DRG payment method, and
- As part of the outlier payment calculation for hospitals paid by the APR DRG.

Hospital outpatient payment methods

The following is an overview of the hospital outpatient services payment methods. For more information, see Chapter 35: Hospitals or refer to WAC 296-23A.

Self-insurers

Self-insurers use the maximum fees in the Professional Services Fee Schedule to pay for:

- Radiology,
- Pathology,
- Laboratory,
- Physical therapy, and
- Occupational therapy services.

Self-insurers use POAC to pay for hospital outpatient services that aren't paid with the Professional Services Fee Schedule.

Link: For more information, see WAC 296-23A-0221.

Ambulatory Payment Classifications (APC)

State Fund pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

Link: For more information, see WAC 296-23A-0220.

Professional Services Fee Schedule

State Fund pays for most services not processed using the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services are paid by a POAC payment method **when they aren't processed using**:

- The APC payment method, *or*
- The Professional Services Fee Schedule, *or*
- By L&I contract.

Out-of-state hospital payment methods

For information on out-of-state hospital outpatient, inpatient, and professional services payment methods, see WAC 296-23A-0230.

Pain management payment methods

Chronic Pain Management Program fee schedule

Insurers pay for Chronic Pain Management Program Services using an all-inclusive, phase based, per diem fee schedule.

Professional provider payment methods

The following is an overview of the payment methods for professional provider services. For more information, see the relevant payment policy chapters or refer to WAC 296-20, WAC 296-21, and WAC 296-23.

The Professional Services Fee Schedule is available online.

Resource-Based Relative Value Scale (RBRVS)

Insurers use the Resource-Based Relative Value Scale (RBRVS) to pay for most professional services.

Services priced according to the RBRVS fee schedule have a fee schedule indicator of R in the Professional Services Fee Schedule.

Links: More information about RBRVS is contained in Chapter 31: Washington RBRVS Payment System.

Anesthesia fee schedule

Insurers pay for most anesthesia services using anesthesia base and time units.

Link: For more information, see Chapter 4: Anesthesia Services.

Pharmacy fee schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule.

Link: For more information, see Chapter 24: Pharmacy Services.

Drugs paid using Average Wholesale Price (AWP)

L&I's maximum fees for some covered drugs administered in or dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug.

Drugs priced with an AWP method have **AWP** in the "Dollar Value" columns and a D in the fee schedule indicator (FSI) column of the Professional Services Fee Schedule.

Links: For more information, see Chapter 24: Pharmacy Services.

For a definition of "Average Wholesale Price" (AWP), see WAC 296-20-01002.

Clinical laboratory fee schedule

L&I's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS.

Services priced according to L&I's clinical laboratory fee schedule have an FSI of "L" in the Professional Services Fee Schedule.

Flat fees

L&I establishes rates for some services that are priced with other payment methods.

Services priced with flat fees have an FSI of “F” in the Professional Services Fee Schedule.

State Fund contracts

State Fund pays for utilization management services by contract.

Services paid by contract have an FSI of “C” in the Professional Services Fee Schedule.

The Crime Victims Compensation Program doesn’t contract for any services listed with an FSI of “C” on the fee schedule.

By report

Insurers pay for some covered services on a **By Report** (BR) basis. Fees for BR services may be based on the value of the service as determined by the report.

Services paid BR have an FSI of “N” in the Professional Services Fee Schedule and BR in other fee schedules.

Program only

Insurers pay for some unique services under specific programs. Example programs include:

- Centers for Occupational Health Education (COHE), *and*
- Progressive Goal Attainment Program (PGAP), *and*
- Orthopedic and Neurological Surgeon Quality Program.

Residential facility payment methods

Assisted living facilities, adult family homes, and boarding homes

Insurers use per diem fees to pay for medical services provided in assisted living facilities, adult family homes, and boarding homes.

Nursing Homes and Transitional Care Units utilizing swing beds for long term care

Insurers use a modified version of the Patient Directed Payment Model (PDPM) utilizing Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facilities (SNF) codes to develop daily per diem rates to pay for Nursing Home Services.

Critical Access Hospitals and Veterans Hospitals utilizing swing beds for sub-acute care or long term care

Insurers use hospital specific POAC rates to pay for sub-acute care (swing bed) services.

Payment policy: Split billing – treating two separate conditions

Requirements for billing

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

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

- A higher level E/M code might be billed, *and*
- If this is the case, the applicable guidelines must be followed and the documentation must support the level of service billed.

For State Fund claims, when submitting:

- Paper bills to L&I, list all claim numbers treated in Box 11 of the **CMS-1500** form (F245-127-000) *or*
- Electronic claims, list all claim numbers treated in the remarks section of the **CMS-1500** form.

L&I will divide charges equally between the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for an accepted L&I or self-insured claim:

- Providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit.

Note: For physical medicine split billing exception, see Chapter 25: Physical Medicine Services

Links: For more information, see WAC 296-20-010, WAC 296-20-06101(10), and the General Provider Billing Manual (F245-432-000), and Chapter 10: Evaluation and Management (E/M) Services

Payment policy: Students and student supervision

General information

This policy applies to all provider types for whom the Washington State Department of Health (DOH) has established rules for student supervision (exception: certain types of physical medicine students have special rules. See Chapter 25: Physical Medicine Services for details).

Unless otherwise specified, students of provider types that do not have DOH rules for student supervision may not perform services for injured workers or crime victims.

Definitions

Student: As part of their clinical training, a **student** is a person who is enrolled and participating in an accredited educational program to become a licensed provider. An accredited educational program must have Washington State Department of Health rules or regulations. Students includes senior students, associate or interim permitted students who have completed their training but aren't yet fully licensed, and clinical post-graduate trainees.

Who does not qualify as a student

Providers with temporary or interim professional licenses are not considered students and this policy does not apply to them.

Agency-affiliated counselors are not considered students and this policy does not apply to them. They may not treat injured workers or crime victims.

Supervising provider: A **supervising provider** is a licensed provider with an active L&I provider account number who has entered into a private agreement with a student and their educational institution to provide hands-on training, instruction and supervision during the clinical phase of the student's coursework. A supervising provider can only supervise a student within their discipline. They are responsible for all services provided to injured workers or crime victims by their students.

Student supervision: **Student supervision** is the act of supervising a student who is treating an injured worker or crime victim. Supervising providers must comply with all Washington State Department of Health rules regarding the supervision of students within their discipline.

Services students may perform

Students may perform any services allowed under the corresponding DOH rules for delegation of services for their profession. The supervising provider shall be responsible for determining the competence of the student to perform the delegated services.

Students must be supervised by their supervising provider in accordance with DOH rules while performing services for injured workers or crime victims. Supervising providers are responsible for all treatment, documentation, and treatment plans.

Services that aren't covered

Students may not perform any services that fall outside their scope of practice, level of education, or any other requirements for students in their discipline laid out by the DOH. Students may not perform any services which L&I's Medical Aid Rules and Fee Schedules (MARFS) prohibit.

Direct supervision must occur in person with the student and isn't allowed when performed via **telehealth** (modifier **–FR**).

Billing requirements

Students may not bill L&I for their services. Supervising providers bill using their own L&I provider account number for services performed by students they supervise. All chart notes and documentation must be co-signed by the supervising provider, indicating they have reviewed and approved of the documentation.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Ambulatory Surgery Center (ASC) payment methods	Washington Administrative Code (WAC) 296-23B
Administrative rules for average wholesale price (AWP)	WAC 296-20-01002
Administrative rules for Advanced Registered Nurse Practitioners (ARNP)	WAC 296-23-245
Administrative rules for billing procedures	WAC 296-20-125
Administrative rules and statues for billing timelines, protests and appeals	WAC 296-20-125, RCW 51.52.060
Administrative rules for charting requirements	WAC 296-20-220 WAC 296-20-01002
Administrative rules for coverage decisions	WAC 296-20-01505 WAC 296-20-02700 through -02850 available in WAC 296-20 WAC 296-20-030 through -03002 available in WAC 296-20 WAC 296-20-1102
Administrative rules for documentation requirements	WAC 296-20-06101
Administrative rules for hospital payment methods	WAC 296-23A

If you're looking for more information about…	Then see…
Administrative rules for initial visit	WAC 296-20-01002 WAC 296-20-015 WAC 296-20-025 WAC 296-20-12401 WAC 296-20-065
Administrative rules for Medical Aid	WAC 296-20-010
Administrative rules for missed appointments (worker no shows)	WAC 296-20-010(5) and (6)
Administrative rules for Physician Assistants (PAs)	WAC 296-20-01501
Administrative rules for provider credentialing and compliance	WAC 296-20-01010 through WAC 20-01090 available in WAC 296-20 WAC 296-20-12401
Administrative rules for recordkeeping requirements	WAC 296-20-121 WAC 296-20-02005 WAC 296-20-02010 WAC 296-23-140
Becoming an L&I provider	Become A Provider on L&I's website
Billing adjustments	Billing adjustments on L&I's website

If you're looking for more information about…	Then see…
Billing Manuals	CMS 1500 Billing Manual (F245-423-000) Crime Victims Direct Entry Billing Manual (F800-118-000) Direct Entry Billing Manual (F245-437-000) Home Health Services Billing Manual (F245-424-000) Hospital Services Billing Manual (F245-425-000) Mental Health Fee Schedule and Billing Guidelines (F800-105-000) for Crime Victims Compensation program Miscellaneous Services Billing Manual (F245-431-000) Pharmacy Billing Manual (F245-433-000) Retraining and Job Modification Billing Manual (F245-427-000)
Billing workshops for providers	Billing workshops on L&I's website
Crime Victims Compensation Program	Crime Victims Compensation Program on L&I's website
Coverage decisions for medical technologies and procedures	Conditions and treatment guidelines on L&I's website
Electronic billing	Provider Express Billing on L&I's website
Fax numbers for **sending correspondence** to the State Fund	Billing L&I on L&I's website
Federal injured worker claims	U.S. Department of Labor website
Federally issued **National Provider Identifier (NPI)**	National Plan & Provider Enumeration System (NPPES) website

If you're looking for more information about…	Then see…
Fee schedules for all healthcare and vocational services	Fee schedules on L&I's website
FileFast website	FileFast on L&I's website
Find a Doctor (FAD) website	Find a Doctor (FAD) on L&I's website
General information about **WACs and RCWs**	Washington State Legislature's website
General Provider Billing Manual	F245-432-000
Interpreter Lookup Service	Interpreter Lookup Service on L&I's website
How providers arrange **interpretive services**	Interpreter services on L&I's website
Join the Network	Become A Provider on L&I's website
Laws (from Washington state Legislature) for documentation requirements	Revised Code of Washington (RCW) 51.48.290 RCW 51.48.270 RCW 51.48.250
Laws for Medical Aid	RCW 51.04.030(2) RCW 51.28.020 RCW 51.36.010 RCW 51.36.100 RCW 51.36.110
Laws for Physician Assistants (PAs)	RCW 51.28.100
L&I's Claim and Account Center	Claim and Account Center on L&I's website
L&I Medical Provider News electronic mailing list	L&I Medical Provider News on L&I's website
Payment policies for **Ambulatory Surgery Centers (ASCs)**	Chapter 32: Ambulatory Surgery Centers (ASCs)

If you're looking for more information about…	Then see…
Payment policies for **anesthesia services**	Chapter 4: Anesthesia Services
Payment policies for **hospitals**	Chapter 35: Hospitals
Payment policies for **interpreters**	Chapter 14: Language Access Services
Payment policies for **other services**	Chapter 22: Other Services
Payment policies for **pharmacy services**	Chapter 24: Pharmacy Services
Payment policies for **physical medicine services**	Chapter 25: Physical Medicine Services
Payment policies for **radiology services**	Chapter 26: Radiology Services
Payment policies for the Resource-Based Relative Value Scale (**RBRVS**)	Chapter 31: Washington RBRVS Payment System
Provider Change Form	F245-365-000
Provider's Initial Report form	Provider's Initial Report
Provider Network and COHE Expansion	COHE Expansion on L&I's website
ProviderOne	ProviderOne
Receiving **email updates on Provider News**	Subscribe to L&I's ListServ
Report of Accident (ROA) Workplace Injury or Occupational Disease form (also known as "Accident Report" or "ROA")	F242-130-000
Self-Insurer Accident Report (SIF-2) form	F207-228-000
Self-insured employer (SIE) or third party administrator (TPA) contact information	Self-insured employer list on L&I's website
Utilization Review	What requires UR

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Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 3: Ambulance, Taxi, and Other Transportation Services

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Bed confined: The worker is:

- Unable to get up from bed without assistance, *and*
- Unable to ambulate, *and*
- Unable to sit in a chair or wheelchair.

Destination: Nearest place of proper treatment.

Loaded miles: Miles traveled from the pickup of the worker(s) to their arrival at the destination.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–GM (Multiple workers, one ambulance trip)	
Use this modifier to indicate when multiple workers are being transported in the same ambulance trip.	This modifier doesn't affect payment but is necessary to describe the service.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: All ambulance services

When these services are paid

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated.

Payment is based on the level of medically necessary services provided, not only on the vehicle used.

How mileage is paid

The insurer pays for mileage (ground and/or air) based only on **loaded miles**, which are the miles traveled from the pickup of the worker(s) to their arrival at the **destination**.

Vehicle and crew requirements

To be eligible to be paid for ambulance services for workers, the provider must meet the criteria for vehicles and crews established in WAC 246-976 Emergency Medical Services and Trauma Care Systems and other requirements as established by the Washington State Department of Health for emergency medical services.

Key sections of this WAC include:

- **General**: WAC 246-976-260 Licenses required,
- **Ground ambulance vehicle requirements**:
  - WAC 246-976-290 Ground ambulance vehicle standards,
  - WAC 246-976-300 Ground ambulance and aid vehicles—Equipment,
  - WAC 246-976-310 Ground ambulance and aid vehicles--Communications equipment,
  - WAC 246-976-390 Trauma verification of prehospital EMS services,
- **Air ambulance services**: WAC 246-976-320 Air ambulance services,
- **Personnel**:
  - WAC 246-976-182 Authorized care,
  - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines.

Services that can be billed

HCPCS code	Description	Fee schedule
A0425	Ground mileage, per statute mile	**$15.56** per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	**$770.82**
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	**$800.05**
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	**$421.07**
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	**$673.74**
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	**$6,874.65**
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	**$7,992.76**
A0433	Advanced Life Support, Level 2 (ALS 2)	**$1,157.98**
A0434	Specialty care transport (SCT)	**$1,368.52**
A0435	Fixed wing air mileage, per statute mile	**$38.26** per mile
A0436	Rotary wing air mileage, per statute mile	**$88.90** per mile
A0999	Unlisted ambulance service	By Report restrictions: 1. Reviewed to determine if a more appropriate billing code is available, *and* 2. Reviewed to determine if medically necessary.

Payment policy: Arrival of multiple providers

Payment limits

When multiple providers respond to a call for services:

- Only the provider that transports the worker(s) is eligible to be paid for the services provided, *and*
- No payment is made to the other provider(s).

Payment policy: Emergency air ambulance transport

Payment limits

Air ambulance transportation services, either by helicopter or fixed wing aircraft, will be paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that couldn't have been provided by ground ambulance, *or*
- The point of pickup is inaccessible by ground vehicle, *or*
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

Payment policy: Multiple patient transportation

Payment limits

The insurer pays the appropriate base rate for each worker transported by the same ambulance.

When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported.

Requirements for billing

The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

The provider must use HCPCS code modifier **–GM** (Multiple patients on one ambulance trip) for the appropriate mileage billing codes.

Payment policy: Nonemergency transport

Who may arrange for these services

Only medical providers may arrange for nonemergency ambulance transportation.

Note: Workers can't arrange nonemergency ambulance transportation.

Medical necessity requirements

Nonemergency transportation by ambulance is appropriate if:

- The worker is **bed confined** and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated, *or*
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Nonemergency transportation may be provided on a **scheduled** (repetitive or non-repetitive) or **unscheduled** basis:

- **Scheduled**, nonemergency transportation may be repetitive (for example, services regularly provided for diagnosis or treatment of the worker's accepted medical condition) or non-repetitive (for example, single time need).
- **Unscheduled** services generally pertain to nonemergency transportation for medically necessary services.

The insurer reserves the right to perform a post audit on any nonemergency ambulance transportation billing to ensure medical necessity requirements are met.

Payment policy: Proper facilities

What makes a facility a place of proper treatment

To be a place of proper treatment, the facility must be generally equipped to provide the needed medical care for the worker.

A facility isn't considered a place of proper treatment if no bed is available when inpatient medical services are required.

Payment limits

The insurer pays the provider for ambulance services to the nearest place of proper treatment.

Payment policy: Taxi, wheelchair van and other transportation services

Prior authorization

Other transportation services including taxi and wheelchair services are payable when pre-authorized by the insurer.

Requirements for billing

All bills must be submitted to the insurer within a year from date of service. See Chapter 2: Information for All Providers for details.

Taxi providers may bill the insurer **1269M** for a worker missed appointment no show for an insurer arranged Independent Medical Exam (IME) or an insurer arranged consultation. For the insurer's authority to reimburse taxi providers for an insurer arranged IME or an insurer arranged consultation no show, see WAC 296-20-010(5). No other no show fees will be reimbursed by the insurer to taxi providers.

Taxi providers may bill a worker for a missed appointment no show other than for an insurer arranged IME or an insurer arranged consultation, see WAC 296-20-010(6).

To bill **1270M**, taxi providers must have completed a trip for an insurer arranged IME or insurer arranged consultation.

See "Services that can be billed" for additional billing codes.

Services that aren't covered

- Local code **0414A** for direct claimant taxi reimbursement (not payable to taxi and other transportation service providers).
- Pick up charges that aren't part of a provider's usual and customary fees.

How mileage is paid

The insurer pays for mileage based on miles traveled from the pickup of the worker(s) to their arrival at the medical or vocational authorized **destination** only. See definition of **loaded miles**.

Documentation requirements for billing

To be eligible to be paid for non-emergent transportation services for workers, the provider must provide an itemized statement (invoice) or trip ticket documenting the following:

- Claim number
- Worker name (name of worker transported)
- Date of trip
- Pick up time
- Pick up address
- **Destination** (drop off) address
- Wait time
- Drop off time
- Driver name (First, Last)
- Driver operator or cab number
- Rates (see WAC 296-20-01002 Definitions - “By Report”)
- Total cost of trip

Services that can be billed

HCPCS Code	Description	Fee schedule
A0100	Taxi, non-emergency	**By Report**
A0110	Transportation and bus, intra or interstate carrier, non-emergency	**By Report**
A0120	Mini-bus, mountain area transports, or other transportation systems, non-emergency	**By Report**
A0130	Wheel-chair van, non-emergency	**By Report**
A0140	Air travel (private or commercial) intra or interstate, non-emergency	**By Report**
A0170	Transportation ancillary: parking fees, tolls, other	**By Report**
0304R	Vocational Retraining Plan Transportation (Taxi)	**By Report**
1269M	Taxi no show fee for insurer arranged Independent Medical Examination (IME) or insurer arranged consultation 1 unit per claimant per day authorized	**$55.00**
1270M	Insurer arranged Independent Medical Examination (IME) or insurer arranged consultation Transportation (Taxi) Services	**By Report**

Link: For the legal definition of By Report (BR), see WAC 296-20-01002.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for ambulance services	Washington Administrative Code (WAC) 246-976
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 (including ambulance services)	Fee schedules on L&I's website

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Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 4: Anesthesia Services

Effective July 1, 2024

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

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Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same patient, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–47 (Anesthesia by surgeon)	
Use this modifier with surgery CPT® codes to indicate when regional or general anesthesia was administered directly by the surgeon. **Note**: This modifier shouldn't be used with anesthesia CPT® codes or for services with local anesthesia.	The insurer won't pay separately for the anesthesia when this modifier is used. When the same physician performs anesthesia and surgery, the anesthesia is considered inclusive with the surgery.
–99 (Multiple modifiers)	
Use this modifier to indicate when more than 2 modifiers affect payment. For billing purposes only, include only this modifier with the service(s) performed on the billing form, along with any modifiers not affecting payment. In the remarks section of the billing form, include the individual descriptive modifiers that affect payment.	This modifier doesn't affect payment but is necessary to accommodate all modifiers billed. Payment is based on the policy associated with each individual modifier that describes the actual services performed.
–AA (Anesthesia services performed personally by anesthesiologist)	
Use this modifier to indicate when anesthesia services were performed personally by the anesthesiologist.	This modifier doesn't affect payment but is necessary to describe the service.

Use	Payment Information
–QK (Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals)	
Use this modifier to indicate when a physician has provided medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals. **Note:** This modifier is for physician use only.	See Team care payment policy for payment information.
–QX (CRNA service: with medical direction by a physician)	
Use this modifier to indicate when a Certified Registered Nurse Anesthetist (CRNA) provides anesthesia services with medical direction by a physician.	See Team care payment policy for payment information.
–QY (Medical direction of 1 certified registered nurse anesthetist (CRNA) by an anesthesiologist)	
Use this modifier to indicate when a physician has provided medical direction of 1 Certified Registered Nurse Anesthetist (CRNA) for a single anesthesia procedure. **Note:** This modifier is for physician use only.	See Team care payment policy for payment information.
–QZ (CRNA service: without medical direction by a physician)	
Use this modifier to indicate when a Certified Registered Nurse Anesthetist (CRNA) has provided anesthesia services without medical direction by a physician.	Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: All anesthesia services

Who must perform these services to qualify for payment

Payment for anesthesia services will only be made to:

- Anesthesiologists, *and*
- Certified registered nurse anesthetists (CRNA).

Services that can be billed

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes **00100** through **01999** and the appropriate anesthesia modifier.

Some selected services are paid using the RBRVS method.

For information on **base and time units** and **RBRVS** methods for anesthesia services, see other payment policy sections of this chapter.

Services that aren't covered

Anesthesia isn't payable for procedures that aren't covered.

The insurer doesn't cover anesthesia assistant services.

Payment for CPT® codes **99100**, **99116**, **99135**, and **99140** is considered bundled and isn't payable separately.

CPT® physical status modifiers (**–P1** to **–P6**) and CPT® 5-digit modifiers aren't accepted.

Requirements for billing

Anesthesia add-on codes

Anesthesia add-on codes must be billed with a primary anesthesia code. There are 3 anesthesia add-on CPT® codes: **01953**, **01968**, and **01969**:

- Add-on code **01953** should be billed with primary code **01952**,
- Add-on codes **01968** and **01969** should be billed with primary code **01967**,
- Add-on codes **01968** and **01969** should be billed in the same manner as other anesthesia codes paid with base and time units.

Note: Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the **CMS 1500** form (F245-127-000).

Anesthesia for burn excisions or debridement (CPT® add-on code 01953)

The anesthesia add-on code for burn excision or debridement must be billed as follows:

If the **total body surface area** is…	Then the **primary code** to bill is:	And the **units to bill of add-on code** 01953 is:
Less than 4 percent	**01951**	None
4 - 9 percent	**01952**	None
Up to 18 percent	**01952**	1
Up to 27 percent	**01952**	2
Up to 36 percent	**01952**	3
Up to 45 percent	**01952**	4
Up to 54 percent	**01952**	5
Up to 63 percent	**01952**	6
Up to 72 percent	**01952**	7
Up to 81 percent	**01952**	8
Up to 90 percent	**01952**	9
Up to 99 percent	**01952**	10

Anesthesia base units

List only the time in minutes on your bill. Don't include the base units (L&I's payment system automatically adds the base units).

Link: The anesthesia codes, base units, and base sources are listed in the Professional Services Fee Schedule.

Anesthesia time

Anesthesia must be billed in 1-minute time units. Anesthesia time:

- **Begins** when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent), and
- **Ends** when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision).

Anesthesia billing code modifiers for anesthesia paid with base and time units

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs should use the CPT® or HCPCS modifiers in the following table. For complete modifier descriptions and instructions, refer to a current CPT® or HCPCS book.

Except for modifier **–99**, the modifiers listed in the following table aren't valid for anesthesia services paid by the RBRVS method.

For use by:	CPT® or HCPCS code modifier	Brief description	Notes
Anesthesiologists and CRNAs	**–99**	Multiple modifiers	Use this modifier when 5 or more modifiers are required. Enter **–99** in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.
Anesthesiologists	**–AA**	Anesthesia services performed personally by anesthesiologist	—
	–QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
CRNAs(1)	**–QX**	CRNA service: with medical direction by a physician	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
	–QZ	CRNA service: without medical direction by a physician(1)	Maximum payment is 100% of the maximum allowed for physician services.

Payment limits

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure.

Patient acuity doesn't affect payment levels.

Services billed with modifier **–47** (anesthesia by surgeon) are considered bundled and aren't payable separately.

Services billed with CPT® 5-digit modifiers and physical status modifiers (**–P1** through **–P6**) aren't paid.

Links: For licensed nursing rules, see WAC 296-23-240.

For licensed nursing billing instructions, see WAC 296-23-245.

For detailed billing instructions, including examples of how to submit bills, refer to L&I's General Provider Billing Manual (F245-432-000).

CRNA payment limits

CRNA services shouldn't be reported on the same CMS-1500 form used to report anesthesiologist services.

Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services (see Team care payment policy at the end of this chapter).

Payment policy: Base and time units payment method for anesthesia

How to calculate anesthesia payment paid with base and time units

Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

For services provided on or after July 1, 2024 the anesthesia conversion factor is **$58.35** per 15 minutes (**$3.89** per minute).

The maximum payment for anesthesia services paid with base and time units is calculated using the:

- Base value for the procedure, *and*
- Time the anesthesia service is administered, *and*
- L&I anesthesia conversion factor.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15, *then*
2. Add the value from step 1 to the total number of whole minutes, *then*
3. Multiply the result from step 2 by **$3.89.**

Example

CPT® code **01382** (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. 3 base units x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x **$3.89** = **$408.45**.

Link: The anesthesia conversion factor is published in WAC 296-20-135.

Payment policy: RBRVS payment method for anesthesia

Which services are paid using the RBRVS method

Some services commonly performed by anesthesiologists and CRNAs are paid using the Resource-Based Relative Value Scale (RBRVS) payment method, including:

- Anesthesia evaluation and management services, *and*
- Most pain management services, *and*
- Other selected services.

Injection code treatment limits

If the **injection type** is…	Then the **treatment limit** is:
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Limited to 2** injections, same side, per date of service **Limited to 3** injections per 6 months; 3rd requires documented improvement **Limited to 4** injections per 365 day-period
Facet injections	**Not covered**, except in preparation for facet neurotomy. Limited to 2 joint levels bilaterally, or 3 unilaterally per day of service.
Intramuscular injections of steroids and other nonscheduled medications.	**Maximum of 6** injections per patient are allowed.
Dry needling and/or trigger point injections	**Maximum of 6** treatments per patient.

Dry needling is considered a variant of trigger point injections. It is a technique where needles are inserted directly into trigger point locations without medications injected. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(7)(d).

Links: For information on billing for medications, see: Chapter 16: Medication Administration and Injections.

See L&I's coverage decision regarding dry needling for more details.

Requirements for billing

Dry needling of trigger points is billed using CPT® codes **20560** or **20561**.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action.

When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed in the Units column (Field 24G on the CMS-1500 form).

When using modifiers:

- Anesthesia modifiers **–AA**, **–QK**, **–QX**, **–QY**, and **–QZ** aren't valid for services paid by the RBRVS method.

For a complete list of modifiers and descriptions, see a current CPT® or HCPCS book.

An E/M service is payable on the same day as a pain management procedure only when:

- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service appending modifier **–25**.

The use of E/M codes on days after the procedure is performed is subject to the global surgery policy.

Links: For more information, see the Global surgery payment policy section of Chapter 29: Surgery Services.

For more information on using modifier **–25**, see the All E/M services payment policy section of Chapter 10: Evaluation and Management (E/M) Services.

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.

Payment limits

Anesthesia teaching physicians

Teaching physicians may be paid at the personally performed rate when the physician is involved in the training of physician residents in:

- A single anesthesia case, *or*
- 2 concurrent anesthesia cases involving residents, *or*
- A single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

Payment policy: Team care (Medical direction of anesthesia)

Requirements for medical direction of anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, *and*
- Prescribe the anesthesia plan, *and*
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, *and*
- Make sure any procedures in the anesthesia plan that he/she doesn't perform are performed by a qualified individual as defined in program operating instructions, *and*
- Monitor the course of anesthesia administration at frequent intervals, *and*
- Remain physically present and available for immediate diagnosis and treatment of emergencies, *and*
- Provide indicated post anesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, *and*
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation requirements for team care

The physician must document in the patient's medical record that the medical direction requirements were met.

Requirements for billing

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate CMS-1500 forms using their own provider account numbers,
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (**–QK** or **–QY**),
- CRNAs should use modifier **–QX**.

How to calculate payment for team care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services (see the How to calculate anesthesia payment paid with base and time units in the payment policy for Base and time units payment method for anesthesia section of this chapter),
- The maximum payment to the physician is 50% of the maximum payment for solo physician services,
- The maximum payment to the CRNA is 50% of the maximum payment for solo physician services.

Additional information: How team care policies are established

L&I follows CMS's policy for team care (medical direction of anesthesia).

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for acupuncture services non-coverage	Washington Administrative Code (WAC) 296-20-03002(2)
Administrative rules for anesthesia	WAC 296-20
Administrative rules for licensed nursing	WAC 296-23-240
Administrative rules for licensed nursing billing instructions	WAC 296-23-245
Administrative rules for treatment guidelines for injections	WAC 296-20-03001(7)
Anesthesia **conversion factor**	WAC 296-20-135
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Coverage decisions for spinal injections	Spinal injections coverage decision
Payment policies for **billing for medications**	Chapter 16: Medication Administration and Injections
Payment policies for **global surgery**	Chapter 29: Surgery Services
Payment policies for using **billing code modifier –25**	Chapter 10: Evaluation and Management (E/M) Services
Professional Services **Fee Schedules**	Fee schedules on L&I's website

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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, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

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

By Report: A code listed in the fee schedule as "By Report" which 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.

Restocking fees: The Washington State Department of Health statute (RCW 18.35.185) and rule (WAC 246-828-290) allow hearing instrument fitter/dispensers and licensed audiologists to retain $150.00 or 15% of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee sometimes is called a "restocking fee."

Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds the purchase agreement.

Links: For more information, see WAC 246-828-290 and RCW 18.35.185.

General information: Advertising limits

False, misleading, or deceptive advertising or representations

L&I can deny a provider's application to provide services, or suspend or revoke an existing provider account if the provider participates in:

- False, misleading, or deceptive advertising, *or*
- Misrepresentations of industrial insurance benefits.

False advertising includes mailers and advertisements that:

- Suggest a worker's hearing aids are obsolete and need replacement, *or*
- Don't clearly document a specific hearing aid's failure, *or*
- Make promises of monetary gain without proof of disability or consideration of current law.

Links: For more information, see RCW 51.36.130 and WAC 296-20-015.

Payment policy: Audiology services

Worker responsibilities

Worker responsible for devices that aren't medically necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given and wants to purchase different hearing aids, **the worker** then becomes completely responsible for the purchase of:

- The hearing aid, and
- Any future repairs.

Worker responsible for some repairs, losses, damages

Workers are responsible to pay for repairs of hearing aids that aren't authorized by the insurer.

The worker is also responsible for non-work related losses or damages to their hearing aids (for example, the worker's pet eats/chews the hearing aid, etc...). In no case will the insurer cover this type of loss or damage. In these instances, the worker will be required to buy a new (not used) hearing aid consistent with current L&I guidelines outlined in this chapter.

After the worker's purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

Services that can be billed

The insurer will only purchase hearing aids, devices, supplies, parts, and services described in the fee schedule (see Additional information: Audiology fee schedule, below.)

A physician or advanced registered nurse practitioner (ARNP) may be paid for a narrative assessment of work-relatedness to the hearing loss condition. An Occupational Disease History Report (1055M) requires a separate report (See Instructions on Form F242-432-000). Simply starring a worker's work history isn't payable. (See Chapter 27: Reports and Forms)

When filing a Report of Accident, Otolaryngologists or Occupational Medicine physicians should also bill **1190M** if they perform a Comprehensive Hearing Loss Exam (see Chapter 12: Impairment Ratings for more information). If auditory testing is performed, the person performing the test will bill the appropriate procedure codes.

Services that aren't covered

The insurer doesn't pay any provider or worker to fill out the:

- Employment History - Hearing Loss form (F262-013-000), or
- Occupational Hearing Loss Questionnaire (F262-016-000).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period.

The insurer won't pay for the reprogramming of hearing aids.

The insurer won't cover disposable shells ("ear molds" in HCPCS codes).

The insurer doesn't cover parts and supplies (such as clips and cords, mic covers, etc.) that aren't deemed medically necessary.

Hearing aids, supplies or parts can't be billed using **E1399**.

The insurer doesn't follow the Food and Drug Administration (FDA) rule that allows the over the counter purchase, without a prescription, of hearing aids for people who have perceived mild to moderate hearing loss. To receive insurer purchased aids and services, a worker must have an allowed hearing loss workers' compensation claim and work through an appropriate state fund or self-insured provider.

Requirements for billing

Hearing aid parts and supplies paid at acquisition cost

Parts and supplies must be billed and will be paid at acquisition cost including volume discounts (manufacturers' wholesale invoice). Acquisition cost and the amount on the invoice must reflect the cost of the item being dispensed to the worker, not the invoice of the replacement to stock.

If the supplies or parts were bought in bulk, the individual cost per part or supply will be calculated based on the manufacturers' invoice.

Don't bill your usual and customary fee. (See specific billing instructions for these items in the following table.)

If you are billing for…	Then these can be:
Supply items for hearing aids, including: • Tubes and domes, • Wax guards, and • Ear hooks.	Billed within the warranty period.

If you are billing for…	Then these can be:
Parts for hearing aids, including: • Switches, • Controls, • Filters, • Battery doors, and • Volume control covers.	Billed as replacement parts only, but not within the warranty period.
Shells (“ear molds” in HCPCS codes)	Billed separately at acquisition cost (the insurer doesn’t cover disposable shells).
Hearing aid extra parts, options, circuits, and switches (for example, T-coil and noise reduction switches)	Only billed when the manufacturer doesn’t include these in the base invoice for the hearing aid.

Payment limits

All hearing services and supplies

Hearing aid services and supplies require documentation to be submitted when billed. Documentation to support billed services must be received by the insurer prior to bill submission or within 30 days of the date of service, whichever comes first. The insurer may recoup, deny, or reduce a provider’s level of payment for a specific visit or service if the required documentation isn’t provided or the level or type of service doesn’t match the procedure billed.

Documentation must include the:

- worker’s name,
- worker’s request for the item supplied,
- item dispensed,
- date the item was dispensed,
- quantity dispensed, *and*
- cost per item and total cost.

Note: Providers can’t automatically send a worker batteries, wax guards, tubes and domes that the worker didn’t specifically request and for which they don’t have an immediate need.

Batteries

The insurer will pay the cost of battery replacement for the life of an authorized hearing aid.

Only a maximum of 60 batteries are authorized within each 90 day period. Providers must document the request for batteries by the worker and maintain proof that the worker actually received the batteries.

Note: Automatically sending workers batteries that they haven't specifically requested and for which they don't have an immediate need violates L&I's rules and payment policies.

Rechargeable hearing aids

For rechargeable hearing aids, the provider must bill both codes **V5014** and **5093V** for repairs or replacements. The insurer won't reimburse for rechargeable hearing aid repairs or replacements within the manufacturer's warranty period.

Rechargeable batteries

When the provider issues the rechargeable batteries to the worker, only code **V5267** may be billed. 1 set of rechargeable batteries is allowed per year. Any additional set(s) of rechargeable batteries within that period require claim manager authorization.

Wax guards

The insurer will pay the cost of wax guards for the life of the authorized hearing aid.

Wax guards are reimbursed up to a maximum of 104 per calendar year. Providers must document the request for wax guards by the worker and maintain proof that the worker actually received the wax guards.

Wax guards are billed using code **5095V**. This service can't be billed as part of a repair.

Tubes and domes

Tubes and domes are used with some hearing aids. Replacement of tubes and domes is considered maintenance.

The insurer will reimburse service for in office replacement of tubes and domes. This amount includes binaural replacement. This service:

- can be billed a maximum 18 times per calendar year,
- can be billed in conjunction with a quarterly cleaning visit,
- can't be billed as part of a repair, *and*
- can't bill more than 1 unit per date of service.

Providers must document the request for tubes and domes by the worker and maintain proof that the worker actually received the tubes and domes.

Tubes and domes are billed using code **5094V**.

Additional information: Audiology fee schedule

HCPCS code	Description	Maximum fee
V5008	Hearing screening	**$93.09**
V5010	Assessment for hearing aid	**Bundled**
V5011	Fitting/orientation/checking of hearing aid	**Bundled**
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V or In House repair V5267)	**$62.07**
V5020	Conformity evaluation	**Bundled**
V5030	Hearing aid, monaural, body worn, air conduction	Acquisition cost
V5040	Body-worn hearing aid, bone	Acquisition cost
V5050	Hearing aid, monaural, in the ear	Acquisition cost
V5060	Hearing aid, monaural, behind the ear	Acquisition cost
V5070	Glasses air conduction	Acquisition cost
V5080	Glasses bone conduction	Acquisition cost
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	Acquisition cost

HCPCS code	Description	Maximum fee
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	Acquisition cost
V5130	Binaural, in the ear	Acquisition cost
V5140	Binaural, behind the ear	Acquisition cost
V5150	Binaural, glasses	Acquisition cost
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,762.64**
V5171	Hearing aid, contralateral routing device, monaural, in the ear (ite)	Acquisition cost
V5172	Hearing aid, contralateral routing device, monaural, in the canal (itc)	Acquisition cost
V5181	Hearing aid, contralateral routing device, monaural, behind the ear (bte)	Acquisition cost
V5190	Hearing aid, cros, glasses	Acquisition cost
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,056.48**
V5211	Hearing aid, contralateral routing system, binaural, ite/ite	Acquisition cost
V5212	Hearing aid, contralateral routing system, binaural, ite/itc	Acquisition cost
V5213	Hearing aid, contralateral routing system, binaural, ite/bte	Acquisition cost
V5214	Hearing aid, contralateral routing system, binaural, itc/itc	Acquisition cost
V5215	Hearing aid, contralateral routing system, binaural, itc/bte	Acquisition cost
V5221	Hearing aid, contralateral routing system, binaural, bte/bte	Acquisition cost
V5230	Hearing aid, bicros, glasses	Acquisition cost

HCPCS code	Description	Maximum fee
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,056.48**
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$881.32**
V5242	Hearing aid, analog, monaural, CIC (completely in the ear canal)	Acquisition cost
V5243	Hearing aid, monaural, ITC (in the canal)	Acquisition cost
V5244	Hearing aid, digitally programmable analog, monaural, CIC	Acquisition cost
V5245	Hearing aid, digitally programmable, analog, monaural, ITC	Acquisition cost
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)	Acquisition cost
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)	Acquisition cost
V5248	Hearing aid, analog, binaural, CIC	Acquisition cost
V5249	Hearing aid, analog, binaural, ITC	Acquisition cost
V5250	Hearing aid, digitally programmable analog, binaural, CIC	Acquisition cost
V5251	Hearing aid, digitally programmable analog, binaural, ITC	Acquisition cost
V5252	Hearing aid, digitally programmable, binaural, ITE	Acquisition cost
V5253	Hearing aid, digitally programmable, binaural, BTE	Acquisition cost
V5254	Hearing aid, digital, monaural, CIC	Acquisition cost
V5255	Hearing aid, digital, monaural, ITC	Acquisition cost

HCPCS code	Description	Maximum fee
V5256	Hearing aid, digital, monaural, ITE	Acquisition cost
V5257	Hearing aid, digital, monaural, BTE	Acquisition cost
V5258	Hearing aid, digital, binaural, CIC	Acquisition cost
V5259	Hearing aid, digital, binaural, ITC	Acquisition cost
V5260	Hearing aid, digital, binaural, ITE	Acquisition cost
V5261	Hearing aid, digital, binaural, BTE	Acquisition cost
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	Acquisition cost
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	**$1.09**
V5267	Hearing aid supply/accessory	Acquisition cost
5091V	Hearing aid **restocking fee** (the lesser of 15% of the hearing aid total purchase price or $150.00 per hearing aid)	**By Report**
5092V	Hearing aid cleaning visit per ear (1 every 90 days, after the first year)	**$28.95**
5093V	Hearing aid repair fee. Invoice required	**By Report**
5094V	Bilateral in office tubes/dome replacement (maximum of 18 times per calendar year)	**$25.00** per unit (limited to 1 unit per date of service)
5095V	Wax guards (maximum of 104 per calendar year)	**$1.25** each

Note: The insurer will only purchase the hearing aids, devices, supplies, parts, and services described in the fee schedule.

Payment policy: Dispensing fees

Services that can be billed

Dispensing fees cover a 30 day trial period during which all aids may be returned. Also included:

- Up to 4 follow up visits (ongoing checks of the aid as the wearer adjusts to it), *and*
- 1 hearing aid cleaning kit, *and*
- Routine cleaning during the first year, *and*
- All shipping, handling, delivery, and miscellaneous fees.

Payment policy: Documentation and record keeping requirements

Documentation to support initial authorization

The provider must keep **all of the following** information in the worker's medical records and submit a copy of each to the insurer:

- Name and title of referring practitioner, if applicable, *and*
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual, *and*
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea, and fever, *and*
- A record of whether the worker has been treated for recent or frequent ear infections, *and*
- Results of the ear examination, *and*
- Results of all hearing and speech tests from initial examination, *and*
- Review and comment on historical hearing tests, if applicable, *and*
- All applicable manufacturers' warranties (length and coverage) plus the make, model and serial number of any hearing aid device(s) supplied to the worker as original or as a replacement, *and*
- Original or unaltered copies of invoices with name of manufacturer included, *and*
- Copy of the Hearing Services Worker Information form (F245-049-000) signed by the worker and provider, *and*
- Invoices and/or records of all repairs.

Documentation to support repair

The provider who arranges for repairs to hearing aid(s) authorized and purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period. Repair requests for State Fund claims must be sent to the Provider Hotline. A copy of the warranty must be on file with the insurer to ensure payment.
Documentation to support replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement:

- The name and credential of the person who inspected the hearing aid, *and*
- Serial number of the aids to be replaced, *and*
- Date of the inspection, *and*
- Observations (for example, a description of the damage, and specific reasons why the device can't be repaired).

Requirements for billing

Correspondence with the insurer

The insurer may deny payment of the provider's bill if the following information hasn't been received:

- Original wholesale invoices from the manufacturer are required to show the acquisition cost, serial numbers, and warranty information, and must be retained in the provider's office records for a minimum of 5 years, *and*
- A copy of the original manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part, or supply is purchased. costs $250.00 or more, or upon the insurer's request, *and*
- Documentation of the repair and who performed it must be submitted to the insurer.

Electronic billing providers must submit a copy of the original or unaltered manufacturer's wholesale invoice with the make, model, and serial number for individual hearing aids prior to submitting bill or within 30 days of date of service, whichever comes first.

To avoid delays in processing, all correspondence to the insurer must indicate the worker's name and claim number in the upper right hand corner of each page of the document.

Providers are required to send warranty information for:

- **State Fund** claims to:

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

- **Self-insured** claims to the SIE/TPA.

Payment policy: Hearing aids, devices, supplies, parts, and services

General requirements

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards.

All manufacturers and assemblers must hold a valid FDA certificate.

Self-insurers with purchasing contracts for hearing aids

SIEs that have entered into contracts for purchasing hearing aid related services and devices may continue to use them.

Link: For more information, see WAC 296-23-165(1b).

SIEs that don't have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this chapter.

Types of hearing aids authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). The decision will be based on recommendations from:

- Physicians, *or*
- ARNPs, *or*
- Licensed audiologists, *or*
- Fitter/dispensers.

The insurer covers the following types of hearing aids:

- Behind the ear (BTE),
- Digital or programmable in the ear (ITE),
- In the canal (ITC),
- Completely in the canal (CIC), *and*
- Receiver in Canal (RIC)

Any other types of hearing aids needed for medical conditions will be considered by the insurer based on justifications from the physician, ARNP, licensed audiologist or fitter/dispenser.

- L&I won't purchase used or repaired equipment.
- The insurer won't purchase hearing devices intended for safety protection.

The following table indicates which services and devices are covered by provider type:

If the **provider** is a…	Then the **services or devices** that can be billed are:
Fitter/dispenser	HCPCS codes for all hearing related services and devices.
Durable medical equipment (DME) provider	Supply codes, *and* Battery codes.
Physician, ARNP, licensed audiologist	HCPCS codes for hearing related services and devices, *and* CPT® codes for hearing-related testing and office calls while claim is open.

Prior authorization

Initial and subsequent hearing related services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies, and accessories (except for tubes, domes, wax guards and batteries).

The insurer won't pay for hearing devices provided prior to authorization.

To initiate the authorization process for:

- **State Fund** claims, call the claim manager or the State Fund's Provider Hotline at 1-800-848-0811 (in Olympia call 360-902-6500).
- **Self-insured** claims, the provider should obtain prior authorization from the SIE or its TPA.

The insurer will notify the worker in writing when the claim is accepted or denied.

Links: For more information, see WAC 296-20-03001 and WAC 296-20-1101.

Cases of special need

In cases of special need, such as when the worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted.

Special authorization for hearing aids and masking devices over $900.00 per ear

If the manufacturer's invoice cost of any hearing aid or masking device exceeds $900.00 per ear, special authorization is required from the claim manager.

The cost of ear molds doesn't count toward the $900.00 for special authorization. Initial ear molds may be billed using **V5264** and replacements may be billed using **V5014** with **V5264** (after warranty period). The cost of any external electronic device, such as chargers, a remote control or Bluetooth, counts towards the $900.00 limit per hearing aid.

Masking devices for tinnitus

In cases of accepted tinnitus, the insurer may authorize masking devices. (Also see Requirements for billing, below.)

Link: L&I's current tinnitus coverage decision is available online.

Required documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work related hearing loss.

An SIE/TPA may use these or similar forms to gather information:

- Report of Accident (F242-130-000),
- Occupational Disease Employment History Hearing Loss form (F262-013-000),
- Occupational Hearing Loss Questionnaire (F262-016-000),
- Valid audiogram,
- Medical report, *and*
- Hearing Services Worker Information form (F245-049-000).

Who must perform these services to qualify for payment

Authorized testing

Testing to fit a hearing aid may be done by a:

- Licensed audiologist,
- Fitter/dispenser,
- Qualified physician, or
- Qualified ARNP.

The provider must obtain prior authorization for subsequent testing.

Fitter/ dispensers aren't reimbursed for audiograms. The provider performing the service must do the billing.

Requirements for billing

All hearing aids, parts, and supplies

All hearing aids, parts, and supplies must be billed using HCPCS codes.

Hearing aids and devices are considered durable medical equipment (DME) and must be billed at their acquisition cost.

Link: For more details, refer to the Acquisition Cost Policy in Chapter 28: Supplies, Materials, and Bundled Services.

Binaural hearing aids

When billing the insurer for hearing aids for both ears, providers must indicate on the CMS-1500 (F245-127-000) or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left), *and*
- The appropriate HCPCS code for binaural aids.

Only bill 1 unit of service even though 2 hearing aids (binaural aids) are dispensed.

Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

Monaural hearing aids

When billing the insurer for 1 hearing aid, providers must indicate on the CMS-1500 (F245-127-000) or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected, and
- The appropriate HCPCS code for monaural aid.

Only bill 1 unit of service.

Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

Tinnitus masking devices

If masking devices are dispensed without hearing aids, providers will bill using code **E1399**.

When dispensed as a component of a hearing aid, providers will bill using code **V5267**.

If masking devices are dispensed without hearing aids, the provider may also bill the appropriate dispensing fee code for monaural or binaural devices.

Payment limits

Authorized testing

The insurer doesn't pay for testing after a claim has closed unless related to fitting of replacement hearing aids.

The insurer will pay for hearing screening (**V5008**) only when performed and billed by an audiologist.

The insurer doesn't cover annual hearing tests.

If free initial hearing screenings are offered to the public, the insurer won't pay for these services.

30-day trial period

A 30-day trial period is the standard established by RCW 18.35.185. During this time:

- The provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids aren't damaged),
- Follow up hearing aid adjustments are **bundled** into the dispensing fee, and
- If hearing aids are returned within the 30 day trial period, the provider must refund the hearing aid and dispensing fees.

Payment policy: Repairs and replacements

Warranties

Hearing aid industry standards provide a minimum of a 1 year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than 1 year, the manufacturer's warranty will apply.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is covered under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid according to the warranty. The worker is responsible for any charges outlined in the manufacturer's warranty.

The insurer doesn't purchase or provide additional manufacturers' or extended warranties beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period. The warranty period begins:

- On the date the hearing aid is dispensed to the worker, *or*
- For repairs, when the hearing aid is returned to the worker.

Prior authorization

Repairs

Prior authorization is required for all billed repairs. The insurer will repair hearing aids and devices when needed due to normal wear and tear. This doesn't include tubes, domes, or wax guards. Also note that:

- At its discretion, the insurer may repair hearing aids and devices under other circumstances, *and*
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased, *and*
- If the aid is damaged in a work related incident, the worker must file a new claim to repair or replace the damaged hearing aid.

Providers must submit a written estimate of the repair cost to the State Fund Provider Hotline or the self-insured employer (SIE) claim manager to get prior authorization for:

- In office repairs, *or*
- Repairs by the manufacturer, *or*
- Repairs by an all make repair company.

Note: Tubes, domes and wax guards aren't considered repairs.

Replacements

- Replacement is defined as purchasing a new hearing aid for the worker according to L&I's current guidelines.
- Insurer authorized hearing aids will be replaced upon request 5 years or more after their issue date, *or*
- For hearing aids less than 5 years from the issue date of the current aids, the insurer will replace hearing aids when they aren't repairable due to normal wear and tear.
    - The insurer will require detailed documentation supporting why hearing aids aren't repairable and should be replaced.

Also note that for hearing aids less than 5 years from their current issue date:

- At its discretion, the insurer may replace hearing aids in other circumstances, *and*
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer won't pay for new hearing aids when only new ear shell(s) are needed, *and*
- The insurer won't replace a hearing aid when the hearing aid is working up to the manufacturer's original specifications, *and*
- The insurer won't replace a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on the job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident, *and*
- The insurer won't replace hearing aids based solely on changes in technology, *and*
- The insurer won't pay for new hearing aids for hearing loss resulting from:
    - Noise exposure that occurs outside the workplace, *or*
    - Further coverage exposure, *or*
    - Non-work related diseases, *or*
    - The natural aging process.

Replacement requests may be sent directly to the insurer using the Hearing Aid Repair/Replacement Durable Medical Equipment Provider Hotline Service Authorization Request form (F245-418-000). If this form isn't used, any request must be in writing and include all information required on the form.

State fund replacement requests are made directly to the claim manager. Requests may be mailed or faxed to 360-902-6490.

Documentation that a hearing aid isn't repairable may be submitted by:

- Licensed audiologists, *or*
- Fitter/dispensers, *or*
- All make repair companies, *or*
- FDA certified manufacturers.

The provider must submit written, logical rationale for the claim manager's consideration if:

- Only of the binaural hearing aids isn't repairable, *and*
- In the professional's opinion, both hearing aids need to be replaced.

Note: The condition of the other hearing aid must be documented.

Who must perform these services to qualify for payment

Repairs

Audiologists and fitters/dispensers may be paid for providing authorized in office repairs.

Requirements for billing

Repairs

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Authorized in-office repairs must be billed using V5014 and V5267. These billings require an invoice and description.

Additional information

Separate charges for accessories are paid at acquisition cost and aren't to be billed with repair codes.

The insurer won't cover repairs, services and supplies that are offered to the general public at no cost.

If a repair is done in the office and no warranty is available, this information must be included in the written description of the repair (the description must be included on paper bill or in the remarks field of the electronic bill).

Replacements

The worker must sign and be given a copy of the Hearing Services Worker Information form (F245-049-000). The provider must submit a copy of the signed form and the replacement request.

A copy of the manufacturer's warranty and a copy of any additional provider warranty must be submitted to the insurer for all hearing devices and hearing aid repairs. The warranty should include the individual hearing aids:

- Make, *and*
- Model, *and*
- Serial number.

The provider must inform the insurer of the type of hearing aid dispensed and the codes they are billing.

Need more help with repairs and replacements?

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

Forms can be found on our website at **Provider Hotline Authorizations.**

Payment policy: Replacement of linear nonprogrammable analog hearing aids

When these hearing aids may be replaced

Linear nonprogrammable analog hearing aids may be replaced with nonlinear digital or analog hearing aid when the worker returns a linear analog hearing aid to their dispenser or audiologist because:

- The hearing aid is inoperable, *or*
- The worker is experiencing an inability to hear, *and*
- The insurer has given prior authorization to replace the hearing aid.

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with nonlinear digital or analog hearing aid is authorized (see Prior authorization, below).

Prior authorization

Prior authorization must be obtained from the insurer **before** replacing linear analog hearing aids. The insurer **won't pay** for replacement hearing aids issued prior to authorization.

Authorization documentation and record keeping requirements

Before authorizing replacement, the insurer will require and request the following documentation from the provider:

- Required: A separate statement (signed by both the provider and the injured worker): This linear analog replacement request is sent in accordance with L&I's linear analog hearing aid replacement policy, *and*
- Required for State Fund claims: Completed Hearing Services Worker Information form (F245-049-000), *and*
- Serial number(s) of the current linear analog aid(s), if available, *and*
- Make/model of the current linear analog aid(s), if available, *and*
- Date original hearing aid(s) issued to worker, if available.

For State Fund claims prior authorization:

- Call the claim manager, *or*
- Fax the request to the Provider Hotline at 360-902-6252.

For self-insured claims prior authorization, contact the SIE/TPA for prior authorization.

Link: A list of SIEs/TPAs is available online.

Who must perform these services to qualify for payment

Audiologists, physicians, ARNPs, and fitter/dispensers who have current L&I provider account numbers may bill for hearing aid replacement. These providers may bill for the acquisition cost of the nonlinear aids and the associated professional fitting fee (dispensing fee).

Payment policy: Restocking fees

Requirements for billing

The insurer must receive a Termination of Agreement (Rescission) form (F245-050-000) or a statement signed and dated by the provider and the worker.

The form must be faxed to L&I at **360-902-6252** or forwarded to the SIE/TPA within 5 business days of receipt of the signatures.

The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer:

- Either for the **restocking fee** of **$150.00** or **15%** of the total purchase price, whichever is less, *and*
- Using billing code **5091V**.

Note: **Restocking fees** can't be paid until the insurer has received the refund.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and **Washington state laws** for audiology and hearing services	Washington Administrative Code (WAC) 246-828-290 WAC 296-20-015 WAC 296-23-165 Revised Code of Washington (RCW) 18.35.185 RCW 51.36.130
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 (including audiology)	Fee schedules on L&I's website
Hearing Services Worker Information form	F245-049-000
Occupational Disease Employment History Hearing Loss form	F262-013-000
Occupational Hearing Loss Questionnaire	F262-016-000
Payment policies for **acquisition cost**	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services
Report of Accident form	F242-130-000
Statement for Miscellaneous Services form	F245-072-000

If you're looking for more information about…	Then see…
Termination of Agreement (Rescission) form	F245-050-000

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 6: Biofeedback, Electrocardiograms (EKG), Electrodiagnostic Services, and Extracorporeal Shockwave Therapy (ESWT)

Effective July 1, 2024

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

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Payment policy: Biofeedback

Prior authorization

Biofeedback treatment requires an attending provider's order and prior authorization.

When the condition is accepted under the industrial insurance claim, the insurer will authorize biofeedback treatment for:

- Idiopathic Raynaud's disease,
- Temporomandibular joint dysfunction,
- Myofascial pain dysfunction syndrome (MPD),
- Tension headaches,
- Migraine headaches,
- Tinnitus,
- Torticollis,
- Neuromuscular reeducation as result of neurological damage in a stroke (also known as "CVA") or spinal cord injury,
- Inflammatory and/or musculoskeletal disorders causally related to the accepted condition.

Link: For more information, see WAC 296-21-280.

12 biofeedback treatments in a 90 day period will be authorized for the conditions listed above when an evaluation report is submitted documenting all the following:

- The basis for the worker's condition, *and*
- The condition's relationship to the industrial injury, *and*
- An evaluation of the worker's current functional measurable modalities (for example, range of motion, up time, walking tolerance, medication intake), *and*
- An outline of the proposed treatment program, *and*
- An outline of the expected restoration goals.

No further biofeedback treatments will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (for example, range of motion, up time, walking tolerance, medication intake). Also:

- Only 1 additional treatment block of **12 treatments per 90 days** will be authorized, *and*
- Requests for biofeedback treatment beyond **24 treatments or 180 days** will be granted only after file review by and on the advice of the department's medical consultant.

In addition to treatment, pretreatment and periodic evaluation will be authorized. Follow-up evaluation can be authorized at 1, 3, 6, and 12 months post treatment.

Home biofeedback device rentals are time limited and require prior authorization.

Link: Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

Who must perform these services to qualify for payment

Practitioners must submit a copy of their biofeedback certification or supply evidence of their qualifications to the department or self-insurer to administer biofeedback treatment to workers. Administration of biofeedback treatment is limited to practitioners who:

- Are certified by the Biofeedback Certification Institute of America (BCIA), *or*
- Meet the minimum education, experience, and training qualifications to be certified.

Link: For more information, see WAC 296-21-280.

Paraprofessionals who aren't independently licensed must practice under the direct supervision of a qualified, licensed practitioner:

- Whose scope of practice includes biofeedback, *and*
- Who is BCIA certified or meets the certification qualifications.

A qualified or certified biofeedback provider who isn't licensed as a practitioner may not receive direct payment for biofeedback services.

Link: For legal definition of licensed practitioner, see WAC 296-20-01002.

Services that can be billed

CPT® codes **90875** and **90876** are payable to L&I approved biofeedback providers who are clinical psychologists or psychiatrists (MD or DO).

CPT® codes **90901**, **90912**, and **90913** are payable to any L&I approved biofeedback provider.

HCPCS code **E0746** is payable to DME or pharmacy providers (for rental or purchase).

Requirements for billing

The supervising licensed practitioner must bill the biofeedback services for paraprofessionals.

When biofeedback is performed along with individual psychotherapy, bill using either CPT® code **90875** or **90876**.

Don't bill CPT® codes **90901**, **90912**, or **90913** with the individual psychotherapy codes.

Use evaluation and management codes for diagnostic evaluation services.

Payment limits

CPT® code **90901** is limited to **1 unit of service per day**, **90912** is limited to **1 unit per day** and **90913** is limited to **3 units per day** regardless of the number of modalities.

For HCPCS code **E0746**, use of the device in the office isn't separately payable.

Payment policy: Electrocardiograms (EKG)

Service that can be billed

Separate payment is allowed for electrocardiograms (CPT® codes **93000**, **93010**, **93040**, and **93042**) when an interpretation and report is included. These services may be paid along with office services.

Services that aren't covered

EKG tracings without interpretation and report (CPT® codes **93005** and **93041**) aren't payable with office services.

Payment limits

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code **R0076**) is bundled into the EKG procedure and doesn't pay separately.

Payment policy: Electrodiagnostic services

Who must perform these services to qualify for payment

Prior to performing and billing for these services, physical therapists (PTs) performing electrodiagnostic testing must provide documentation of proper Department of Health (DOH) licensure to L&I's Provider Credentialing.

PTs who meet the requirements of DOH rules may provide electroneuromyographic tests.

Links: For information on where to send proper license documentation, contact L&I's Provider Credentialing at PACMail@Lni.Wa.Gov.

To see the DOH rules, refer to WAC 246-915-370.

Services that can be billed

The insurer covers the use of electrodiagnostic testing, including nerve conduction studies and needle electromyography only when:

- Proper and necessary, *and*
- Testing meets the requirements described in L&I's Electrodiagnostic Testing policy.

Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommended number of tests may be reviewed for quality and whether it is "proper and necessary."

Qualified PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed.

Services that aren't covered

Electrodiagnostic testing isn't covered when:

- It isn't proper and necessary (see Note and Link, below this list), *or*
- Performed in a mobile diagnostic lab in which the specialist physician isn't present to examine and test the patient, *or*
- Performed with noncovered devices, including:
    - Portable, *and*
    - Automated, *and*
    - "Virtual" devices not demonstrated equivalent to traditional lab based equipment (for example, NC-stat®, Brevio), *or*
- Determined to be outside of AANEM recommended guidelines without proper documentation supporting that the testing is proper and necessary.

In general, repetitive testing isn't considered proper and necessary except if:

- Documenting ongoing nerve injury (for example, following surgery), *or*
- Required to provide an impairment rating, *or*
- Documenting significant changes in clinical condition.

Link: The legal definition of "proper and necessary" is available in WAC 296-20-01002.

Requirements for billing

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels.

Link: The complete requirements for appropriate electrodiagnostic testing are available online.

Billing of the technical and professional portions of the codes may be separated. However, the physician billing for interpretation and diagnosis (professional component) must have direct contact with the patient at the time of testing.

Note: The insurer may recoup payments made to a provider, plus interest, for NCS and EMG tests paid inappropriately.

Example: Reasonable limits on units required to determine a diagnosis

The table below was developed by the AANEM and summarizes reasonable limits on units required, per diagnostic category, to determine a diagnosis 90% of the time.

Note: Review of the quality and appropriateness (whether the test is "proper and necessary") may occur when testing repeatedly exceeds AANEM recommendations.

Recommended maximum number of studies by indication (from "AANEM Table 1"; recreated and adapted with written permission from AANEM):

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	**Motor NCS with and without Fwave**	**Sensory NCS**	**H-Reflex**	**Neuromuscular Junction Testing** (repetitive stimulation)
Carpal tunnel (unilateral)	1	3	4	—	—
Carpal tunnel (bilateral)	2	4	6	—	—
Radiculopathy	2	3	2	2	—
Mononeuropathy	1	3	3	2	—
Poly/ mononeuropathy multiplex	3	4	4	2	—
Myopathy	2	2	2	—	2
Motor neuronopathy (for example, ALS)	4	4	2	—	2
Plexopathy	2	4	6	2	—

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	Motor NCS with and without Fwave	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Neuromuscular Junction	2	2	2	—	3
Tarsal tunnel (unilateral)	1	4	4	—	—
Tarsal tunnel (bilateral)	2	5	6	—	—
Weakness, fatigue, cramps, or twitching (focal)	2	3	4	—	2
Weakness, fatigue, cramps, or twitching (general)	4	4	4	—	2
Pain, numbness, or tingling (unilateral)	1	3	4	2	—
Pain, numbness or tingling (bilateral)	2	4	6	2	—

Payment policy: Extracorporeal shockwave therapy (ESWT)

Services that aren't covered

The insurer doesn't cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for biofeedback	Washington Administrative Code (WAC) 296-21-280
Administrative rules for the definitions of "licensed practitioner" and "proper and necessary"	WAC 296-20-01002
Administrative rules for the policy on rental equipment	WAC 296-20-1102
Administrative rules for the requirements on who may provide electroneuromyographic tests	WAC 246-915-370
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Coverage decision for extracorporeal shockwave therapy	Extracorporeal shockwave therapy coverage decision
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Policy for **electrodiagnostic testing**	Electrodiagnostic testing policy
Sending proper license documentation to perform electrodiagnostic services	PACMail@Lni.Wa.Gov

Need more help?

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Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 7: Chiropractic Services

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Body regions: One of the factors contributing to clinical decision-making complexity for chiropractic care visits. Body regions include:

- Cervical (includes atlanto-occipital joint),
- Thoracic (includes costovertebral and costotransverse joints),
- Lumbar,
- Sacral,
- Pelvic (includes sacroiliac joint),
- Extra-spinal (considered one region), which includes:
    - Head (includes temporomandibular joint; doesn't include atlanto-occipital), *and*
    - Upper and lower extremities, *and*
    - Rib cage (doesn't include costotransverse and costovertebral joints).

Chiropractic care visits: Office or other outpatient visits involving subjective and objective assessment of patient status, management, and treatment.

Clinical decision-making complexity: The primary component influencing the level of care for a chiropractic care visit. Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to clinical decision-making complexity for injured workers include:

- The current occupational condition(s),
- Employment and workplace factors,
- Non-occupational conditions that may complicate care of occupational condition,
- Care planning and patient management,
- Chiropractic intervention(s) provided,
- Number of **body regions** involved, *and*
- Response to care.

The number of **body regions** being adjusted is only one of the factors that may contribute to visit complexity, but should be weighted less heavily than other components.

L&I defines clinical decision-making complexity according to the definitions for medical decision-making complexity in the Evaluation and Management Services Guidelines section of the CPT® book.

Complementary and preparatory services: Interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. For example, the application of heat or cold is considered a complementary and preparatory service.

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Established patient: One who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

New patient: One who hasn't received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–22 (Increased Procedural Services)	
Use this modifier to indicate the work to provide the service was substantially greater than typically required. Documentation must include an explanation of the increased complexity and why it was required for proper treatment. **Note**: This modifier shouldn't be used with E/M services.	Procedures with this modifier are reviewed and priced on an individual basis (by report). If allowed, payment is made at a maximum of **125%** of the fee schedule level or billed charge, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same patient, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

Use	Payment Information
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Chiropractic care visits

Prior authorization

Prior authorization is required for all types of conservative care, including chiropractic, when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

Links: For more information, see WAC 296-20-030(1) and WAC 296-20-03001(1).

Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** account for both professional management (clinical complexity) and technical service (manipulation and adjustment). There are three levels of **chiropractic care visits**:

The primary component is clinical decision-making. If it is…	OR the **number of body regions** adjusted or manipulated is…	and typical **face-to-face time** with patient or family is…	Then the **appropriate billing code** and maximum fee is…
Straightforward	Up to 2	Up to 15 minutes	**2050A** (Level 1) **$50.49**
Low complexity	Up to 3 or 4	15-25 minutes	**2051A** (Level 2) **$64.17**
Moderate complexity	Up to 5 or more	Over 25 minutes	**2052A** (Level 3) **$78.19**

Re-evaluations

Depending on the amount of clinical complexity and services rendered, an E/M code may better capture the level of service performed during a re-evaluation.

If a re-evaluation of a patient meets the CPT® criteria for **established patient** E/M, the provider may bill the appropriate E/M code instead of a chiropractic care local code (**2050A**, **2051A**, or **2052A**). See the Chiropractic evaluation and management (E/M) services payment policy for additional details.

Services that aren't covered

CPT® chiropractic manipulative treatment (CMT) codes **98940**-**98943** aren't covered.

Instead of using CMT codes, L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop local codes that can be billed for **chiropractic care visits** (see Services that can be billed, above).

Treatment of chronic migraine or chronic tension-type headache with chiropractic manipulation/manual therapy isn't a covered benefit.

Link: The L&I coverage decision for treatment of Chronic Migraine or Chronic Tension-type Headache is available online.

Payment limits

Only one **chiropractic care visit** per day is payable.

Extra-spinal manipulations aren't billed separately from each other (all extremities are considered to be one **body region**).

Providers may not bill an **established patient** E/M code and a chiropractic care local code (**2050A**, **2051A**, or **2052A**) for the same date of service.

Examples of chiropractic care levels of complexity

These examples are for illustration only and aren't clinically prescriptive:

Level 1:	**Straightforward clinical decision-making** (billing code **2050A**)
Patient	26 year old male.
Cause of injury	Lifted a box at work.
Symptoms	Mild, low back pain for several days.
Treatment	Manipulation or adjustment of the lumbar region, anterior thoracic mobilization, and lower cervical adjustment.
Level 2:	**Low complexity clinical decision-making** (billing code **2051A**)
Patient	55 year old male, follow-up visit.
Cause of injury	Slipped and fell on stairs while carrying heavy object at work.
Symptoms	Ongoing complaints of neck and low back pain. New sensation of periodic tingling in right foot. Two days off work.
Treatment	Discuss need to minimize lifting and getting assistance when carrying heavier objects. Five minutes of myofascial release prior to adjustment of the cervical, thoracic, and lumbar regions.
Level 3:	**Moderate complexity clinical decision-making** (billing code **2052A**)
Patient	38 year old female, follow-up visit.
Cause of injury	Moved heavy archive boxes at work over the course of three days.
Symptoms	Low back pain with pain at the sacrococcygeal junction, pain in the sacroiliac regions, and right-sided foot drop. Obesity and borderline diabetes. Tried light-duty work last week, but unable to sit for very long, went home. Tried prescribed stretching from last visit, but worker couldn't continue and didn't stretch because of pain.
Treatment	Review MRI report with the worker. Discussed obesity and diabetes impact on recovery, 10 minutes. 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/ adjustment to the lumbar, sacroiliac, and sacrococcygeal regions.

Payment policy: Chiropractic consultations

General information

Consultations are requested by the attending provider. A chiropractic consultant may render a second opinion for any conservative management of musculoskeletal conditions even if the attending provider isn't a chiropractor.

Prior authorization

While chiropractic consultations don't require prior authorization, consultations do require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer per WAC 296-23-195.

Who must perform these services to qualify for payment

Only an L&I-approved chiropractic consultant can perform office consultation services to qualify for payment.

Services that can be billed

Approved consultants may bill all levels of CPT® office consultation codes.

Additional information: Chiropractic consultations

L&I periodically publishes:

- A policy on consultation referrals, *and*
- A list of approved chiropractic consultants.

Link: More information about consultations, how to become a chiropractic consultant, and a list of approved chiropractic consultants is available online.

Payment policy: Chiropractic evaluation and management (E/M) services

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

Link: For more information, see WAC 296-20-030(1) and WAC 296-20-03001(1).

Services that can be billed

Case management services

Codes and billing instructions for case management services telephone calls, team conferences, and secure email can be found in the Case management services section of Chapter 10: Evaluation and Management. These codes may be billed in addition to other services performed on the same day.

Office visits

Chiropractic physicians may bill all levels of office visit codes for **new and established patients**.

For complete code descriptions, definitions, and guidelines, refer to a CPT® book.

Link: Fees appear in the Professional Services Fee Schedule.

Payment limits

A **new patient** E/M office visit code is payable only once for the initial visit.

An **established patient** E/M office visit code isn't payable on same day as a **new patient** E/M.

Modifier **–22** isn't payable with E/M office visit codes or chiropractic care services.

For follow-up visits, E/M office visit codes aren't payable when performed on the same day as L&I **chiropractic care visit** codes. Refer to the Chiropractic care visits section of this chapter for policies about the use of E/M office visit codes with L&I codes for **chiropractic care visits**.

Chiropractic E/M office visits are only payable on the same date as a **chiropractic care visit** when all of the following are met:

- It is the first visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the **chiropractic care visit**), *and*
- Modifier **–25** is added to the E/M code, *and*
- The patient's record contains supporting documentation describing both the E/M and the chiropractic care services.

Link: Additional E/M information is available in Chapter 10: Evaluation and Management Services.

Payment policy: Chiropractic independent medical exams (IMEs) and impairment ratings

Prior authorization

Prior authorization is only required when an IME is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an IME is scheduled.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

Who must perform these services to qualify for payment

Only an L&I-approved IME examiner can perform IMEs or impairment ratings to qualify for payment.

For an impairment rating, an attending chiropractic physician may:

- Perform the rating on their own patients if the physician is an approved IME examiner, *or*
- Refer to an approved IME examiner.

Link: For more information, see: Chapter 12: Impairment Rating Services

Services that can be billed

Use the CPT® codes, local codes, and the payment policy for IMEs described in Chapter 13: Independent Medical Exams.

Additional information: Becoming an approved IME examiner

To apply for approval, chiropractic physicians must complete:

- Two years as an approved chiropractic consultant, *and*
- Impairment rating course approved by the department.

Links: For more information, see L&I's Become a Chiropractic Consultant webpage.

Payment policy: Chiropractic radiology services (X-rays)

Prior authorization

Medically necessary x-rays performed as part of the initial evaluation don't require prior authorization. All subsequent x-rays require prior authorization.

Who must perform these services to qualify for payment

Chiropractic physicians in the network may bill for radiographs taken as allowed under their license. It is required that a written x-ray report of radiologic findings and impressions be included in the patient's chart.

Only chiropractic physicians on L&I's list of approved radiological consultants may bill for X-ray consultation services. A chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I to become an approved radiological consultant.

Services that can be billed

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the Requirements and Payment limits described in Chapter 26: Radiology Services.

Diagnostic ultrasounds performed by the chiropractor are bundled into the E/M service. See Chapter 26: Radiology Services for additional details on ultrasounds and documentation requirements.

Services that aren't covered

Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion x-ray, vertebral motional analysis and spinal x-ray digitization.

DSV isn't a covered benefit. Procedure code **76496** shouldn't be used to bill the insurer for these services.

Link: For more information about DSV, see the Dynamic Spinal Visualization coverage decision.

Payment policy: Complementary and preparatory services, and patient education or counseling

General information

Patient education or counseling includes discussing or providing written information about:

- Lifestyle, *or*
- Diet, *or*
- Self-care and activities of daily living, *or*
- Home exercises.

The application of heat or cold is an example of a **complementary and preparatory service**.

Payment limits

The following services are bundled into the E/M or chiropractic local codes and aren't separately payable:

- **Complementary and preparatory services**, *or*
- Patient education or counseling.

Payment policy: Physical medicine treatment

Services that can be billed

Local code **1044M** for physical medicine modalities or procedures (including the use of traction devices) may only be billed by an attending provider who isn't board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

Link: For more information, see Chapter 25: Physical Medicine Services.

Services that aren't covered

CPT® physical medicine codes (**97001**-**97799**) aren't payable to chiropractic physicians.

Requirements for billing

Documentation of the visit must support billing for local code **1044M**.

Payment limits

Local code **1044M** is limited to six units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.

After six units, the patient must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment except when the attending provider practices in a remote location. (Refer to WAC 296-21-290 for more information.)

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

Low-level laser therapy

For details on coverage of this treatment modality, see Chapter 25: Physical Medicine Services.

Powered traction devices

The insurer won't pay any additional cost when powered traction devices are used. This policy applies to all FDA-approved powered traction devices.

Published literature hasn't substantially shown that powered traction devices are more effective than other forms of traction, other conservative treatments, or surgery. Powered traction devices are covered as a physical medicine modality under existing physical medicine payment policy. When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider under code **1044M**.

Link: For additional information, see powered traction therapy in Chapter 25: Physical Medicine Services.

Payment policy: Telehealth for chiropractic services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- When the service to be performed requires a hands-on component, *or*
- A worker files a reopening application, *or*
- It is the first visit of the claim, *or*

- Restrictions or changes are anticipated (the Activity Prescription Form [APF] requires an update), *or*
- Consultations requested to determine if continued conservative care is appropriate (including but not limited to 60 and 120 day consults), *or*
- A worker requests a transfer of attending provider.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Teleconsultations

Teleconsultations are **consultations** requested by the attending provider, department, self-insurer, or authorized department representative that are performed via **telehealth**. Per WAC 296-20-051, providers may not bill **consultation** codes for **established patients**.

The insurer covers teleconsultations when the following conditions have been met:

- The **telehealth** provider must be an approved chiropractic **consultant**, *and*
- The referring provider must be one of the following: MD; DO; ND; DPM; OD; DMD; DDS; DC; ARNP; PA; or PhD clinical psychologist, *and*
- The consulting provider must note the name of the provider who referred the worker, *and*
- The **telehealth** provider must submit a written report that meets all in-person consultation and **telehealth** documentation requirements to the referring provider, and must send a copy to the insurer.

Links: Learn more about coverage of these services in WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site and store and forward fees are covered, when applicable.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same patient.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the **telehealth** service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Q3014 billing example

A worker attends an in-person Evaluation and Management (E/M) appointment at their attending provider's office. The attending provider documents all necessary information as part of this visit and bills for the E/M service. The **originating site** (attending provider's

office) also arranges a secure and private space for the worker to participate in a consultation with their cardiologist at another location (**distant site** provider). The **originating site** provider separately documents the use of their space as part of their bill for **Q3014**.

How to bill for this scenario

The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their space for their **telehealth** visit with the **distant site** provider. The **distant site** provider bills for the services they provide; they can't bill **Q3014**.

For this **telehealth** visit:

- The **distant site** provider would bill the appropriate CPT® E/M code with modifier **–GT**.
- The **originating site** provider would bill **Q3014**.

Note: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services.

Store and Forward

G2010 is covered for patient-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the patient provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only evaluation or treatment billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a patient,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report), *and*
- Home health monitoring.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for physical medicine	Washington Administrative Code (WAC) 296-21-290
Becoming an Chiropractic Consultant	Become a Chiropractic Consultant on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information For All Providers
Chiropractic Services including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources	IICAC website
Dynamic Spinal Visualization coverage decision	Dynamic Spinal Visualization coverage decision
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Payment policies for **case management services**	Chapter 10: Evaluation and Management Services
Payment policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **IMEs**	Chapter 13: Independent Medical Exams (IMEs)
Payment policies for **impairment ratings**	Chapter 12: Impairment Rating Services
Payment policies for **physical medicine treatment** or **powered traction therapy**	Chapter 25: Physical Medicine Services
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 8: Dental Services

Effective July 1, 2024

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

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Payment policy: All dental services

Prior authorization

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and Crime Victims Compensation (CVC) claims, *or*
- Self-insured employer or their third party administrator.

Only claim managers can authorize dental services for State Fund workers' compensation claims and CVC claims.

For self-insured workers' compensation claims, contact the insurer directly for prior authorization procedure details.

Link: A list of self-insured employers' contact information is available online.

Prior authorization review of treatment plan

Dental services requiring prior authorization require a treatment plan. Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to:

- Restorative,
- Endodontic,
- Prosthodontic,
- Prosthetic,
- Implant,
- Orthodontics,
- Surgery, *and*
- Anesthesia procedures.

In cases presenting complication, controversy or diagnostic/therapeutic problems, the claim manager may request consultation by another dentist to support authorization for procedures.

Who must perform these services to qualify for payment

Dental providers licensed in the state in which they practice may be paid for performing dental services, including:

- Dentists,
- Oral and Maxillofacial surgeons,
- Orthodontists,
- Endodontists,
- Periodontists,
- Pediatric Dentists,
- Prosthodontists,
- Denturists,
- Hospitals, *and*
- Dental clinics.

Dental providers **must be enrolled in the provider network** to treat injured workers beyond the initial visit. The initial visit is the first visit to a healthcare provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers compensation. See information about the Medical Provider Network in Chapter 2: Information for All Providers - Becoming a provider. Network requirements do not apply to Crime Victim services.

Links: You can find more information about dental services in WAC 296-20-110, WAC 296-23-160, and WAC 296-20-015, and about becoming an L&I provider at Becoming an L&I Provider.

Services that aren't covered

Pre-existing conditions

Pre-existing conditions aren't payable unless medically justified as related to the injury. Prior authorization is required for treatment.

Underlying conditions

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker. It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that won't be covered.

Periodontal disease

Periodontal disease is an underlying condition that isn't covered because it isn't related to industrial injuries.

Link: For more information, see WAC 296-20-110.

Requirements for billing

Bills must be submitted within 1 year from the date the service is rendered. See the HCPCS fee schedule for dental billing codes.

Link: For more information, see WAC 296-20-125.

All workers' compensation dental claims should be billed using the ADA American Dental Association Dental Claim form (© 2024 American Dental Association J43024), or L&I's Statement for Miscellaneous Services form (F245-072-000).

For Crime Victims Compensation (CVC) claims, dentists should use the ADA American Dental Association Dental Claim form (© 2024 American Dental Association J43024), or CVC's Statement for Crime Victims Miscellaneous Services form (F800-076-000).

Failure to use the most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the:

- Full billing code, including the letter D if using a Current Dental Terminology (CDT®) code,
- Materials used, *and*
- Injured tooth number(s).

Note: When using Current Dental Terminology (CDT®) codes, please include the D in front of the code billed to avoid delays in claim/bill processing.

Treatment plan requirements

Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The dentist should outline the extent of the dental injury and the treatment plan. To **obtain authorization** for a treatment plan, all of the following are **required**:

- Causal relationship of injury to condition of the mouth and teeth,
- Extent of injury,
- Alternate treatment plan,
- Time frame for completion, *and*
- Medical history and risk level for success.

Please include:

- Procedure code,
- Tooth number,
- Tooth surface, *and*
- Charge amount.

To avoid delays in treatment, please **exclude** information regarding treatment that isn't directly related to the injury. The ADA American Dental Association Dental Claim form (© 2024 American Dental Association J43024) may be attached to treatment plan. Select Request for Predetermination/Preauthorization in section 1 of the ADA form.

In addition, to **avoid delays in authorization** of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number, *and*
- State the condition of the mouth and involved teeth including:
    - Missing teeth, existing caries and restorations, *and*
    - Condition of involved teeth prior to the injury (caries, periodontal status).

Link: For more information, see WAC 296-20-110.

Where to submit a treatment plan

State Fund treatment plans (not billing info) may be:

- Faxed to **360-902-4567**, or
- Mailed to:

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

Crime Victims Compensation (CVC) treatment plans (not billing info) may be:

- Faxed to **360-902-5333**, or
- Mailed to:

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

Mail **self-insured** treatment plans to the Self-insured employer (SIE) or third party administrator (TPA).

Documentation and recordkeeping requirements

Acceptance of a claim

If you are the first provider seen by the injured worker and you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. To initiate the State Fund claim or CVC claim for your worker, send L&I a **Report of Industrial Injury or Occupational Disease** form (F242-130-000) (also known as Accident Report or Report Of Accident (ROA) Workplace Injury, Or Occupational Disease).

Links: You can order copies of the **Report Of Accident** (ROA) Workplace Injury, Accident or Occupational Disease (F242-130-000) or by calling **1-800-LISTENS** or **1-360-902-4300**. To request a supply of the **Provider's Initial Report** (PIR) form used for workers of self-insured employers (F207-028-000), or call **1-360-902-6898**.

Chart notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service. Legible copies of office notes are required for all initial and follow up visits.

Links: For more information, see WAC 296-20-010 and WAC 296-20-06101.

Attending provider

If dental treatment is the only treatment the injured worker requires and you are directing the care, you will be the attending provider (AP).

Your responsibility as the AP includes documenting employment issues in the injured worker‘s chart notes, including:

- A record of the worker‘s physical and medical ability to work,
- Information regarding any rehabilitation that the worker may need to undergo,
- Restrictions to recovery,
- Any temporary or permanent physical limitations, *and*
- Any unrelated condition(s) that may delay recovery must also be documented.

For ongoing treatment, use the **SOAP-ER** (Subjective, Objective, Assessment, Plan and progress, Employment issues, Restrictions to recovery) format.

Link: Information on the charting format can be found in Chapter 2: Information for All Providers.

Additional information: L&I’s periodic review of dental services

L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but aren‘t limited to, review of the injured worker‘s dental records.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules Medical Aid	Washington Administrative Code (WAC) 296-20-110 WAC 296-20-015 WAC 296-20-125 WAC 296-20-06101
Administrative rules dental services, general information and instructions	WAC 296-23-160
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Charting format (SOAP-ER) instructions	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including dental)	Fee schedules on L&I's website
Payment policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Provider's Initial Report (PIR) form for all State Fund and crime victims claims	F207-028-000
Report Of Accident (ROA) Workplace Injury, Accident or Occupational Disease form for all State Fund and crime victims claims	F242-130-000
Statement for Crime Victims Miscellaneous Services form for all crime victims claims	F800-076-000
Statement for Miscellaneous Services form for all worker's compensation claims	F245-072-000

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Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 9: Durable Medical Equipment (DME)

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Bundled codes: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Pharmacy and DME providers can bill HCPCS codes listed as bundled on the fee schedules because, for these provider types, there's not an office visit or a procedure into which supplies and/or equipment can be bundled.

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

By Report: A code listed in the fee schedule as "By Report" which 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.

Durable medical equipment (DME): DME means equipment that:

- Can withstand repeated use, *and*
- Is primarily and customarily used to serve a medical purpose, *and*
- Generally isn't useful to a person in the absence of illness or injury, *and*
- Is appropriate for use in the worker's place of residence.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

Pneumatic compression devices: Pneumatic compression devices, specifically vasopneumatic devices, are comprised of inflatable garments for the arms or legs and an electrical pneumatic pump that fills the garments with compressed air. The garments intermittently inflate and deflate with cycle times and pressures that vary. The Food and Drug Administration (FDA) classifies these devices as Cardiovascular Therapeutic Devices, Compressible limb sleeve.

Portable oxygen systems: Portable oxygen systems, sometimes referred to as ambulatory systems, are lightweight (less than 10 pounds) and can be carried by most patients. These systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.

- Small gas cylinders are available as portable systems. Some are available that weigh less than five pounds.
- Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights.

Stationary oxygen systems: Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems, and oxygen concentrators.

- Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders.
- Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas, but takes up less space and can be transferred more easily to a portable tank.
- Oxygen concentrators are electric devices that extract oxygen from ambient air and compress it to 85% or greater concentration. A backup oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–NU (New purchased DME)	
Use this modifier to indicate when the DME dispensed is being purchased and doesn't need to be returned to the supplier. **Note**: DME codes that are applicable to purchasing are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–NU** rate for each specific DME provided or billed charge, whichever is less.
–RR (Rented DME)	
Use this modifier to indicate when the DME dispensed will be rented and returned to the supplier. **Note**: DME codes that are applicable to rental are listed in the L&I Professional Services Fee Schedules	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–RR** rate for each specific DME provided or billed charge, whichever is less.
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Hot or cold therapy DME

Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for **DME** providers only and is **bundled** for all other provider types.

Link: See L&I's coverage decision for additional details.

Services that aren't covered

Hot water bottles, heat and/or cold wraps aren't covered.

Hot or cold therapy **DME** isn't covered. Examples include heat devices for home use, including heating pads. These devices either aren't covered or are **bundled**.

Cryotherapy **DME** with or without compression is not covered for home use. This modality used in a clinical setting is considered to be **bundled** into existing physical medicine services billable under CPT® **97010** and/or **1044M**.

HCPCS code **E1399** isn't appropriate for cryotherapy **DME** in any setting.

Link: For more information, see WAC 296-20-1102.

Payment limits

Application of hot or cold packs (CPT® code **97010**) is **bundled** for all providers.

Payment policy: Negative pressure wound therapy (NPWT)

General information

Negative Pressure Wound Therapy (NPWT) is a method of wound treatment involving the use of a device that creates subatmospheric pressure around a wound to enhance healing.

NPWT devices are rental only. They won't be purchased even if rented for periods of 12 months or more.

Prior authorization

Rental of NPWT **DME** is covered when the wound is related to an injury or illness allowed on the claim. See the L&I coverage decision for authorization requirements.

Prior authorization is required before starting NPWT and every 30 days thereafter during a given episode of care.

Billing requirements

Unlike most other forms of rented **DME**, NPWT devices are rented by day. Each rental day equals 1 unit.

Payment limits

If the item is a…	And the code is…	Then the payment limits are…
Wound therapy device	**E2402**	Limit 1 pump per episode. Limit 4 months of treatment per episode; see below.
Wound therapy device dressing kit	**A6550**	Limit 15 kits per month.
Wound therapy device canister	**A7000**	Limit 10 canisters per month.

NPWT devices are limited to 4 months (120 days or 120 units) of treatment per episode of care. See L&I's coverage decision for more information.

Payment policy: Oxygen and oxygen equipment

Requirements for billing

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes.

Delivery charges, shipping and handling, tax, and fitting fees aren't payable separately. Include these charges in the total charge for the supply.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Services that can be billed

To bill for oxygen, if the worker has a:

- **Portable oxygen system**, bill using either **E0443** (gaseous contents) or **E0444** (liquid contents), *or*
- **Stationary oxygen system**, bill using either **E0441** (gaseous contents) or **E0442** (liquid contents).

Examples of oxygen accessories

Oxygen accessories include but aren't limited to:

- Cannulas (**A4615**),
- Humidifiers (**E0555**),
- Masks (**A4620**, **A7525**),
- Mouthpieces (**A4617**),
- Regulators (**E1353**),
- Nebulizer for humidification (**E0580**),
- Stand/rack (**E1355**),
- Transtracheal catheters (**A4608**), *and*
- Tubing (**A4616**).

Payment limits

Except on rare occasions, oxygen equipment is always rented and never purchased. Oxygen equipment may only be purchased for a worker with explicit authorization from the insurer. The reason for purchase should be explained in detail in the claim file.

If the worker **rents** the oxygen system:

- A monthly fee is paid for oxygen equipment. This fee includes payment for the equipment, contents, necessary maintenance, and accessories furnished during a rental month, *and*
- Oxygen accessories are included in the payment for rented systems. The supplier must provide any accessory ordered by the provider. (See Examples of oxygen accessories, below.)

If the worker **owns** the oxygen system:

- The fee for oxygen contents must be billed once a month, not daily or weekly. 1 unit of service equals 1 month of rental, *and*
- Oxygen accessories are payable separately only when they are used with a patient-owned system.

Payment policy: Pneumatic compression devices

General information

Pneumatic compression devices are used in the following ways:

- During surgery only, *or*
- During and after surgery, either in the facility or at home, *or*
- At home only.

Pneumatic compression devices used during surgery and subsequently sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and isn't separately payable. **DME** providers won't be reimbursed for pneumatic compression devices used in this capacity.

Services that can be billed

Pneumatic compression devices are considered **DME** and are separately billable using HCPCS codes **E0650-E0675** when **all** of the following criteria are met:

- The device isn't used during surgery in any capacity, *and*
- The worker is being treated for lymphedema or is at risk for developing venous thromboembolism (VTE). If at risk for VTE, the worker has been evaluated and the risk has been documented using a validated thrombosis risk factor assessment tool, *and*
- The provider documents a statement of medical necessity indicating the device is medically necessary to prevent VTE based on the results of the screening tool or treat lymphedema and the device being supplied is intended for home use only.

Services that aren't covered

Pneumatic compression devices are considered surgical supplies and aren't separately billable when *any* of the following conditions are met:

- The device is used during surgery in any capacity, *or*
- The device is used following surgery while the worker is in the facility, *or*
- The device isn't prescribed by the provider.

CPT® code **99070** isn't covered.

HCPCS code **E0676** isn't covered.

Link: For more information on the use of **pneumatic compression devices** in a clinical setting, see Chapter 25: Physical Medicine Services.

Payment policy: Prosthetic and orthotic services

Prior authorization

Prior authorization is required for prosthetics, surgical appliances, and other special equipment described in WAC 296-20-03001 and replacement of specific items on closed claims as described in WAC 296-20-124.

For **State Fund** claims, contact the Provider Hotline at **1-800-848-0811**.

For **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

If **DME**, prosthetics, or orthotics requires prior authorization and it isn't obtained, then bills may be denied.

Link: The Professional Services Fee Schedule has a column designating which codes require prior authorization.

Who must perform these services to qualify for payment

Pre-fabricated orthotics that are off-the-shelf and given to the worker as-is or are customized to fit the worker are billable. The insurer will only pay for custom-made (sometimes called "custom-fabricated") prosthetic and orthotic devices manufactured by these providers specifically licensed to produce them:

- Prosthetists,
- Orthotists,
- Occupational therapists,
- Certified hand specialists, *and*
- Podiatrists.

Link: To determine if a prosthetic or orthotic device is in this category, see the "license required" field in the fee schedule.

Requirements for billing

An itemized invoice showing total cost for the item must be submitted to support charges for any custom prosthetic or orthotic device listed as **By Report** in the fee schedule. To find out which codes pay **By Report**, see the Professional Services Fee Schedule.

Each **By Report** code billed should be listed individually. Sales tax and shipping and handling charges aren't paid separately and must be included in the total charge. Bills without an invoice may be denied.

For covered prosthetics that pay **By Report**, providers must bill their usual and customary fees.

Links: For more information on billing usual and customary fees, see WAC 296-20-010 (2).

For information on where to send bills and invoices, see Chapter 2: Information for All Providers.

Payment limits

For **By Report** prosthetic items, the insurer will pay 80% of the appropriate charges.

Payment policy: Purchasing DME

General information

This policy contains rules regarding when and how **DME** is purchased for a worker.

Purchased **DME** belongs to the worker, not the provider or insurer. Purchased **DME** doesn't need to be returned to the provider or insurer even after treatment is complete.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Prior authorization

Prior authorization is required for some **DME**. If prior authorization is required but isn't obtained, bills may be denied. The Professional Services Fee Schedule has a column designating which codes require prior authorization. These codes include (but aren't limited to):

- HCPCS E codes,
- HCPCS K codes,
- Replacement of specific items on closed claims (see WAC 296-20-124), *and*
- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).

To obtain prior authorization for State Fund claims, contact the Provider Hotline at **1-800-848-0811**. For self-insured claims, contact the self-insured employer or their third party administrator.

Requirements for billing

Delivery charges, shipping and handling, tax, and fitting fees aren't separately payable.

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes. Errors will result in suspension and/or denial of payment.

Modifiers for purchased DME

The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which **DME** items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).

Example: **E0117-NU** (Underarm spring-assist crutch) is only purchased (there isn't a modifier **–RR** for that code).

Always include a modifier with a **DME** HCPCS code (except repair codes **K0739** and **K0740**). Bills submitted without the correct modifier will be denied. Providers may continue to use other modifiers (for example **–LT** or **–RT**) in conjunction with the mandatory modifiers, if appropriate (up to 4 modifiers may be used with any 1 HCPCS code).

Miscellaneous DME

Bills for miscellaneous **DME** (**E1399**) are payable only for **DME** that doesn't have a valid HCPCS code. The item must be appropriate relative to the injury or type of treatment received by the worker. A description of the item must be on the paper bill or in the remarks section of the electronic bill.

All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).

Documentation requirements

All providers must submit documentation to support billing for the purchase of any **DME**. Documentation must include (for each item):

- Worker's name,
- Type of item,
- Name of the item's manufacturer,
- Item's model name and model number (if applicable),
- Item's serial number (if applicable),
- Full description of the item,
- Date the item was dispensed,
- Copy of the manufacturer's warranty (see details below), *and*
- Itemized list of all costs charged to the insurer.

Warranties

Upon purchase of any **DME**, the supplier must send a copy of the manufacturer's warranty to the claim file as part of their documentation to support their bill. Payment may be denied if no warranty is filed.

The insurer doesn't purchase or provide additional or extended warranties beyond the manufacturer's initial warranty (or any other provider's warranty).

Different types of **DME** require different warranty specifications. Where a manufacturer provides a warranty greater than what is required below, the manufacturer's warranty will apply. The following table outlines required warranty specifications:

If the **DME item type** is…	Then the **required warranty coverage** is…
DME purchased new (excluding disposable and non-reusable supplies)	Limited to the manufacturer's warranty
Power-operated vehicles (3-wheel or 4-wheel non-highway scooter)	Minimum of 1 year or manufacturer's warranty, whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	
Wheelchair codes **K0004**, **K0005**, and **E1161**	Lifetime warranty on side frames and cross braces

Payment limits

Supplies used during or immediately after surgery and not sent home with a worker aren't **DME** and won't be reimbursed as **DME**.

If any **DME** item is rented for 6 months or more, the insurer may review rental payments and decide to purchase the equipment at that time. Rental payments won't exceed 12 months. After the 12th month of rental, the equipment is considered "purchased" and is now owned by the worker. No additional rental fees are payable (with the exception of oxygen equipment; see the Oxygen and oxygen equipment payment policy for details).

DME purchase after rental period of less than 12 months

For equipment rented for less than 12 months that is determined after rental to be permanently needed by the worker:

- For **State Fund** claims, the worker may be asked to return the rented **DME** and the provider may issue new **DME** to be purchased by the insurer. The provider should bill their usual and customary charge for the new **DME** and append modifier **–NU**. L&I will pay the fee schedule amount for the new **DME** or billed charge, whichever is less.
- For **self-insured** claims, self-insurers may purchase the equipment and receive rental credit toward the purchase.

Used DME

State Fund and Crime Victims Compensation Program won’t purchase used **DME**.

Self-insured employers may purchase used **DME**.

Payment policy: Renting DME

General information

This policy contains rules regarding when and how **DME** is rented for a worker.

During the authorized rental period, the **DME** belongs to the provider. When the **DME** is no longer authorized, the worker must return it to the provider.

If unauthorized **DME** isn't returned to the provider within 30 days, the provider can bill the worker for charges related to **DME** rental, purchase, and supplies that accrue after the insurer denies authorization for the **DME**.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Prior authorization

Prior authorization is required for some **DME**. If prior authorization is required but isn't obtained, bills may be denied. The Professional Services Fee Schedule has a column designating which codes require prior authorization. These codes include but aren't limited to:

- HCPCS E codes,
- HCPCS K codes,
- Replacement of specific items on closed claims (see WAC 296-20-124),
- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).

To obtain prior authorization for State Fund claims, contact the Provider Hotline at **1-800-848-0811**. For self-insured claims, contact the self-insured employer or their third party administrator.

Requirements for billing

Delivery charges, shipping and handling, tax, and fitting fees aren't separately payable.

If the **DME** is rented for:

- **1 day**: use the same date for the first and last dates of service.
- **More than 1 day**: use the actual first and last dates of service.

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes. Errors will result in suspension and/or denial of payment.

Modifiers for purchased DME

Always include a modifier with a **DME** HCPCS code (except repair codes **K0739** and **K0740)**. Bills submitted without the correct modifier will be denied. Providers may continue to use other modifiers (for example **–LT** or **–RT**) in conjunction with the mandatory modifiers, if appropriate (up to 4 modifiers may be used with any 1 HCPCS code).

The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which **DME** items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).

Example: **E0117–NU** (Underarm spring-assist crutch) is only purchased (modifier **–RR** can't be used with this code).

Miscellaneous DME

Bills for miscellaneous **DME** (**E1399**) are payable only for **DME** that doesn't have a valid HCPCS code. The item must be appropriate relative to the injury or type of treatment received by the worker. A description of the item must be on the paper bill or in the remarks section of the electronic bill.

All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).

Documentation requirements

All providers must submit documentation to support billing for the rental of any **DME**. Documentation must include (for each item):

- Worker's name,
- Type of item,
- Name of item's manufacturer,
- Item's model name and model number,
- Item's serial number (if applicable),
- Full description of the item,
- Date the item was dispensed, *and*
- Itemized list of all costs charged to the insurer.

Payment limits

For most **DME**, each month of rental should be billed as 1 unit of service. Rental periods of less than 1 month should be billed as 1 unit unless otherwise noted in the rental limit exceptions below or in other policies in this chapter.

If any **DME** item is rented for 6 months or more, the insurer may review rental payments and decide to purchase the equipment at that time. Rental payments won't exceed 12 months. After the 12th month of rental, the worker owns the equipment and no additional fees are payable (with the exception of oxygen equipment; see the Oxygen and oxygen equipment payment policy for details).

Rental limit exceptions

DME item	Code(s)	Rental requirements
Continuous passive motion exercise devices	**E0935-E0936**	Rented on a per diem basis up to 14 days. 1 unit of service = 1 day.
Extension / flexion devices	**E1800-E1818** **E1825-E1840**	Rented for 1 month. If needed beyond 1 month, insurer's authorization is required.
Oxygen equipment	See Payment policy: Oxygen and oxygen equipment for codes.	Rented in perpetuity. Can't be purchased without permission from the insurer.
Wound therapy devices	**E2402**	Rented per day. 1 unit of service = 1 day.

Payment policy: Repairs and non-routine services

Requirements for billing

DME repair codes (**K0739**, **K0740**) must be billed per each 15 minutes. One unit of service equals 15 minutes.

- **Example**: 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with 3 units of service.

Only equipment out of warranty will be considered for repair, non-routine service, and maintenance coverage. If an item is still under warranty, bills for warranty-covered repairs for that item will be denied.

Repair codes **K0739** and **K0740** don't require modifiers.

Payment limits

Purchased equipment repair

The insurer won't pay for any repairs (including parts and labor) that are covered by a manufacturer's warranty during the period of warranty coverage.

Repair or replacement of **DME** is the responsibility of the worker when the item is:

- Damaged due to worker abuse, neglect, misuse, *or*
- Lost or stolen.

Rented equipment repair

Repairs, non-routine service, and maintenance are included as part of the monthly rental fee for **DME**. No additional payment will be provided.

The insurer won't pay for rental of disposable or non-reusable supplies.

Payment policy: Ventilator management services

Payment limits

Ventilation management service codes (CPT® codes **94002**-**94005**, **94660**, and **94662**) are payable only when an Evaluation and Management (E/M) service (CPT® codes **99202**-**99499**, except for case management services) is not performed on the same day. When an E/M service is performed on the same day, ventilation management is **bundled** into the payment for the E/M service.

Payment policy: Virtual reality devices

General information

Virtual reality devices may be used as a delivery mechanism for a covered therapeutic service, such as physical therapy exercises delivered with virtual reality tasks or cognitive behavioral therapy with virtual reality exposure therapy.

Services that aren’t covered

Providers can’t charge an additional fee for the use of virtual reality devices as part of a service.

Purchase or rental of virtual reality **DME** isn’t covered for clinical or home use.

Payment limits

The cost of virtual reality as a modality for treatment in a clinical setting is **bundled** into the cost of therapy services and isn’t separately payable.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules (Washington state laws) for purchasing or renting DME	Washington Administrative Code (WAC) 296-20-1102
Administrative rules for miscellaneous services and appliances	WAC 296-23-165
Administrative rules for payments for rejected and closed claims	WAC 296-20-124
Administrative rules for treatments requiring authorization	WAC 296-20-03001
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Negative Pressure Wound Therapy coverage and treatment	Negative Pressure Wound Therapy coverage decision
Professional Services **Fee Schedules**	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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 10: Evaluation and Management (E/M) Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Consultant: A consultant is a provider who has not agreed to accept transfer of care before an initial evaluation.

Consultation: A type of evaluation and management (E/M) service provided at the request of an attending provider, the department, self-insurer, or authorized department representative to either recommend care for a specific condition or problem, or to determine whether to accept a worker for further treatment. See WAC 296-20-045.

L&I doesn't use the CPT® definitions for consultation services with respect to who can request a consultation service, when a consultation can be requested, and requirements for when to bill a consultation vs. established or new patient codes.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Established patient: One who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

When advance registered nurse practitioners and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

New patient: One who hasn't received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

Online communications: Electronic communication conducted over a secure network, including but not limited to electronic mail (email), patient portals, or Claim and Account Center (CAC).

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)	
Use this modifier to indicate when an E/M service is performed during a postoperative period that was unrelated to the surgical procedure.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same patient, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

Use	Payment Information
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) is not recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: All E/M services

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

Link: For more information, see WAC 296-20-030(1) and WAC 296-20-03001(1).

Requirements for billing

All medical records must contain documentation that justifies the level, type and extent of service billed. See Documentation requirements for more details.

Determining type of visit: New, established or consultation evaluation and management service

If a patient presents with a work related condition and meets the definition in a provider's practice as:

- A **new patient**, then a **new patient** E/M service must be billed, *or*
- An **established patient**, then an **established patient** E/M service must be billed, even if the provider is treating a new work related condition for the first time, *or*
- A **consultation** that has been requested by the attending provider, the department, self-insurer or authorized department representative and all requirements for a **consultation** service has been met, then a **consultation** E/M service must be billed.

Per WAC 296-20-051 providers may **not** bill **consultation** codes for **established patients**.

Links: For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

Using CPT® billing code modifier –25

Modifier **–25** must be appended to an E/M code when reported with another procedure or service on the same day. This applies to all E/M services.

The E/M visit and the procedure must be documented separately.

To be paid, modifier **–25** must be reported in the following circumstances:

- Same worker, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Worker's condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

Scheduling back-to-back appointments doesn't meet the criteria for using modifier **–25**.

Consultations

In accordance with WAC 296-20-051, in cases presenting diagnostic or therapeutic problems to the attending provider, a **consultation** with a specialist may be requested without prior authorization. **Consultations** can only be requested by the attending provider, the department, self-insurer, or authorized department representative.

The **consultant** must submit their findings and recommendations to the attending provider and the department or self-insurer. The report must be received by the insurer within 15 days from the date of the **consultation**, per WAC 296-20-051. This timeframe is shorter than the requirement noted in Chapter 2: Information for All Providers, which states that documentation to support the service billed must be received prior to bill submission or within 30 days of the date of service, whichever comes first.

Consultation codes (**99242-99245**) may only be reported by a provider who has not agreed to accept transfer of care before an initial evaluation. **Consultation** services won't be reimbursed for workers who are currently, or have been, under the provider's care within the last 3 years or another provider of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years. Such services should be billed as **established patient** E/M services, as listed in the fee schedules.

Note: Per WAC 296-23-195, prior notification (by electronic communication, letter, or phone call) to the insurer is required for chiropractic consultations. Refer to Chapter 7: Chiropractic Services for more information regarding the requirements for chiropractic consultations.

Documentation requirements

The American Medical Association (AMA) made substantial changes to the **New** and **established patient** E/M services effective January 1, 2021 and expanded those guidelines to all other E/M services (including **consultations**) effective January 1, 2023. The insurer has chosen to adopt these updated changes with slight modification as of July 1, 2023.

Modifications include policies on separately billable services and admissions within the course of an encounter at another site. Additionally, the insurer doesn't allow shared billing for visits in which multiple providers contribute to an E/M service.

SOAP-ER note requirements

As outlined in Chapter 2: Information for All Providers, the insurer requires the addition of ER (Employment and Restrictions) to the SOAP format. Chart notes must document the worker's status at the time of each visit.

Providers are required to submit medical records that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation or crime victims must contain the pertinent history and the pertinent findings found during an exam.

Consultation reports

In addition to the above, **consultation** reports must include the elements listed in WAC 296-20-01002. Documentation of the referral must be present in either the attending physician notes or the **consultant's** report.

Links: For additional guidelines and requirements see 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes.

For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

For more information about chiropractic **consultation** services, see WAC 296-23-195.

Selecting the level of service

Select the appropriate level of E/M service based on coding guidelines in the CPT® book. This information can also be found in the 2021 AMA E/M new and established outpatient visit guideline updates or the 2023 AMA E/M guideline updates for all other E/M services.

Only time spent in covered activities by the provider on the calendar day of the visit (midnight to 11:59pm) can be counted toward the E/M visit time. Check-in and check-out time can't be used when determining the length of a visit as this may include ancillary staff time, wait time, etc.

When billing based on time, documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.

Examples of services that can't be included in the time used to determine the level of E/M service, include but are not limited to:

- The performance of other services that can be reported separately. See Separately Billable Services,
- Travel,
- Teaching that is general and not limited to a discussion that is required for the management of a specific worker,
- Discussions of the L&I claims process with the worker/family/caregiver.

Note: All questions, discussions, and/or concerns regarding the administrative process of L&I claims should be directed to the insurer.

Separately billable services

Any procedure represented by its own CPT®, HCPCS, or local codes must be billed separately, and the time spent on these services can't be included in the time used to determine the level of E/M service.

This includes but is not limited to services, such as:

- Care coordination (such as telephone calls or online communications), *or*
- Completing forms (such as a Report of Accident (ROA) or Activity Prescription Form (APF)), *or*
- Independently interpreting results (when represented by its own CPT® code), *or*
- Procedures (such as injections or Osteopathic Manipulative Treatment), *or*
- Any treatment-based service.

When these services are performed in conjunction with an E/M service, you must append modifier **–25.** See Using CPT® billing code modifier –25.

Note: Evaluation and reporting is bundled into the payment of many services.

Examples of billing with modifier –25

Example 1: Minor procedure and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related elbow and shoulder injury. The provider evaluates and documents findings of the shoulder injury and suggests a steroid injection based on their findings. The provider also evaluates and documents findings related to the elbow injury and determines that physical therapy may provide benefit and provides a referral.

The provider performs the pre-service work (such as cursory history, palpatory examination, discusses side effects). The provider then performs the steroid injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The provider documents the steroid injection (including pre-, intra- and post service work), totaling 25 minutes and an additional separately identifiable E/M service including record review, history, exam, counseling provided and charting time, totaling 30 minutes.

How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the steroid injection, and
- CPT® code **99214**, with modifier **–25**.

The provider can't include the time or activities spent performing the steroid injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service, including time spent on each service.

Example 2: Case management service and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the provider finds that they have questions regarding the current treatment plan. The provider documents a 10 minute telephone conversation with the neurologist on the day of the visit including all required documentation elements of that CPT® code. The provider evaluates and documents findings of the head injury as well as the treatment plan.

The provider documents 10 minutes for the telephone call as noted above. The provider also documents the separately identifiable E/M service including record review, history and exam, and charting, totaling 40 minutes.

How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the telephone call, and
- CPT® code **99215**, with modifier **–25**.

The provider can't include the time or activities spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately. The provider must clearly document each service, including time spent on each service.

Example 3: OMT and E/M service

A worker goes to an osteopathic provider's office to be treated for back pain. The provider performs an E/M visit, including a multi-system examination, reviewing the worker's prior records and counseling the worker on the importance of appropriate lifting techniques for when they return to work. Based on their findings the provider then advises the worker that osteopathic manipulative treatment (OMT) is a therapeutic option for treatment of the condition.

The provider obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (such as cursory history, palpatory examination, discusses side effects). The provider then performs the manipulation, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The provider documents the OMT, including the pre, intra and post service work, in their chart note along with the separately identifiable E/M service (such as multi- system examination above and beyond the palpatory exam completed for the OMT service, reviewing records and counseling the worker on return to work).

How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the OMT service, and
- **New** or **established patient** E/M code, with modifier –**25**.

The provider can't include the activities or time spent performing OMT services (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

Link: More information on billing for OMT is available in Chapter 25: Physical Medicine Services.

Example 4: Multiple E/M visits performed on the same day

A worker arrives at a provider's office in the morning for a scheduled follow up visit for a work related injury.

That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The triage nurse agrees that the worker needs to be seen. The provider sees the worker for a second office visit.

How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed with the appropriate level of **established patient** E/M code for this visit alone, with no modifier appended, and
- The unscheduled visit would be billed with the appropriate level of **established patient** E/M code for this visit alone, with modifier **–25**.

The activities or time spent performing each separate E/M service can't overlap between the 2 visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (such as review of records, referrals). You can only count these activities under the applicable visit.

Additional information

Hospital admissions in the course of an encounter at another site

If a provider sees a worker at a location (initial site) and then sends them to the hospital to be admitted and performs the admission on the same date of service, only the initial hospital inpatient or observation care CPT® code can be billed (99221-99223). Any E/M performed at the initial site is considered bundled into the initial hospital inpatient visit and isn't payable separately. L&I follows CMS (Centers for Medicare and Medicaid Services) in regards to hospital admissions in the course of encounter at another site for E/M services.

Behavioral Health Interventions

Behavioral health interventions (BHI) performed by an attending provider as part of the evaluation and management service should be billed per CPT®. See Chapter 22: Other Services for more information regarding BHI payment policies.

Payment policy: Care plan oversight

Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

Requirements for billing

Payment for care plan oversight to a provider providing post-surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, and
- Modifier **–24** is used.

The medical record must document the medical necessity as well as the level of service performed.

Payment limits

Payment is limited to once per attending provider, per worker, in a 30-day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren’t separately payable.

Payment policy: Case management services – Online communications

Who must perform these services to qualify for payment

Online communications are payable only to providers who have an existing relationship with the worker and personally provide and bill for the service.

Requirements for billing

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association, *or*
- The Federation of State Medical Boards, *or*
- The eRisk Working Group for Healthcare.

Services that can be billed

Payable **online communications** are billed using local code **9918M** and include:

- Follow up resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent services for an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications,
- Discussing or coordinating care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claim manager.

Payable **online communications** must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The **online communications** must be with:

- The worker,
- L&I staff,
- Attending Provider,
- Vocational rehabilitation counselors,
- PT, OT, speech language pathologist,
- Nurse case managers,
- L&I medical **consultants**,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

Services that aren't covered

CPT® codes **99421**-**99423** are not covered. The provider must bill local code **9918M**.

Services that aren't payable include:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine communications related to appointments (including, but not limited to requests and reminders),
- Ordering prescriptions, including requests for refills,
- Test results that are informational only, *or*
- Communications with office staff.

Documentation requirements

Online communication documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The details of the **online communication** (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

A copy of the **online communication** must be sent to L&I.

Providers are not required to submit a separate document for **online communications** with an L&I claim manager made through the Claims and Account Center (CAC). CAC meets the documentation requirements for secure messaging.

Payment limits

9918M is limited to once per day, per claim, per provider. If a communication pertains 2 or more open claims, providers are expected to split the billing between the claims. See Split Billing Policy for billing instructions.

Payment policy: Case management services – Team conferences

Who must perform team conferences to qualify for payment

Payable **team conferences** must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The **team conference** must include 2 or more of the following:

- Current or former medical providers,
- Concurrent care providers, *or*
- Consulting providers, *or*
- Vocational rehabilitation counselors, *or*
- Nurse case managers, *or*
- PTs, OTs, and speech language pathologists, *or*
- Psychologists, *or*
- L&I staff, *or*
- L&I medical **consultants**, *or*
- Employers, *or*
- SIEs/TPAs.

The insurer doesn't follow CPT® by requiring all providers to have seen or treated the worker in the previous 60 days. However, all participating providers, with the exception of **consultants**, must have an established relationship with the worker.

Requirements for billing

Team conferences must be in-person or performed via telehealth. Team conferences performed via telehealth must follow the telehealth guidelines. See Payment Policy: Telehealth.

The following criteria must be met for team conferences:

- The need for a conference exceeds the day-to-day correspondence/communication among providers, and
- The worker isn't participating in a program in which payment for a conference is already included in the program payment (such as brain injury rehab program, or pain clinic), and
- Two or more disciplines/specialties need to participate.

ARNPs, PAs, psychologists, MLTs, speech-language pathologists, PTs, and OTs must bill using non-physician codes.

If the **worker status** is…	And you are **physician**, then bill CPT® code:	And you are a **non-physician**, then bill CPT® code:
Worker present	Appropriate level E&M	**99366**
Worker not present	**99367**	**99368**

For conferences **exceeding 30 minutes**, multiple units of CPT® codes **99366**, **99367**, or **99368** may be billed. For example, if the duration of the conference is:

- 1-30 minutes, then bill 1 unit, *or*
- 31-60 minutes, then bill 2 units.

Services that aren't covered

The insurer won't reimburse PT/OT and/or speech language pathologists for team conferences with members of the same clinic or care organization's physical medicine team unless part of an approved work rehabilitation program care conference.

Documentation requirements

Each provider must submit their own team conference documentation; joint documentation isn't allowed for any provider. Each team conference participant's documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the visit, *and*
- The nature of the visit, *and*
- All medical, vocational or return to work decisions made.

In addition to the documentation requirements noted above, team conference documentation must also include a goal oriented, time limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, *or*
- Objective measures of function.

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function. For PTs and OTs, the team conference documentation must include an evaluation of the effectiveness of the previous therapy plan.

Additionally, if the worker is present, and you are a physician, you must comply with all Evaluation and Management (E/M) requirements, including documentation requirements.

Payment limits

Providers in a hospital setting may only be paid if the services are billed on a **CMS-1500** with their L&I provider account number.

Team Conferences are limited to once per day, per claim, per provider. If a conference pertains 2 or more open claims, providers are expected to split the billing between the claims. See Split Billing Policy for billing instructions.

Payment policy: Case management services – Telephone calls

Who must perform these services to qualify for payment

Telephone calls are payable to the attending provider, **consultant**, psychologist, or other provider and only when the provider personally participates in the call.

Services that can be billed

Payable telephone calls include:

- Follow up resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent services for an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications,
- Discussing or coordinating care or treatment, for example, in-depth conversations on medical rationale and employability, or detailed notification of non-compliance to the claims manager, *and*
- Discussions of return to work activities with workers, employers, or the claims manager.

These services are payable when discussing or coordinating care or treatment with the following covered participants:

- The worker,
- L&I staff,
- Attending Provider
- Vocational rehabilitation counselors,
- Nurse case managers,
- Health services coordinators (COHE),
- L&I medical **consultants**,
- Other physicians,
- Other providers,
- SIEs/TPAs, *or*
- Employers.

Telephone calls are payable regardless of when the previous or next office visit occurs. The insurer will pay for telephone calls if the provider leaves a detailed message for the recipient and meets all of the documentation requirements.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues,
- Routine requests for appointments or reminders,
- Ordering prescriptions, including requests for refills,
- Test results that are informational only,
- Communications with the worker's attorney, *or*
- Communications with office staff.

The provider can't include the time spent performing or documenting the telephone call in selecting the appropriate E/M level as this service is required to be billed separately.

Audio-Only Services

Telephone calls aren't an appropriate replacement for in-person or telehealth services. The insurer won't pay for audio-only services using modifier –93 (audio-only), with the exception of some mental health services. See Chapter 17: Mental Health Services for more information.

Requirements for billing

ARNPs, PAs, psychologists, MLTs, speech-language pathologists, PTs, and OTs must bill using non-physician codes.

If the **duration** of the telephone call is…	And you are a **physician**, then bill CPT® code:	And you are a **non-physician,** then bill CPT® code:
1-10 minutes	**99441**	**98966**
11-20 minutes	**99442**	**98967**
21+ minutes	**99443**	**98968**

Note: Only 1 unit of CPT® code **99443** or **98968** is payable for calls over 20 minutes. Billing a combination of these codes is not allowed.

Mental health services must be authorized for psychiatrists and clinical psychologists to bill for these services, per WAC 296-21-270.

Documentation requirements

Each provider must submit comprehensive documentation for the telephone call that must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The details of the call (see Services that can be billed), *and*
- All medical, vocational or return to work decisions made.

Payment policy: End stage renal disease (ESRD)

General information

L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital inpatient or observation visit (CPT® codes **99221**-**99223**),
- An inpatient or observation **consultation** (CPT® codes **99252**-**99255**), *or*
- A hospital inpatient or observation discharge service (CPT® code **99238** or **99239**).

Payment limits

E/M services (CPT® codes **99231**-**99233** and **99307**-**99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are bundled in the dialysis service.

Payment policy: Medical care in the home or nursing facility

General information

L&I allows attending providers to charge for E/M services in:

- Nursing facilities, *and*
- Home or residence.

Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

Documentation requirements

In addition to the documentation requirements for E/M services, the medical record must document the location where the service was performed.

Payment policy: Prolonged E/M

Requirements for billing

Refer to the table below for prolonged services billing requirements. Refer to CPT® for further details, including documentation requirements.

If you are billing for this **CPT® code**…	Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service**:
99417	**99205**, **99215, 99245, 99345, 99350** or **99483**
99418	**99223, 99233, 99236, 99255, 99306** or **99310**

Prolonged Services Example

Prolonged service for an established patient visit

For an 84-minute **established patient** E/M service bill **99215** and **99417** x 2.

To calculate this, the first 40 minutes are applied to the **99215**, which leaves a remaining 44 minutes of prolonged service. This equates to 2 units of **99417**. Do not report **99417** for any additional time increment of less than 15 minutes.

Separately billable services and the time spent on those services can't be included in the calculation for the E/M service, including prolonged services. See also separately billable services section.

Payment limits

E/M office visits are limited to a maximum of 3 hours per day. Payment of prolonged services is allowed within the maximum.

Prolonged E/M service codes are payable only when another time-based E/M is billed on the same day.

The following prolonged services are not payable:

- Prolonged services on date other than the face-to-face evaluation and management service without direct patient contact, (CPT® **99358**, **99359**), *or*
- Prolonged clinical staff services (CPT® **99415**, **99416**).

Links: For more information on prolonged E/M services, see the 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes.

Payment policy: Split billing – Treating 2 separate conditions

Requirements for billing

If the worker is treated for 2 separate conditions at the same visit, the charge for the service must be divided equally between the payers and/or claims.

If evaluation of the 2 injuries increases the complexity of the visit:

- A higher level E/M code might be billed, *and*
- If this is the case, the applicable guidelines must be followed and the documentation must support the level of service billed.

For State Fund claims, when submitting:

- Paper bills to L&I, list all claim numbers treated in Box 11 of the **CMS-1500** form (F245-127-000) *or*
- Electronic claims, list all claim numbers treated in the remarks section of the **CMS-1500** form.

L&I will divide charges equally between the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for an accepted L&I or self-insured claim:

- Providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit.

Note: For physical medicine split billing exceptions, see Chapter 25: Physical Medicine Services, Unrelated conditions.

Payment limits

A provider would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day (see Example 4 in Separately Billable Services).

Scheduling back-to-back appointments doesn't meet the criteria for using modifier **–25**. See Using billing code modifier –25 in this chapter for more information.

Examples of split billing

Example 1: Two work-related injuries

A worker goes to a provider to be treated for a work-related shoulder injury and a separate work related knee injury. The provider treats both work related injuries.

How to bill for this scenario

For State Fund claims, the provider bills for 1 visit listing both workers' compensation claims in Box 11 of the **CMS-1500** form (F245-127-000).

L&I will divide charges equally to the claims. For self-insured claims, contact the SIE or their TPA for billing instructions.

Example 2: Work injury and automobile injury

A worker goes to a provider's office to be treated for the work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident.

How to bill for this scenario

The provider would bill:

- 50% of their usual and customary fee to L&I or the SIE, and
- 50% of their usual and customary fee to the insurance company paying for the motor vehicle accident.

L&I or the self-insurer would only be responsible for the portion related to the accepted work related injury.

Payment policy: Standby services

Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face worker contact, *and*
- The standby provider isn't concurrently providing care or service to other workers during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Round all fractions of a 30-minute period downward.

Payment policy: Telehealth for Evaluation and Management (E/M) services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

Non-mental health services are required to be in-person when:

- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- Consultations requested to determine if continued conservative care is appropriate (including but not limited to 60 and 120 day consults), *or*
- A worker requests a transfer of attending provider.

In-person services are required, in all cases, when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- A worker files a reopening application.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Teleconsultations

Teleconsultations are **consultations** requested by the attending provider, department, self-insurer, or authorized department representative that are performed via **telehealth**. Per WAC 296-20-051, providers may not bill **consultation** codes for **established patients**.

The insurer covers teleconsultations when the following conditions have been met:

- The **telehealth** provider must be a(n): doctor as described in WAC 296-20-01002; ARNP; PhD clinical psychologist; or approved chiropractic **consultant**, *and*
- The referring provider must be one of the following: MD; DO; ND; DPM; OD; DMD; DDS; DC; ARNP; PA; or PhD clinical psychologist, *and*
- The consulting provider must note the name of the provider who referred the worker, *and*
- The **telehealth** provider must submit a written report that meets all in-person consultation and telehealth documentation requirements to the referring provider, and must send a copy to the insurer.

Links: Learn more about coverage of these services in WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

For more information regarding requirements for approved chiropractic **consultant**'s, see Chapter 7: Chiropractic Services.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site and store and forward fees are covered, when applicable.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same patient.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Q3014 billing example

A worker attends an in-person Evaluation and Management (E/M) appointment at their attending provider's office. The attending provider documents all necessary information as part of this visit and bills for the E/M service. The **originating site** (attending provider's office) also arranges a secure and private space for the worker to participate in a consultation with their cardiologist at another location (**distant site** provider). The **originating site** provider separately documents the use of their space as part of their bill for **Q3014**.

How to bill for this scenario

The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their space for their telehealth visit with the **distant site** provider. The **distant site** provider bills for the services they provide; they can't bill **Q3014**.

For this telehealth visit:

- The distant site provider would bill the appropriate CPT® E/M code with modifier **–GT**.
- The originating site provider would bill **Q3014**.

Store and Forward

G2010 is covered for worker-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of an E/M visit. Follow up must occur within 24 business hours of receiving the images or video recordings. Follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2010** isn't covered if the worker provides the image or video recording as follow-up from an E/M visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to an E/M service within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only E/M services billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under Services that must be performed in person,
- Services that require physical hands-on and/or attended treatment of a patient,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report, except for mental health only claims), *and*
- Home health monitoring.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for E/M services	Washington Administrative Code (WAC) 296-20-045 WAC 296-20-051 WAC 296-20-01002 WAC 296-23-195 WAC 296-20-030
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
CMS 1500 form	F245-127-000
The **2021 American Medical Association (AMA) E/M Code and Guideline Changes** for new and established outpatient office visits	2021 AMA E/M guidelines
The **2023 American Medical Association (AMA) E/M Code and Guideline Changes** for all other E/M services	2023 AMA E/M guidelines
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Payment policies **Chiropractic Services**	Chapter 7: Chiropractic Services
Payment Policies **Physical Medicine Services**	Chapter 25: Physical Medicine Services

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 11: Home Health Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

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.

By report: A code listed in the fee schedule as "By Report" which 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.

Home health services: Multidisciplinary (RN, LPN, nursing aide, PT, OT, speech,) assessments and interventions for short-term rehabilitative therapy, home assessments for equipment and safety and long term nursing supervision for wound care, bowel and bladder management.

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, ostomy care, feeding assistance, mobility assistance, turning and positioning, range of motion exercises, transfers or walking, supervision due to cognitive impairment, behavior, or blindness.

Payment policy: Home health services

General information

When services become proper and necessary to treat a worker's accepted condition, the insurer will pay for aide, registered nurse (RN)/licensed practical nurse (LPN), physical therapy (PT), occupational therapy (OT), and (ST) 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.

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

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.

Who must perform these services to qualify for payment

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

Providers who perform services for home health agencies must be one of the following: Aide, RN, LPN, PT, OT, or ST.

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	**$45.38**
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day	**$47.06**
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day	**$47.06**
G0159	Plan of care established by Physical Therapist in the home, 15 min units	**$47.06**
G0160	Plan of care established by Occupational Therapist in the home, 15 min units	**$47.06**
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units	**$47.06**
G0299	Services of skilled nurse RN in the home. 15 min units	**$47.06**
G0300	Services of skilled nurse LPN in the home. 15 min units	**$42.33**
8970H	Home Health Aide Service up to 2 hours	**$86.00**
8971H	Home Health Aide Services each additional 15 minutes	**$10.75**

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

Link: To see which codes require prior authorization, see the HCPCS fee schedule.

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 isn't 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.

Link: See WAC 296-23-246 for details about attendant services.

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.

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 RN supervision of caregivers providing care to a worker.

Examples of services include nursing and 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 isn't billed separately (this doesn't 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 1 caregiver, unless specifically authorized.

The insurer won't pay for care during the time the caregiver is sleeping.

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	**$43.00**
S9123	Attendant in the home provided by a registered nurse per hour	**$86.43**
S9124	Attendant in the home provided by licensed practical nurse per hour	**$62.44**

Link: To see which codes require prior authorization, see the HCPCS fee schedule.

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.

Chore services

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

Link: Chore services aren't a covered benefit. See WAC 296-23-246.

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 by a Nurse Case Manager or Home Health Agency RN. Home Health Agency RNs bill code **G0162**, 1 unit per 15 minutes. Nurse Case Managers, see Chapter 20: Nurse Case Management for additional details.

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.

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 home health services to provide respite (relief) for a spouse or family member who provides either paid or unpaid attendant care.

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	**$16.28**

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

CPT® code	Description and notes	Max fee
99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit	**$181.59**
99602	Skilled RN visit for each additional hour per visit	**$76.36**

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 prior authorized 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.

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

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for home health services	Washington Administrative Code (WAC) 296-20-03001(8) WAC 296-20-1102 WAC 296-23-246
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 (including home health)	Fee schedules on L&I's website
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 25: Physical Medicine Services
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 12: Impairment Rating Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Body areas: The following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Genitalia, groin, buttock,
- Back,
- Abdomen, *and*
- Each extremity.

Each extremity is counted once per extremity examined when determining standard or complex codes.

Organ systems: The following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Respiratory,
- Genitourinary,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, *and*
- Hematologic/lymphatic/immunologic.

Payment policy: Impairment ratings

Prior authorization

Prior authorization is only required when:

- A psychiatric impairment rating is needed, *or*
- An Independent Medical Exam (IME) is scheduled.

Only the claim manager may request and authorize local billing code **1198M (Impairment rating, addendum report)**.

When and how to perform an impairment rating

When to rate impairment

When the worker has reached maximum medical improvement (MMI) or when requested by the insurer. Impairment rating should occur during the closing exam.

Rate impairment only for medical conditions accepted under the claim.

Body areas and organ systems

The definitions of **body areas** and **organ systems** from noted in the definition section if this chapter must be used to distinguish between standard and complex impairment rating.

How to rate impairment

Use the appropriate rating system.

Link: For an overview of systems for rating impairment, see the Medical Examiners' Handbook.

Include the objective findings to support the impairment rating. The objective medical information is required if a worker requests the claim be reopened. **If there isn't an impairment, document that in the report.**

Impairment rating reports must include all of the following elements:

- **MMI**: Statement that the patient has reached maximum medical improvement (MMI) and that no further curative or rehabilitative treatment is recommended, *and*
- **Examination**: Pertinent details of the physical examination performed (both positive and negative findings). The report must include pertinent measurements (such as range of motion) even if they are within normal limits. This is important to document for comparison with potential reopening applications, *and*

- **Diagnostic tests**: Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam, *and*
- **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example:
    - The AMA Guidelines to the Evaluation of Permanent Impairment Fifth Edition, *or*
    - The Washington State Category Rating System.
- **Rationale**: The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

Links: Refer to WAC 296-20-19000 through WAC 296-20-19030 and WAC 296-20-200 through WAC 296-20-690, and for amputations refer to RCW 51.32.080.

Who must perform these services to qualify for payment

Qualified Attending Providers (APs) (see table below) may rate impairment of their own patients.

APs who are permitted to rate their own patients don't need a separate provider account number and may use their existing provider account number.

Providers may only give ratings for areas of the body or conditions within their scopes of practice.

If the AP is unable or unwilling to perform the rating examination, the AP can ask a consultant to perform the rating examination in accordance with table below.

Psychologists can't be an attending provider (except for Crime Victim's claims) and can't rate impairment for injured workers but may rate impairment for victims of crime.

Providers qualified to provide impairment ratings include the following:

Provider type	Can you rate impairment as an AP or consultant?
Medicine and surgery	Yes
Osteopathic medicine and surgery	Yes
Podiatric medicine and surgery	Yes
Dentistry	Yes
Chiropractic	Yes, if L&I-approved IME examiner
Naturopathy	No
Optometry	No
Physicians' Assistant	No
Advanced Registered Nurse Practitioners (ARNP), including Psychiatric ARNPs	No

Links: To see how these qualifications are set in state law, see WAC 296-20-2010.

For more details on the topic of impairment ratings, refer to the Medical Examiners' Handbook.

Services that can be billed

When an impairment rating exam is requested by the insurer, it must be sufficient to achieve the purpose and reason per the request.

Choose the local billing code based on the number of **body areas** or **organ systems** that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related (see fee schedule, below).

Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

Local billing code	Description	Maximum fee
1190M	**Comprehensive Hearing loss exam** Use this code for comprehensive examination of the hearing system. The hearing system is comprised of 2 **organ systems** that need to be thoroughly examined for evaluation of the contended or accepted condition(s). Use of this code requires: • This specialty exam is directed only toward the affected body area or organ system. • Familiarity with the history of the industrial injury, exposure or condition through worker interview and medical and work records if available. • Appropriate diagnostic tests needed, including audiograms, are ordered and interpreted by the physician. • The degree of impairment is based on the audiogram and is interpreted by a physician. • The report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined **body areas** or **organ systems** relate to the accepted or contended work related injury(s) or conditions(s). • A statement regarding eligibility for permanent partial impairment. Note: Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within 2 years of last injurious exposure. Office visits are considered a bundled service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1191M	**Impairment rating by attending physician, standard, 1-3 body areas or organ systems.** Use this code if there are 1-3 **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area(s) or organ system(s). • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas **or** organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1192M	**Impairment rating by attending physician, complex, 4 or more body areas, or organ systems.** Use this code if there are 4 or more **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s). • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee.	**$910.07**

Local billing code	Description	Maximum fee
1194M	**Impairment rating by consultant, standard, 1-3 body areas or organ systems.** Use this code if there are 1-3 **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Records are reviewed. • Physical exam is directed only toward the affected body area(s) or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1195M	**Impairment rating by consultant, complex, 4 or more body areas or organ systems.** Use this code if there are 4 or more **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Records are reviewed. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee.	**$910.07**
1198M	**Impairment rating, addendum report.** Must be requested and authorized by the claim manager. Addendum report for additional information which necessitates review of new records. Payable to attending physician or consultant. This code isn't billable when the impairment rating report didn't contain all the required elements. (See the Medical Examiners' Handbook for the required elements.)	**$137.91**

Rating hearing loss

When performing a comprehensive exam for hearing loss, the report must include a statement regarding eligibility for permanent partial impairment. Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within 2 years of last injurious exposure.

Additional information: How to find out if an impairment rating is scheduled

To see if an IME is scheduled, for a claim that is:

- **State Fund**, use our secure online Claim & Account Center.
- **Self-insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call 1-800-762-3716.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and other Washington state laws for impairment ratings	Washington Administrative Code (WAC) 296-20-19000 WAC 296-20-19030 WAC 296-20-200 WAC 296-20-2010 WAC 296-20-690 Revised Code of Washington (RCW) 51.32.080
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 services (including impairment ratings)	Fee schedules on L&I's website
How to perform an impairment rating	Medical Examiner's Handbook
Laws for Medical Aid	RCW 51.28.055

Need more help?

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Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 13: Independent Medical Exams (IME)

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Body areas: The following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Abdomen,
- Genitalia, groin, buttock,
- Back, *and*
- Each extremity (each extremity is counted once per extremity examined when determining standard or complex codes)

By report: A code listed in the fee schedule as "By Report" which 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.

Distant site: The location of the provider who performs **telehealth** services. This provider is not at the originating site with the worker.

Organ systems: For IMEs, the following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Genitourinary,
- Respiratory,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, and

- Hematologic/ Lymphatic/ Immunologic.

Originating site: The place where the worker is located when receiving **telehealth**. For the purposes of this policy, the worker may be at home when receiving **telehealth**.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, 2-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–7N (Services in conjunction with an IME)	
Use this modifier to indicate when services are requested for an IME.	This modifier doesn't affect payment but is necessary to describe the service performed.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Independent medical exams (IMEs)

General information

Independent medical exams (IMEs) are medical examinations requested by the department or self-insured employers to answer medical and legal questions about the claim. Performing IMEs or impairment ratings requires considerable judgement and understanding of specialized terms and a mastery of skills that aren't always part of a doctor's original training. IME providers must be familiar with and follow the Medical Examiners' Handbook.

Per RCW 51.36.070(2), the department or self-insurer shall provide the physician performing the exam all relevant medical records from the worker's claim file.

Who must perform services to qualify for payment

Only **department-approved** IME Providers with an IME provider account number can bill IME codes. Applications are available on our website.

For more information on **becoming an approved IME provider** or to perform impairment ratings, see the Medical Examiners' Handbook.

To receive email updates on IMEs, subscribe to the ListServ.

Services that can be billed

Interpretation services during IMEs

Interpreter services are covered during IMEs. All interpreter requests must be scheduled through the scheduling system. For additional information regarding interpreter services, see Chapter 14: Language Access Services. For Sign Language interpretation, see Chapter 22: Other Services.

IME fee schedule

Local code	Description and notes	Maximum fee
1104M	**IME, addendum report.** Must be requested and authorized by claim manager. Addendum report is for additional information that isn't requested in original assignment, which necessitates review of records. Additional charges aren't payable. Not to be used in place of a new IME, if requested by the insurer. Fee already includes additional reimbursement for file review. To bill for review of job analysis, only use when records are re-reviewed and a report attesting to that re-review is submitted with the job analysis. The review of diagnostic testing or study results ordered by the examiner isn't payable under this code. Not payable with **1066M**.	**$168.19**
1105M	**IME Physical Capacities Estimate** (F242-387-000) Must be requested by the insurer. If an exam is performed by multiple examiners, bill under only one of the performing examiner's provider account number. (Bill once per exam.)	**$36.81**

Local code	Description and notes	Maximum fee
1108M	**IME, standard exam – 1-3 body areas or organ systems** Use this code if there are only 1-3 **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s). L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only towards the affected body area(s) or organ system(s). • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas **or** organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional examiners use **1112M**. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$728.06**

Local code	Description and notes	Maximum fee
1109M	**IME, complex exam – 4 or more body areas or organ systems** Use this code if there are 4 or more **body areas** or **organ systems** examined for sufficient evaluation of the accepted condition(s) or contended conditions. L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only toward the affected **body areas** or **organ systems**. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional complex examiners use **1126M**. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$910.07**

Local code	Description and notes	Maximum fee
1112M	**IME, additional examiner for Standard IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 examiner on IMEs with a combined report should bill a standard (**1108M**). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$728.06**
1118M	**IME by psychiatrist** Psychiatric diagnostic interview with or without direct observation of a physical exam. L&I expects these exams will typically involve at least 60 minutes of face-to-face time with the worker. Includes: • Review of records, other specialist's or provider's exam results, if any. • Consultation with other examiners and submission of a joint report if scheduled as part of a panel. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Impairment rating performed if requested. • Review of up to 2 job analyses. Also includes impairment rating, if applicable. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1123M	**IME, communication issues** Exam was unusually difficult due to expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report. If an interpreter is needed, verify and record name of interpreter in report. Bill once per examiner per exam. Isn't payable with a no show fee (1144M).	**$241.37**
1124M	**IME, other, by report** Requires prior authorization and prepay review: • For State Fund claims, contact the claims manager, or • For self-insured claims, contact the self-insured employer or third party administrator. Billable services under this code are limited to: • Research and review for chemically related illness (CRI) claims to be billed only by contracted providers authorized to perform CRI IMEs, • Security services for potentially violent workers, or • Guard services for incarcerated workers.	**By Report**
1125M	**Physician travel per mile** Allowed when roundtrip exceeds 14 miles using Personally Owned Vehicles. Code usage is limited to extremely rare circumstances, such as IMEs in correctional facilities. Requires prior authorization and prepay review: • For State Fund claims, call Provider Quality and Compliance at **800-468-7870**, or • For self-insured claims, contact the self-insured employer or third party administrator.	**$5.90**

Local code	Description and notes	Maximum fee
1126M	**IME, additional examiner for Complex IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, and • Contribution to combined report. L&I expects these exams will typically involve at least 45 minutes of face-to-face time with the worker. **Note**: One examiner on an IME with a combined report should bill a complex IME (1109M). The IME report must meet the criteria required for a complex IME (**1109M**). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$910.07**
1128M	**Occupational disease report** (Doctor's Assessment of Work Relatedness for Occupational Diseases) Must be requested by insurer. Examples of conditions which L&I considers occupational diseases are: • Occupational carpal tunnel syndrome, • Noise-induced hearing loss, • Occupational dermatitis, and • Occupational asthma. The legal standard is different for occupational diseases from occupational injuries. Refer to RCW 51.080.140 on the definition for occupational disease. This is a detailed assessment of work relatedness, with the exact content presented in the Medical Examiners' Handbook. An examiner may bill this code **only once for each worker.** **Note:** An examiner can't use **1055M. 1055M** is used by attending providers and consultants.	**$223.21**

Local code	Description and notes	Maximum fee
1129M	**IME, extensive file review by examiner** Units of service are based on the number of hardcopy pages reviewed by the IME examiner on microfiche, paper, Claim and Account Center, or other medium. Review of the **first 400 hardcopy pages** is included in the base exam fee (**1108M**, **1109M**, **1112M**, **1118M**, **1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**). Bill for each additional page reviewed beyond the first 400 hardcopy pages. Isn't payable with IME late cancellations (**1143M**) or IME no show fee (**1144M**)**.** Only the following document categories will be paid for **unless** the authorizing letter requests a review of **all** documents: • Medical files, • History, • Report of Accident, • Reopen Application, *and* • Other documents specified by claim manager or requestor. Bill per examiner. Not payable for review of duplicate documents. **Note**: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook.	**$1.22**

Local code	Description and notes	Maximum fee
1130M	**IME, terminated exam** Bill for exam ended prior to completion. Requires file review, partial exam by the examiner and report (including reasons for early termination of exam). Bill per examiner. Terminated exams don't include failure to obtain an interpreter. Terminated exams are payable when the worker is uncooperative, becomes obstructive (for example, the exam starts and the worker insists on recording but hadn't provided required notice), or becomes ill in the middle of the exam. **Note**: A partial exam is face-to-face time between the examiner and the worker where, at a minimum, the worker's history is obtained. **Note**: **1130M** or **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$427.58**
1139M	**No show fee for missed neuropsychological testing.** Must be scheduled or approved by department or self-insurer in conjunction with an independent medical examination. (For more information, see: WAC 296-20-010(5).) This code is payable only once per independent medical examination assignment. Must notify department or self-insurer of no-show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$1,073.30**

Local code	Description and notes	Maximum fee
1140M	**No show fee for missed Functional Capacity Evaluation (FCE).** Must be scheduled or approved by department or self-insurer in conjunction with an independent medical examination. (For more information, see: WAC 296-20-010(5) This code is payable only once per independent medical examination assignment. Must notify department or self-insurer of no show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$343.34**

Local code	Description and notes	Maximum fee
1141M	**IME, rare specialty exam – 1-4 or more body areas or organ systems** Use this code in lieu of 1108M or 1109M when exam is performed by 1 of the following rare provider specialties: • Allergy and Immunology • Cardiology • Dermatology • Endocrinology • Gastroenterology • Hematology • Obstetrics and Gynecology • Oncology • Ophthalmology • Pain Medicine/Dolorology • Pulmonology • Thoracic surgery • Urology • Vascular surgery L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: Follow the exam requirements for either 1108M or 1109M depending on number of body areas or organ systems involved. This specialty list may be updated depending on the number of examiners available. For additional rare specialty examiners use 1142M. 1108M or 1109M may be billed with an 1141M if 1 of the examiners is completing a standard or complex exam, and the other is completing a rare specialty exam. Only the rare specialty examiner may bill 1141M. **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1142M	**IME, additional examiner for Rare Specialty IME** Use where input from more than 1 rare specialty examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 rare specialty examiner on IMEs with a combined report should bill a rare specialty IME exam (**1141M**). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$1,319.61**
1143M	**IME late cancellation fee, per examiner** Bill only if worker cancels the appointment within 5 business days prior to exam May be billed if worker arrives for exam but the exam can't start due to obstructive behavior (for example, worker insists on recording exam but didn't provide required notice). Billable if appointment time can't be filled. (Business days are Monday through Friday.) Isn't payable for no shows of IME related testing (for example, neuropsychological) or when IME provider cancels exam (for example, provider wants to co-record and worker doesn't allow) Must notify department or self-insurer of no show as soon as possible. **Note**: **1130M** or **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$395.92**

Local code	Description and notes	Maximum fee
1144M	**IME no show fee, per examiner** Bill only if worker fails to show, and appointment time can't be filled. Isn't payable for no shows of IME related services (for example, neuropsychological evaluations). Must notify department or self-insurer of no show as soon as possible. For more information, see WAC 296-20-010.	**$395.92**
1145M	**IME, 1 or more additional claims included in evaluation, up to 5 additional claims total**. Requires prior authorization Bill by unit (1 unit = 1 additional claim). This code is used in addition to the primary IME exam code (**1108M, 1109M, 1112M, 1118M, 1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**) only. This can't be reported as a stand-alone code A maximum of 5 additional claims (units) are billable with this code. Anytime 6 or more additional claims are included, special review and authorization is required by the insurer. Not payable when only 1 claim is examined. Bill per examiner. **Note:** Don't bill a unit for the first claim. The first claim must be billed using a base exam code (such as **1108M)**.	**$139.14 per unit**
1146M	**Forensic IME** Requires prior authorization Bill only if the worker is unavailable for the physical portion of the IME exam. Isn't payable for no shows of IME related services (for example, neuropsychological evaluations). **Note**: Compensation for downloading, printing and sorting files is bundled into the reimbursement for the examination fees.	**$427.58**

Local code	Description and notes	Maximum fee
1147M	**Correctional facility IME** Bill for IMEs conducted at a correctional facility, if the examiner travels to the facility. This code requires prior authorization. Examiners may also bill travel for IMEs conducted at a correctional facility; bill using **1125M**, which requires prior authorization.	**$2,730.22**

Requirements for billing

State Fund (L&I) provider account number requirements for IMEs

For IMEs, examiners need 1 IME provider account number for each payee they wish to designate.

An IME examiner who isn't working through any IME firms will need just 1 IME number, which will also serve as their payee number.

Bills for testing or other services performed in conjunction with an IME must be submitted by the provider who rendered the service (WAC 296-20-125(3)(o)). These services include:

- X-ray, diagnostic laboratory tests in conjunction with IME (append modifier **–26** and **–7N**).
- Psychological/neurological testing CPT® codes – **90791**, **96136, 96137, 96138, 96139.** Automated testing and results for psychological/neurological CPT® code **96146**. (For more detailed information on psychological/neurological services, refer to Chapter 17: Mental Health Services.)
- Functional Capacity Evaluations (FCE) – **1045M.**

Standard and complex coding

The exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the code based on the number of **body area(s)** or **organ system(s)** that are examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related.

Be sure the report documents the relationship of the areas examined to the accepted work related injury(s) or contended condition(s).

The definitions of **body areas** and **organ systems** from the definitions section of this chapter must be used to distinguish between standard and complex IMEs.

Payment limits

Limit on total scheduled exams per day

L&I has placed a limit of 12 independent medical examinations scheduled per examiner per day. For psychiatrist examiners, the limit is 8 per day.

This limit includes IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- **1108M IME**, standard exam – 1-3 **body areas** or **organ systems**,
- **1109M IME**, complex exam – 4 or more **body areas** or **organ systems**,
- **1112M IME**, additional examiner for Standard IME,
- **1118M IME** by psychiatrist,
- **1126M IME** additional examiner for Complex IME,
- **1130M IME**, terminated exam,
- **1141M IME,** rare specialty exam,
- **1142M IME,** additional examiner for Rare Specialty IME,
- **1143M IME,** late cancellation fee,
- **1144M IME,** no show fee,
- **1146M IME,** forensic exam,
- **1147M IME,** correctional facility exam

Payment policy: Radiology reporting requirements for IMEs

Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing.

Documentation includes:

- Charting of justification,
- Findings,
- Diagnoses, *and*
- Test result integration, including a comparison between repeat radiology studies where applicable.

When billing for the professional component of radiology services, bill using modifier **–26** and modifier **–7N**.

IME providers who read imaging studies they order in relation to an IME, or reinterpret imaging studies previously performed, are required to document their findings within the IME report. Each imaging study must be separately documented in its own section and include all of the following:

- Date the imaging study was performed, *and*
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- When ordering imaging studies, a brief sentence describing the reason for the study, such as:
    - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
    - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description of, or listing of, imaging findings:
    - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
    - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical

considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*

- Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*

- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the IME report. If the same imaging study was performed on multiple dates of service, the provider must document a comparison between the studies, in sequential order, noting any significant changes that occurred. For example:
  - For a neck comparison where there is a difference between the original imaging study and the most recent findings, the impression could be: “A comparison of this recent study from 7/1/2019 is made to the study of 5/1/2018. 5/1/2018 which noted narrowing of the disc space at C-5 with bony protuberance at right facet causing impingement. New image from 7/1/2019 shows bony protuberance has grown 5mm and is contributing to increased impingement of the nerve root. This appears to be a continuation of a natural growth process.”

In addition to the above information, when reinterpreting imaging studies, the IME provider must document whether they are or aren’t in agreement with original interpretation of the imaging study.

Note: Documentation such as "X-rays are negative" or "X-rays are normal", or documentation that just restates the notes/recommendations of the radiologist doesn’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances. The provider reviewing the radiologist’s report must document their own interpretation of the diagnostic service.

Payment limits

Reinterpretation of imaging studies

Reinterpretation of imaging studies may only be billed once per panel exam. The reinterpretation is only payable for studies related to the accepted or contended condition.

In addition, services must be billed with the correct CPT® code for the specific imaging study reinterpreted, along with modifier **-26** and modifier **-7N**.

Example of how to bill for IME services including reinterpretation of imaging studies

The following example demonstrates how to bill when IME providers perform a reinterpretation of imaging studies. This example isn't reflective of the documentation requirements for an IME.

Example: A panel IME is performed on 7/1/21 meeting the documentation criteria for a complex IME. The IME providers review and appropriately document the review of the following imaging studies, all related to the accepted conditions:

- 1 – 3 view knee x-ray performed 6/1/19
- 2 – 2 view shoulder x-rays performed 6/1/19 and 8/2/20
- 1 – Shoulder MRI without contrast

The correct billing for the services is:

Examiner 1

Line item	Procedure code (and modifiers)	Number of Units
1	**1109M**	1
2	CPT® **73562-26-7N**	1
3	CPT® **73030-26-7N**	2
4	CPT® **73221-26-7N**	1

Examiner 2

Line item	Procedure code (and modifiers)	Number of Units
1	**1126M**	1

Note: Reinterpretation is only payable once per panel exam.

Payment policy: Telehealth for independent medical exams (IMEs)

General Information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from an IME firm's location, or the worker's home (**originating site**). IME telehealth services can't be delivered from the employer's worksite, any location owned or controlled by the employer or any other medical or vocational site.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services.

Services that must be performed in person

In-person examination is required for IMEs when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status, *or*
- When the service to be performed requires a hands-on component.

System requirements

Telehealth services require an interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

The following IMEs may be conducted via **telehealth**:

- Mental health,
- Dermatology,
- Speech when there is no documented hearing loss,
- Kidney function,
- Hematopoietic system,
- Endocrine.

Upon request of the department or self-insured employer and with agreement of the worker, a telehealth IME may be approved on a case-by-case basis for additional specialties not listed above per WAC 296-23-359.

When scheduling the **telehealth** visit, the provider is responsible for ensuring **telehealth** is the appropriate method of service delivery to effectively conduct an IME.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to an IME provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a different IME provider at another location (**distant site** provider). To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

An IME **originating site** may only bill **Q3014 when:**

- When the worker is in Washington State and the **telehealth** IME provider is in another state, *and*
- The worker has an in-person exam at the **originating site** that happens the same day as a **telehealth** exam at the **distant site**, *and*
- The worker requires the use of the firm's space for the **telehealth** visit with an approved IME provider for an exam, *and*
- The firm isn't using that space for another worker, *and*
- No other service may be provided to the worker concurrently during the **telehealth** exam.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service concurrently during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The IME firm uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render an in-person exam to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any IME provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Q3014 billing example

A worker attends an in-person IME with a neurologist at an IME firm's office in Yakima. The IME provider documents all necessary information as part of this visit and bills for the examination. The originating site (Yakima) also arranges a secure and private space for the worker to participate in a mental health IME with a psychiatrist at one of their other firm locations (Seattle). The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their Yakima location for their **telehealth** visit with the **distant site** provider in Seattle. The **originating site** provider is required to separately document the use of their space as part of their bill for **Q3014**. The **distant site** provider bills for the exam provided, but can't bill **Q3014**.

How to bill for this scenario

For this **telehealth** visit:

- The **distant site** provider would bill the appropriate IME code.
- The **originating site** provider would bill **Q3014**.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer will not pay for audio-only IME services billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The services listed under Services that must be performed in-person, including:
  - **1104M**, IME addendum report,
  - **1105M**, IME Physical Capacities Estimate,
  - **1124M**, IME, other, by report,
  - **1125M**, physician travel per mile,
  - **1129M**, IME, extensive file review by examiner,
  - **1147M**, Correctional facility IME,
- Services that require physical hands-on and/or attended treatment of a worker, *and*
- Completion and filing of any form that requires a hands-on physical examination.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Don't bill using the **–GT** modifier. **Distant site** providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** IME, *and*
- Documented consent from the insurer regarding the appropriateness of the IME to be conducted via **telehealth**.

The IME report must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same payment limits listed in this chapter apply regardless of how the exam is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Billing procedures	Washington Administrative Code (WAC 296-20-125)
Administrative rules for IME no shows	WAC 296-20-010
Administrative rules and other Washington state laws for impairment ratings	WAC 296-20-19000 through WAC 296-20-690 available in WAC 296-20 Revised Code of Washington (RCW) 51.32.080
Application to become an IME provider	F245-046-000
Becoming an L&I IME provider	Become an IME 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
Mental Health Services	Chapter 17: Mental Health Services
Receiving **email updates on IMEs**	Subscribe to L&I's ListServ
Performing **impairment ratings**	Medical Examiner's Handbook

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 14: Language Access Services for Spoken Languages

Effective June 17, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Appointment: A scheduled encounter between a provider and a worker or crime victim.

Client: A worker, an individual, or a group of people that uses the professional services of an interpreter. May also be known as a patient.

Encounter: An interpretation service request initiated by the provider or their staff and scheduled by SOS International LLC (SOSi) which has been completed (not cancelled or re-scheduled) by a language access provider (LAP).

Encounter fee: A set fee for each encounter where the worker or crime victim, provider, and appointment are the same.

Independent medical examination (IME): An objective medical legal examination requested by the department or self-insurer to establish medical facts about a worker's physical condition. Only department-approved examiners may conduct these exams.

Link: For more information, see WAC 296-23-302.

Initial visit: The first visit to a healthcare provider during which the Report of Accident (Workplace Injury, Accident or Occupational Disease) is completed and the worker files a claim for workers' compensation.

Language Access Provider (LAP): Individual providing spoken language interpretation services for workers or crime victims during medical and vocational visits.

On-demand appointment: Unscheduled appointment where interpretation services are necessary for emergency care, urgent care, or where the medical provider determines that advanced notice is not feasible. Appointments for treatments which would typically be scheduled in advance don't qualify as on-demand.

Sight translation: Oral rendition of text written from one language into another language, usually done in the moment by the interpreter.

Wait time: The time between the scheduled start time and the actual start time of an appointment. No other covered services are performed during this time.

General information: All spoken language interpretation services

Purpose of this section

Workers or crime victims who have limited English proficiency or sensory impairments may need interpreter services to communicate effectively with healthcare or vocational providers. This section outlines requirements, expectations, and information applicable to all providers who offer spoken language access services or utilize them for the benefit of workers or crime victims.

This section contains information about:

- The roles and responsibilities of medical and vocational providers,
- The roles and responsibilities of language access providers (LAPs), *and*
- L&I's interpretation services scheduling system, operated by SOSi.

Who the policies in this chapter apply to and when

The policies in this chapter apply to all language access providers (LAPs) for all spoken languages when providing services:

- For healthcare, **independent medical examinations (IMEs)**, and vocational **encounters**,
- In all geographic locations,
- To workers and crime victims having limited English proficiency or sensory impairment, and receiving benefits from:
    - The State Fund, *or*
    - Self-insured employers, *or*
    - The Crime Victims Compensation Program.

Self-insured employers and/or their Third Party Administrators (TPAs) are required to comply with L&I's payment policies and must obtain interpreter services using L&I's contracted vendor.

Note: The policies in this chapter don't apply to sign language interpreters. See Chapter 22: Other Services for sign language interpretation policy.

Information for medical and vocational providers

Avoiding discrimination based on limited English proficiency (LEP) status

Title VII of the Civil Rights Acts of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. This includes discrimination based on limited English proficiency (LEP). As a result, recipients and sub-recipients of Federal financial assistance are responsible for taking reasonable steps to ensure meaningful access by LEP persons to the recipient's and sub-recipient's programs or activities, including the use of an interpreter. **Failure to ensure meaningful access constitutes illegal discrimination and is a violation of an individual's civil rights.**

The Americans with Disabilities Act (ADA) encourages healthcare or vocational providers serving L&I workers or crime victims to consult with the patient to identify appropriate aid or service necessary to treat them effectively. L&I covers the cost of interpretation services for approved interpreters; however, the healthcare or vocational provider is responsible for following the ADA guidance for interacting with individuals with communication challenges.

Determining when an LAP is needed

The healthcare or vocational provider will determine, with input from the worker, if the assistance of an LAP is needed for effective communication to occur.

If assistance is needed, the healthcare or vocational provider will schedule an LAP to provide interpretation during an **appointment**.

Checking claim status prior to obtaining interpretation services

Prior to requesting an LAP, providers must check claim status with the insurer. For State Fund claims, call **1-800-831-5227** for automated updates on claim status. For self-insured claims, contact the Self-insured Employer (SIE) or their Third Party Administrator (TPA).

If the interpretation services are not compensable by L&I, an SIE or their TPA, or the Crime Victims Compensation Program, the provider requesting the interpretation services will be responsible for the cost of the services.

Requesting and selecting an LAP

Visit our website for details on requesting LAPs through SOSi.

The scheduling system is responsible for connecting LAPs with providers who need their services. Providers can choose:

- The time, date, and duration of the interpretation visit,
- The language and dialect of the LAP,

- The most appropriate method for the visit (in-person, over-the-phone, or video remote), *and*
- The preferred gender of the LAP, at worker's request.

Providers generally can't choose a specific LAP, except in certain situations (see Using the same LAP for multiple visits).

Changing LAPs or interpretation methods

SOSi will make every effort to secure an LAP in the method requested by the provider. However, if SOSi is unable to secure an LAP using the requested method within 48 hours of the scheduled start time for the visit, the system will automatically offer another method as a backup (for example, if video remote is requested but can't be filled, the system will offer over-the-phone and in-person, if available).

If the LAP provided by the scheduling system isn't meeting the interpretation needs of the visit, contact SOSi to provide feedback.

Using the same LAP for multiple visits

Healthcare and vocational providers can't select the same interpreter for every **appointment** scheduled with the worker unless there are extenuating circumstances. Situations in which the same LAP may be used for each **appointment** are limited to the following:

Crime victims

When it is necessary for continuity of care and case familiarity for a **crime victim.**

Mental health treatment by a mental health provider

If the worker has authorized coverage for **mental health** (a mental health condition must be allowed on the claim). The ability to request the same LAP is only for the mental health provider furnishing mental health treatment and/or a diagnosis to a worker, not every provider involved in the worker's care. See Chapter 17: Mental Health Services for information regarding who must perform mental health services to qualify for payment.

Pain management or brain injury program

If the worker is participating in a **pain management program** or a **brain injury rehabilitation program** where having the same LAP is beneficial to the outcome of the program, and the provider is providing services as part of an approved structured intensive pain management program (SIMP) or brain injury rehabilitation program. The program must be insurer-approved and authorized.

Languages of lesser diffusion ("rare" languages)

For workers who require interpretation in a **language of lesser diffusion** (sometimes referred to as a "rare" language). Requests for the same LAP may be allowed on a case-by-case basis and are dependent on availability of the LAP.

Using unapproved interpreters

As a last resort, if the medical or vocational provider can't find an L&I-approved LAP and no phone or video services are available, they may use non-certified or unapproved interpreters. **The insurer won't pay for these services and strongly discourages their use.**

Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers may provide services to **clients** if the provider determines it is most appropriate for their clinic or facility to employ their own interpreter. The insurer doesn't reimburse interpreters in this case. The provider is responsible for ensuring the interpreter is credentialed and provides meaningful access to the **client**.

Information for language access providers (LAPs)

Professional conduct and ethical guidelines

L&I is responsible for ensuring workers and crime victims receive proper and necessary services. LAPs are expected to adhere to the ethics requirements set forth by their certification or WAC 388-03-050 if the certification the LAP holds doesn't have an ethics component. L&I adopts a modified version of this WAC as the ethics expectation standard for LAPs.

Required credentials

In-state LAPs must hold an active, up-to-date credential in good standing (not revoked) from one or more of the following organizations:

If the **agency or organization** is…	Then the **credential** is a…
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate, or letter of authorization as a qualified social and/or medical services interpreter
Washington State Administrative Office for the Courts (AOC)	Certificate
National Board of Certification for Medical Interpreter (NCMI)	Certified Medical Interpreter (CMI)
Certification Commission for Healthcare Interpreters (CCHI)	Certified Healthcare Interpreter
Federal Court Interpreter Certification Test (FCICE)	Certificate, or letter of designation or authorization
US State Department Office of Language Services	Verification letter or Certificate

LAPs are responsible for maintaining their credentials as required by the credentialing agency or organization. LAPs may only be paid for services in the languages for which they have provided credentials. Provisional certifications aren't accepted. See the Accepted Credentials page on our website for more details.

If the LAP's credentials expire or are revoked for any reason, the LAP must immediately notify the scheduling system vendor. Out-of-state LAPs must immediately notify L&I of the expiration or changes. Bills for services rendered after an LAP's credentials expire or are revoked will be denied.

Out-of-state interpreters

For out-of-state interpreters, accepted credentials include those from:

- Any organization listed in the table above, *or*
- State credentialing agency or organization equivalent to WA DSHS, *or*
- State Medicaid programs, *or*
- Other nationally recognized programs.

Certifications will be reviewed on a case-by-case basis. Testing must be administered by a third-party organization whose business is to conduct certification for interpreters. L&I reserves the right to review all testing and decline certification if the certificate doesn't meet the minimum criteria.

Identification numbers

All LAPs are required to have a National Provider Identification (NPI) number. NPIs are unique 10-digit numbers used to identify specific providers. To obtain an NPI number, visit the National Plan & Provider Enumeration System website.

LAPs providing services as part of the scheduling system aren’t required to have an L&I provider account.

All out-of-state LAPs must have an active L&I provider account. To obtain an L&I provider account number, out-of-state LAPs must submit credentials using the **Submission of Provider Credentials for Interpreter Services** form (F245-055-000). See our Become an Interpreter page for more details.

Additional LAP requirements for hospitals and other facilities

Hospitals, freestanding surgery and emergency centers, nursing homes, and other facilities may apply additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider isn’t a contractor or a facility employee.

The facility is responsible for notifying the scheduling system of their additional requirements and managing compliance with the facility’s requirements.

Information about the interpretation services scheduling system

Using the scheduling system

L&I has a contract with SOS International LLC (SOSi) for the scheduling of:

- All on-demand and scheduled in-person interpretation (IPI) services in and near Washington State,
- Video remote interpretation (VRI) throughout the state of Washington and any other state within the United States,
- Over-the-phone interpretation (OPI) services throughout the state of Washington and any other state within the United States, *and*
- OPI services for out-of-country requests.

In order to receive covered language access services, medical and vocational providers must use the scheduling system for all interpretation requests (except out-of-state IPI).

Link: Email L&I's Interpreter Services program for general feedback regarding the scheduling system.

Types of services that can be requested

In-person interpretation (IPI) is on-site interpretation where all individuals specified for the **appointment** are physically present.

Over-the-phone (OPI) is a telecommunication service using telephonic technology hosted by SOSi that utilizes a remote or offsite LAP to provide language access services through an audio-only connection. This includes when some or all parties are located remotely.

Video remote interpretation (VRI) is a video-based interpreting event that utilizes a HIPAA-compliant video telecommunication service hosted by SOSi to connect devices such as web cameras or videophones and utilizes a remote or off-site LAP to provide language access services on screen. This includes when some or all parties are located remotely and includes telehealth **appointments**.

Check-in and check-out procedures

LAPs must check in and check out electronically using SOSi's app or website to ensure their interpretation time is accurately captured.

LAPs should check in at the start time of the **appointment** (unless arriving after the start time, in which case they should check in at the time of arrival). LAPs may only check in 15 minutes before the **appointment** if the **client** shows up early and is checked-in for the **appointment**. LAPs should promptly check out when the **appointment** ends.

The medical or vocational provider may be required to validate that services were rendered by the LAP and confirm the check-in or check-out times logged by the LAP.

Out-of-state in-person interpretation requests

IPI services provided by interpreters working strictly out-of-state and outside the border zip codes that start with 970, 971, 972, 978 in Oregon and 835 or 838 in Idaho are not included in the scheduling system and must be arranged by the provider by contacting the interpreter directly. Resources are available on our website.

International calls

Providers may access OPI services for international calls. The provider, LAP, and **client** will have access to a Zoom meeting, which can be joined using a link or by calling in with a phone number. The provider will have the ability to call the **client** from the Zoom meeting if needed.

Payment policy: Interpretation services

Prior authorization

Interpretation services don't require prior authorization on open claims.

Services that can be billed

The following services and charges are billable:

- Interpretation during the **initial visit**,
- Interpreter services which facilitate language communication between the worker and a healthcare or vocational provider,
- Time spent waiting for an **appointment** that doesn't begin at time scheduled (when no other covered services are being delivered during the **wait time**)
- Up to 15 minutes prior to the scheduled start time of an appointment if the LAP and worker are both checked in,
- Services related to the completion of a reopening application (if a claim is reopened, the insurer will determine which services are reimbursable),
- Interpretation during insurer-requested IMEs,
- No-show fees for IMEs, *and*
- Interpretation for family members or guardians of minor workers.

Interpretation services fee schedule

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9902M	**SOSi Encounter Fee**	Payable only to SOSi, once per in-person, video, or over-the-phone interpreter encounter.	1 encounter	**$14.95** per encounter

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9984M	**SOSi in-person interpreter, per minute** Direct service time between the **client** and healthcare or vocational provider.	Scheduled and on-demand in-person interpreter services (IPI) throughout the state of Washington and border zip codes that start with 970, 971, 972, 978 for Oregon, or 835 or 838 for Idaho.	1 minute	**$1.03** per minute
9990M	**SOSi video interpreter, per minute** Direct service time between the **client** and healthcare or vocational provider.	Scheduled and on-demand video remote (VRI) interpreter services throughout the state of Washington and any other state within the United States.	1 minute	**$0.82** per minute
9983M	**SOSi over-the-phone interpreter, per minute** Direct service time between the **client** and healthcare or vocational provider.	Scheduled and on-demand over-the-phone (OPI) interpreter services throughout the state of Washington, any other state within the United States, and out-of-country requests.	1 minute	**$0.67** per minute

Services provided on rejected claims

Language access services provided for claims which are ultimately rejected will be paid for dates of service up to (but not including) the date of the rejection order.

Services that aren't covered

Any use of an interpreter who isn't part of the scheduling system and/or hasn't been approved by L&I isn't covered. Bills for services provided by interpreters who aren't part of the scheduling system and don't have active L&I provider account numbers will be denied.

Assisting the worker to complete forms required by the insurer and/or healthcare or vocational provider using **sight translation** isn't a separately billable service.

In addition, the following services and charges aren't covered:

- Interpretation services of any kind (IPI, OPI, and/or VRI) exceeding **480 minutes** (8 hours) per day per interpreter,
- Interpretation services for treatment visits that aren't covered by the insurer (see WAC 296-20-03002),
- Interpretation services provided for a closed claim, except services associated with the **initial visit**, the visit for the worker's application to reopen a claim, or for a worker receiving a pension with a treatment order,
- Interpretation services provided on rejected claims for dates of service after the date of the rejection order, except for visits authorized and requested by the insurer,
- No-show fees for any service other than an insurer-requested IME,
- Personal assistance on behalf of the worker such as scheduling **appointments**, translating correspondence, or making phone calls,
- Interpretation services not related to the worker's communications with healthcare or vocational providers,
- Overhead costs such as phone calls, photocopying, and preparation of bills,
- Document translation (see Chapter 22: Other Services),
- Interpretation provided by family members or friends of the worker or crime victim,
- Interpretation provided by anyone under the age of 18,
- Interpretation services rendered by interpreters who are not registered in the scheduling system or registered directly with L&I to provide out-of-state services,
- Interpretation services provide by LAPs who have had their certification revoked by a certifying authority,
- Mileage and/or travel time,
- Any time prior to the start of an **appointment** if the worker is not present, *and*
- Interpretation services provided by credentialed employees of providers.

Interpretation for legal counsel

Payment for interpreter services for legal purposes including but not limited to attorney **appointments**, legal conferences, testimony at the Board of Industrial Insurance Appeals or any court, or depositions at any level is the responsibility of the attorney or other requesting party and isn't covered by the insurer.

Requirements for billing

The scheduling system will handle bills for in-state LAPs. SOSi is required to pay LAPs 15 days after receiving payment from the insurer.

Payment limits

LAPs are limited to **480 minutes** (8 hours) per day for all interpretation services rendered (IPI, VRI, and OPI).

Only time spent delivering interpretation services may be billed. Time is counted from when the **appointment** is scheduled to begin or when the interpreter arrives and the worker is present and checked in for the visit, whichever is later, to when the services end. Time spent providing **sight translation** isn't counted separately.

Exception: If the **appointment** starts early, time is counted from when the **appointment** actually begins. For example, the **appointment** is scheduled to start at 8:30 a.m. but interpreter arrives at 8:00 a.m. and **appointment** starts early at 8:15 a.m. Time is counted from 8:15 a.m. when the **appointment** actually started.

Link: Email SOSi for any billing questions regarding services rendered through the scheduling system and registration questions.

Example

The **client** goes to emergency clinic without a prescheduled **appointment**. The provider determines that an in-person LAP is appropriate for this visit due to the sensitivity of the medical services being rendered and submits a request for on-demand in-person LAP. SOSi secures an in-person LAP. However, it will take the LAP 20 minutes to get to the service address. SOSi offers the provider the use of OPI or VRI services until the in-person LAP shows up. The provider accepts the use of OPI services until the in-person LAP shows up.

SOSi will submit one bill to the insurer and include the following charges (if applicable):

- Encounter fee
- Actual OPI services rendered (per-minute)
- Actual IPI services (per-minute)

Encounter fees

Surgical **appointments** that exceed 8 hours may require multiple back-to-back interpretation services requests to be submitted in the system. Only in situations where the encounter is for more than 8 hours will the insurer compensate SOSi an encounter fee for each request due to the 8-hour LAP cap.

In cases where the encounter is for a **client** who has multiple claims, the insurer will only compensate SOSi for one encounter fee. Furthermore, if SOSi secures multiple interpreter services (OPI, VRI, or IPI) or multiple LAPs for the same encounter, the insurer will only pay SOSi one encounter fee.

Payment policy: Interpretation services for independent medical exams (IMEs)

Prior authorization

Prior authorization from the insurer is required for **9996M**.

Who must perform these services to qualify for payment

When an IME is scheduled, the IME provider will arrange for interpretation services through SOSi.

Interpreters who accompany the worker without being scheduled by SOSi won't be paid or allowed to interpret at the IME.

Services that can be billed

In addition to the codes outlined in Payment policy: Interpretation services, SOSi or the out-of-state interpreter may bill for a no-show if the **client** fails to appear at an insurer-requested IME.

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9996M	**Interpreter "IME no-show"** **Wait time** when **client** doesn't attend the insurer requested IME, flat fee.	Only 1 no-show per **client** per day.	1 **client** no-show at IME	**$60.15**

Link: For more information, see WAC 296-20-010(5) which states, "L&I or self-insurers will not pay for a missed appointment unless the appointment is for an examination arranged by the department or self-insurer."

Services that aren't covered

Interpretation services provided by persons (including interpreters through SOSi) who meet any of the following criteria aren't covered:

- Those related to the worker or crime victim, *or*
- Those with an existing personal relationship with the worker or crime victim, *or*
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative, *or*

- The employer's legal or lay representative or employees of the legal or lay representative, *or*
- Any person who couldn't be an impartial and independent witness, *or*
- Persons under age 18.

Link: See WAC 296-23-362(3), which states, "The worker may not bring an interpreter to the examination. If interpreter services are needed, the insurer will provide an interpreter."

Payment limits

Only one no-show fee per **client** per day is payable.

For IME panel **appointments** only, provider may request the same LAP for the duration of the **appointment** time. Breaks in the schedule aren't covered by the insurer.

Additional information

If SOSi is unable to fill a request for an LAP and 24 or fewer hours remain before the scheduled appointment time, the request will be escalated. Every effort will be made to fill the **appointment** using the requested method (in-person, over-the-phone, or video remote); however, if the request for the desired method can't be filled, SOSi will offer other methods, if available.

Payment policy: Out-of-state interpretation services

General information

This policy applies to interpretation services rendered outside of Washington State. Interpretation services are covered regardless of the location of the worker.

The rules outlined in General information: All spoken language interpretation services section also apply to out-of-state interpreters.

Services that can be billed

For in-person interpretation services outside of Washington State and outside border zip codes that start with 970, 971, 972, 978 in Oregon and 835 or 838 in Idaho, healthcare or vocational providers must arrange services with a local interpreter. Interpreters must have a unique L&I provider account number and submit an **ISAR** with their bill.

Out-of-state interpretation services fee schedule

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9991M	**Out-of-state in-person spoken language interpreter, per minute**	**ISAR** required. Payable to individual interpreters registered with L&I to provide in-person interpreter (IPI) services out-of-state.	1 minute	**$1.03** per minute

Billing requirements

An Interpreter Services Appointment Record (**ISAR**) form (F245-056-000) is required for each visit. All **ISAR** forms must be signed by the healthcare or vocational provider or the provider's staff to verify services. All **ISAR** forms must submitted in the claim file without crossed-out information, comments, or notes in margins.

If the **appointment** involves multiple claims, a separate **ISAR** must be submitted for each claim and the healthcare or vocational provider or their staff must verify services on each **ISAR**.

All services provided to a worker on the same date for the same claim must be billed together. However, a separate **ISAR** must be completed for each visit.

For self-insured claims, contact the employer for their specific billing requirements. See Chapter 2: Information for All Providers for more details about identifying self-insured claims.

Link: For more information about billing, see the General Provider Billing Manual.

Payment limits

Out-of-state interpreters are limited to 480 minutes (8 hours) of interpretation per day per interpreter.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for interpreter services	Washington Administrative Code (WAC) 296-20-010(5) WAC 296-23-362(3) WAC 296-23-302
Administrative rules for missed appointments	WAC 296-20-010(5)
Becoming an L&I interpreter provider	Become an Interpreter on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing adjustments	Billing adjustments on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Common Errors on the Interpreter Services Appointment Record (ISAR)	F245-436-000
DES Telephone and Video Interpreter Services contract	Washington State Government DES website
Ethics for Interpreters	WAC 388-03-050
Federal laws relevant to interpreter services	Civil Rights Act of 1964
Fee schedules for all healthcare professional services (including interpreter services)	Fee schedules on L&I's website
How providers **arrange interpreter services**	How to arrange for interpreter services on L&I's website
Interpreter Lookup Service	Interpreter lookup service on L&I's website
Interpreter Services Website	Interpreter services
Interpreter Services Appointment Record (ISAR) form	F245-056-000

If you're looking for more information about…	Then see…
L&I's **General Provider Billing Manual**	F245-432-000
National Provider Identification number	Centers for Medicare and Medicaid Services website
Sign up for **L&I provider news and updates through GovDelivery**	Sign up for GovDelivery
Statement for Miscellaneous Services form	F245-072-000

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 15: Medical Testimony

Effective July 1, 2024

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

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Payment policy: Medical testimony and depositions

Who arranges testimonies and depositions

The Office of the Attorney General, the self-insured employer (SIE), the state-fund employer, the retrospective rating group, the injured worker, or attorneys representing them makes arrangements with expert witnesses to provide testimony or deposition.

Responsibilities of providers

Any provider who treated or consulted the injured worker, per Chapter 296-20 WAC, or examined the worker at the request of the Department or Self-Insured Employer, per RCW 51.36.070, must:

- Abide by the fee schedule, *and*
- Testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General, the self-insurer, the state fund employer, the retrospective rating group, the injured worker, or attorneys representing them.

Link: For more information, see RCW 51.04.050.

Reasonable availability

The Office of the Attorney General, the self-insurer, the state fund employer, the retrospective rating group, the injured worker, or attorneys representing them and the provider must schedule a reasonable time for the provider's testimony during business hours.

Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeals.

Cancellation fees

If the **cancellation notice** for the testimony or deposition is…	Then the Attorney General/SIE:
3 working days or less than 3 working days before a hearing or deposition	**Will pay a cancellation fee** for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days before a hearing or deposition	**Won't pay** a cancellation fee.

Services that can be billed

The medical witness fee schedule (see below) is set by the Department in consultation with the Office of the Attorney General. Whoever schedules the testimony, record review, conference, etc. is responsible for payment pursuant to this fee schedule.

In the fee schedule below, 1 unit equals 15 minutes of actual time spent, rounded up to the nearest unit.

Fee schedule for testimony and related fees

If the service provided by a **doctor**, **attending ARNP, chiropractor, attending physician assistant, or psychologist** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	**$200.00**/unit* (maximum of 17 units)
Record review	**$200.00**/unit* (maximum of 25 units)
Conferences (live or by telephone)	**$200.00**/unit* (maximum of 9 units)
Travel (See note below)	**$200.00**/unit* (maximum of 17 units)

If the service provided by **all other healthcare providers** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	**$46.00**/unit* (maximum of 17 units)
Record review	**$46.00**/unit* (maximum of 25 units)
Conferences (live or by telephone)	**$46.00**/unit* (maximum of 9 units)
Travel (See note below)	**$46.00**/unit* (maximum of 17 units)

If the service provided by a **vocational provider** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition), regular vocational services Medical testimony (live or by deposition), forensic vocational services	**$46.00**/unit* **$55.00**/unit* (maximum of 17 units)
Record review, regular vocational services Record review, forensic vocational services	**$46.00**/unit* **$55.00**/unit* (maximum of 25 units)
Conferences (live or by telephone), regular vocational services Conferences (live or by telephone), forensic vocational services	**$46.00**/unit* **$55.00**/unit* (maximum of 9 units)
Travel, regular vocational services Travel, forensic vocational services (See note below)	**$46.00**/unit* **$55.00**/unit* (maximum of 17 units)

If the injured worker was examined outside of Washington State and the service provided by a **doctor** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	**$250.00**/unit* (maximum of 17 units)
Record review	**$250.00**/unit* (maximum of 25 units)
Conferences (live or by telephone)	**$250.00**/unit* (maximum of 9 units)
Travel (Justification for travel must be provided in advance to the requesting party. Out of state travel is payable on a case-by-case basis.)	**$250.00**/unit* (maximum of 17 units)

Link: For legal definitions of “doctor” or “attending doctor”, see WAC 296-20-01002.

Services that aren’t covered

Requests for a nonrefundable amount will be denied.

Pre-payment

L&I can’t provide pre-payment for any of these services.

Requirements for billing

For testimony or conferences, etc. arranged by the Office of the Attorney General:

- Providers shouldn’t use the CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the Office of the Attorney General. State Fund uses a separate voucher **A19 form**, which will be provided to you by the Office of the Attorney General.

For testimony or conferences, etc., arranged by self-insured employers or their attorneys:

- SIEs must allow providers to use CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the SIE/TPA.

For testimony or conferences, etc. arranged by injured workers, state fund employers, retrospective rating groups, or their attorneys:

- Bills for these services should be submitted directly to the injured worker, the state fund employer, the retrospective rating group, or their attorneys.

Documentation requirements

To be eligible for reimbursement for travel, the provider must submit an itemized statement (invoice) documenting the following:

- Claim number,
- Worker name,
- Date of trip,
- Starting address,
- Ending address,
- Total travel time

Submit this invoice to the Office of the Attorney General, the self-insurer, the state fund employer, the retrospective rating group, the injured worker, or attorneys representing them.

Payment limits

Calculating timed fees

The time calculation for testimony, deposition, or related work performed in the provider's office or by phone is based upon the actual time used for the testimony or deposition. Unit limits can only be exceeded upon prior approval of the party requesting testimony.

Note: If travel is necessary to get to the location of testimony, travel time will be paid from the nearest location the provider provides services to the location of the testimony and back. No side trips will be paid for. If testimony occurs where the provider provides services, telephonically, or via video, no travel time will be paid.

Interpretive services

The party requesting interpretive services for depositions or testimony is responsible for payment.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for definitions	Washington Administrative Code (WAC) 296-20-01002
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 services	Fee schedules on L&I's website
Legal statute (Washington State law) for physician or licensed advanced registered nurse practitioner's **testimony not privileged**	Revised Code of Washington (RCW) 51.04.050

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 16: Medication Administration and Injections

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

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

Dry Needling: Dry needling is considered a variant of trigger point injections. It is a technique where needles are inserted directly into trigger point locations without medications injected. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(7)(d).

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.

Use	Payment Information
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–TC (Technical component)	
Use this modifier to indicate when only the technical component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's technical component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the technical component (**–TC**) rate for each specific radiology service performed or billed charge, whichever is less.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Botulinum toxin (BTX)

Prior authorization

Botulinum toxins are payable when authorized.

Coverage of Onabotulinumtoxin A for treatment of chronic migraine is exempt from the 2-course limit based on an HTCC coverage determination. A maximum of 5 courses may be authorized.

Link: Prior authorization criteria and L&I's coverage decision information is available online.

Requirements for billing

Billing codes

Refer to the fee schedule for current fees.

If the **injection** is…	Then the appropriate **HCPCS billing code** is:
Onabotulinumtoxin A, 1 unit (Botox® or Botox Cosmetic®)	**J0585**
If the **injection** is…	Then the appropriate **HCPCS billing code** is:
Abobotulinumtoxin A, 5 units (Dysport®)	**J0586**
Rimabotulinumtoxin B, 100 units (Myobloc®)	**J0587**
Incobotulinumtoxin A, 1 unit (Xeomin®)	**J0588**

Services that aren't covered

The insurer won't authorize payment for BTX injections for off label indications.

Onabotulinumtoxin A for the treatment of chronic tension-type headache isn't a covered benefit.

Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk nonpayment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

Link: For more information, see the L&I coverage decision on compound drugs.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA approved alternatives, on the Outpatient Drug Formulary such as:

- Oral generic nonsteroidal anti-inflammatory drugs,
- Muscle relaxants,
- Tricyclic antidepressants,
- Gabapentin, *and*
- Topical salicylate and capsaicin creams.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient.

Payment limits

No separate payment will be made for **99070** (Supplies and materials).

Payment policy: Hyaluronic acid for osteoarthritis of the knee

Coverage Change

Hyaluronic acid is no longer covered for osteoarthritis of the knee based on a coverage decision effective 3/1/2024. For more information on this change, see L&I's coverage decision.

Payment policy: Immunizations

Prior authorization

Immunization materials are payable when authorized.

Services that can be billed

CPT® codes **90471** and **90472** are payable, in addition to the immunization materials code(s).

For each additional immunization given, add on CPT® code **90472** may be billed.

Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a modifier **–25**.

Additional information

Bloodborne pathogens and infectious diseases

Information on L&I's coverage decision for bloodborne pathogens is available online. For more information about work related exposure to an infectious disease, see WAC 296-20-03005.

Payment policy: Immunotherapy

Services that aren't covered

Complete service codes aren’t paid.

Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- 1 of the injection codes, *and*
- 1 of the antigen/antigen preparation codes.

Payment policy: Infusion therapy services and supplies for RBRVS providers

Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

An exception is **outpatient services**, which are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. (See Services that can be billed below.)

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, baclofen).

Services that can be billed

Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

Supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782-E0783**, *and*
- **E0785-E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered with the following exceptions for accepted conditions:

- To treat pain caused by cancer or other end-stage diseases, *or*
- To administer anti-spasticity drugs when spinal cord injury is an accepted condition.

Link: For more information, see WAC 296-20-03002.

Requirements for billing

Equipment and 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.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for home infusion services in Chapter 11: Home Health Services for more information.

Link: For information on home infusion therapy in general, see the home infusion services section of Chapter 11: Home Health Services.

Drugs

Drugs for outpatient use 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 are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

Payment limits

E/M office visits

Providers will only be paid for E/M office visits in conjunction with infusion therapy if the services provided meet the code definitions.

Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren't covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term postoperative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

Link: For more information, see WAC 296-20-03014.

Equipment and supplies

Infusion therapy supplies and related DME, such as infusion pumps, aren't separately payable for RBRVS providers. Payment for these items is **bundled** into the fee for the professional service.

Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373** and **96374**, won't be paid separately in conjunction with the IV infusion codes.

Payment policy: Injectable medications

Requirements for billing

Providers must use the HCPCS J codes for injectable drugs that are administered during an E/M office visit or other procedure. The HCPCS J codes aren't intended for self-administered medications.

When billing for a nonspecific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, **providers must bill their acquisition cost for the drugs**. To get the total billable units, divide the:

- Total strength of the injected drug, *by*
- The strength listed in the manual.

For example:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

Payment limits

Payment is made according to the published fee schedule amount, or the acquisition cost for the covered drug(s), whichever is less.

Payment policy: Medical foods and co-packs

Services that aren't covered

Medical food products and their convenience packs or "co-packs" aren't covered.

Examples of medical food products include:

- Deplin® (L-methylfolate), *and*
- Theramine® (arginine, glutamine, 5-hydroxytryptophan, and choline).

Examples of "co-packs" include:

- Theraproxen® (Theramine and naproxen), *and*
- Gaboxetine® (Gabadone and fluoxetine).

Link: For more information, see L&I's coverage decision on medical foods and co-packs.

Payment limits

Medical foods and co-packs administered or dispensed during office procedures are considered **Bundled** in the office visit.

No separate payment will be made for **99070** (Supplies and materials), which is a **bundled** code.

Payment policy: Non-injectable medications

Services that can be billed

Providers may use distinct HCPCS J codes that describe specific non-injectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The HCPCS J codes aren't intended for self-administered medications.

Services that aren't covered

No payment will be made for pharmaceutical samples or repackaged drugs.

Requirements for billing

Providers must bill their acquisition cost for these drugs.

The name, NDC, strength, dosage, and quantity of the drug administered must be documented in the medical record and noted on the bill.

Link: For more information, see the payment policy for Acquisition cost in Chapter 28: Supplies, Materials, and Bundled Services.

Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Noninhalation drug for DME), *or*
- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*
- **J8499** (Oral prescription drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

Payment policy: Spinal injections

Payment methods

Physician or CRNA/ARNP

The payment methods for physician or CRNA/ARNP are:

- Injection procedure: **–26** component of Professional Services Fee Schedule, *and*
- Radiology procedure: **–26** component of Professional Services Fee Schedule

A separate payment for the injection **won't be made** when computed tomography (CT) is used for imaging, unless documentation demonstrating medical necessity is provided.

Radiology facility payment methods

The payment methods for radiology facilities are:

- Injection procedure: No facility payment, *and*
- Radiology procedure: **–TC** component of Professional Services Fee Schedule.

Hospital payment methods

The payment methods for hospitals are:

- Injection procedure: APC or POAC (payment method depends on the payer and/or the hospital's classification), *and*
- Radiology procedure: APC, POAC or **–TC** component of Professional Services Fee Schedule. Radiology codes may be packaged with the injection procedure.

Payment policy: Therapeutic or diagnostic injections

Prior authorization

These services require prior authorization:

- Trigger point injections and **dry needling** (refer to guideline for limits), and
- Sympathetic nerve blocks (refer to the CRPS guideline).

Links: See L&I's coverage decision for more information on trigger point and dry needling injections and L&I's CRPS guidelines for more information on sympathetic nerve blocks.

Required along with utilization review

These services require both prior authorization and utilization review:

- Therapeutic epidural and spinal injections for chronic pain,
- Therapeutic sacroiliac joint injections for chronic pain, *and*
- Diagnostic facet and medial branch block injections (refer to neurotomy guideline).

Links: See L&I's coverage decision and guidelines on spinal injections, L&I's neurotomy guidelines, and L&I's coverage decision on discography.

Services that can be billed

These services can be billed without prior authorization:

- E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable,
- Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS J code for the drug,
- Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360**, **96361**, **96365**-**96368**), *and*
- Spinal injections that don't require fluoroscopy or CT guidance:
  - CPT® code **62270** – diagnostic lumbar puncture,
  - CPT® code **62272** – therapeutic spinal puncture for drainage of CSF, and
  - CPT® code **62273** – epidural injection of blood or clot patch.

Services that aren't covered

CPT® code **99211** won't be paid separately.

If billed with the injection code, providers will be paid only the E/M service and the appropriate HCPCS J code for the drug.

Perineural Injection Therapy (PIT), also known as sclerotherapy, neurofascial, subcutaneous or neural prolotherapy, are considered forms of prolotherapy. L&I does not cover any form of prolotherapy per WAC 296-20-03002. Providers may not bill or be paid for PIT. These procedures should not be confused with peripheral nerve blocks (CPT® code **64450**), which are allowed for regional anesthesia and acute pain management.

Link: See L&I's coverage decision on perineural injection therapy.

The insurer doesn't cover:

- Therapeutic medial branch nerve block injections, *or*
- Therapeutic or diagnostic intradiscal injections, *or*
- Therapeutic facet injections, *or*
- Diagnostic sacroiliac joint injections, *or*
- Therapeutic genicular nerve blocks for chronic knee pain, *or*
- Perineural injection therapy.

Links: For more information, see L&I's coverage decision on these injections and L&I's coverage decision on therapeutic genicular blocks for chronic knee pain.

Requirements for billing

Dry needling

Dry needling of trigger points must be billed using CPT® codes **20560** and **20561**.

Spinal injections that require fluoroscopy

For spinal injection procedures that require fluoroscopy:

- 1 fluoroscopy code must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied, *and*
- Only 1 fluoroscopy code may be billed for each injection (see table below).

Only 1 of these **CPT® fluoroscopy codes** may be billed for each injection…	…and it must be billed along with this underlying **CPT® code**:
77002, **77012**, **76942**	**62268**
77002, **77012**, **76942**	**62269**
77003, **72275**	**62281**
77003, **72275**	**62282**
77003, **77012**, **76942**, **72240**, **72255**, **72265**, **72270**	**62284**
72295	**62290**
72285	**62291**
72295	**62292**
77002, **77003**, **77012**, **75705**	**62294**
77003, **72275**	**62320**
77003, **72275**	**62322**
77003, **72275**	**62324**
77003, 72275	**62326**

Spinal injection procedures that include fluoroscopy, ultrasound, or CT in the code description

Paravertebral facet joint injections now include fluoroscopic, ultrasound, or CT guidance as part of the description. This includes these CPT® codes:

- **64479-64480**, *and*
- **64483-64484**, *and*
- **64490-64495**, *and*
- **0213T-0218T**, *and*
- **0228T-0231T**.

Fluoroscopic, ultrasound, or CT guidance can't be billed separately.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for drug limitations (such as opiates)	Washington Administrative Code (WAC) 296-20-03014
Administrative rules for treatment authorization (including prolotherapy)	WAC 296-20-03002
Administrative rules for work related exposure to an infectious disease	WAC 296-20-03005
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bloodborne pathogens	Bloodborne pathogens guidelines
Botulinum toxin (BTX) injections	Botulinum toxin coverage decision
Complex Regional Pain Syndrome (CRPS) guidelines	Complex Regional Pain Syndrome guidelines
Compound drugs coverage decision	Compound drugs coverage decision
Discography guidelines	Discography guidelines
Dry needling and trigger point injections coverage decision	Dry needling and trigger point injections coverage decision
Fee schedules for all healthcare professional services (including medication administration)	Fee schedules on L&I's website
Hyaluronic acid injections	Hyaluronic acid injections coverage decision

If you're looking for more information about…	Then see…
Medical coverage decision for **acupuncture**	WAC 296-20-03002(2) Acupuncture guidelines on L&I's website
Medical foods and co-packs coverage decision	Medical foods and co-packs coverage decision
Neurotomy guidelines	Neurotomy guidelines
Payment policies for **acquisition cost policy**	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for **home infusion therapy**	Chapter 11: Home Health Services
Spinal injections coverage decision and guidelines	Spinal injections coverage decision

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 17: Mental Health Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Attending Provider (AP): A person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry; and advanced registered nurse practitioner. An Attending Provider actively treats an injured or ill worker. Typically, this is the primary care provider for a worker, although the worker may elect to change their attending provider and select another attending provider of their choosing. At times, the Attending Provider may be a concurrent care provider instead of the primary care provider. References throughout MARFS apply to Attending Provider types and not solely the attending provider on the claim.

Link: For the legal definition of AP, see WAC 296-20-01002. For information on transferring care between APs, see WAC 296-20-065.

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

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

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Residential facility for mental health: These facilities provide high-level care to workers with long-term or severe mental disorders, or workers with substance-related disorders, with 24-hour medical and nursing services. **Residential facilities for mental health** typically provide less intensive medical monitoring than subacute hospitalization care. Treatment includes a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. **Residential facilities for mental health** include training in the basic skills of living as determined necessary for each worker. Treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care. Adult family homes, skilled nursing facilities, or boarding homes aren't included in this definition.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: All mental health services

Prior authorization

All outpatient mental health services require prior authorization, unless it is the initial visit to open a mental health only claim.

Who the policies in this chapter apply to

The mental health services payment policies in this chapter apply to workers covered by the State Fund and self-insured employers.

The policies in this chapter don't apply to crime victims or behavioral health services.

Links: For more information on mental health services for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300.

For information about mental health services policies for the Crime Victims' Compensation Program, see WAC 296-31.

For information about behavioral health services policies see Chapter 22: Other Services.

Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Licensed clinical psychologist (PhD or PsyD), *or*
- Social workers and other Master's Level Therapists (MLTs).

Mental Health Providers

A mental health provider may only be an **attending provider** when the insurer has accepted a psychiatric condition and it is the only condition being treated.

Attending providers can complete the Report of Accident (ROA), Time loss certification and other reports and forms applicable to **attending providers**. For more information on who can be an **attending provider** and what forms are applicable, see WAC 296-20-01002 and Chapter 27: Reports and Forms.

	Psychiatrist (MD/DO)	Psychiatric ARNP	Psychologist (PsyD or PhD)	Social workers and other master's level therapists (MLTs)
Attending Provider	Yes	Yes	**No**	**No**
Mental Health Counseling	Yes	Yes	Yes	Yes
Prescribing Medication	Yes	Yes	**No**	**No**
IME Examiner	Yes	**No**	**No**	**No**
Impairment Rating/Permanent Partial Disability	Yes	**No**	**No**	**No**

Note: Psychologists must document workers' return to work issues related to accepted mental health conditions in chart notes or reports.

Social workers and other Master's Level Therapists

Mental health evaluation isn't covered when provided by Licensed Clinical Social Workers (LICSWs), Licensed Marriage and Family Therapists (LMFTs), and Licensed Mental Health Counselors (LMHCs), even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. These providers may provide treatment only, after the worker has seen an appropriate provider for evaluation.

Psychological and Neuropsychological testing

Technicians supervised by a psychiatrist or licensed clinical psychologist may administer psychological or neuropsychological testing and scoring. The psychiatrist or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*
- Bill for the psychological or neuropsychological test administration and scoring performed by their technicians.

Services that can be billed

Brief Emotional/Behavioral Screens & Risk Assessments

For initial or repeat screening (such as the PHQ-9 or GAD-7) to determine if a worker should be referred for mental health treatment, use CPT® code **96127** Brief emotional/behavioral assessment. **96127** is limited to 3 assessments per day, per provider, with a maximum of 6 assessments per provider, per worker.

This code can't be used during active mental health treatment. These assessments aren't for diagnosing a mental health condition, but may be necessary to determine the need for more in-depth assessment or further intervention. For re-assessments during active mental health treatment of a diagnosed mental health condition, use the appropriate evaluation CPT® code.

96127 can't be billed with other mental health CPT® codes, such as psychotherapy and evaluations.

Interactive complexity

The add-on code for interactive complexity (**90785**) is only payable according to the limits found in CPT®. It isn't payable solely for the use of a language access provider. Documentation must include an explanation of the increased complexity and why it is required for proper treatment. Must be billed with **90791**, **90792**, **90832**, **90833**, **90834**, **90836**, **90837**, **90838**, or **90853**.

Services that aren't covered

The following CPT® codes and their services aren't covered:

- **90845**,
- **90846**,
- **90849**,
- **90863**.

Psychologists and MLTs can't bill E/M CPT® codes for office visits.

MLTs can't bill for mental health evaluations or consultations.

Link: See L&I's coverage decision for treatment of Chronic Migraine or Chronic Tension-type Headache.

Requirements for billing

Psychiatrists and psychiatric ARNPs may only bill an E/M service (CPT® **99202-99255, 99304-99316, 99341-99350**) for office visits on the same day psychotherapy is provided.

The time spent performing psychotherapy can't be included in selecting the E/M level of service. The provider must clearly document each service (E/M and psychotherapy), including time spent on each service.

Mental health providers must follow the reporting requirements in CPT® for the service billed.

Documentation requirements

Mental health providers are required to submit documentation to the insurer and the **attending provider**.

The documentation requirements for mental health services can be found in the following locations:

- Treating Mental Health Conditions webpage
- Chapter 2: Information for All Providers
- Specific service documentation requirements in this chapter.

Mental health providers must submit documentation on the following schedule:

Frequency	Documentation	Additional Information
Every visit	Chart notes	Must contain all required information, as noted above, in order for the insurer to make appropriate decisions regarding coverage and payment.
Every 30 days	Report	Submitted only when treating an unrelated mental health condition that is retarding recovery of an accepted condition. **This report isn't required if this information is submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements.
Every 60 days	Report	A separate report is required when treating an accepted mental health condition and visit chart notes do not contain enough information to provide a clear picture of progress to the insurer. **This report isn't required if this information is submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements.

Payment limits

These following CPT® codes and their services are **bundled** and aren't payable separately:

- **90885**,
- **90887**,
- **90889**.

Payment policy: Audio-only mental health services

General information

The insurer covers mental health treatment via audio only when prior authorization for mental health has been obtained, and only in specific circumstances.

For telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

Audio-only shouldn't be used in place of telehealth or in-person services.

Services that must be performed in person

An in-person visit is required once every 6 months. An in-person visit is also required when:

- The provider has determined the worker isn't a candidate for audio only either generally or for a specific service, *or*
- The worker doesn't want to participate via audio only, *or*
- A worker files a reopening application, *or*
- A worker needs neuropsychological (CPT® **96132**, **96133**) or psychological testing (CPT® **96130**, **96131**), *or*
- A consultation is necessary to satisfy the 6-month in person requirement.

In-person visits consultations can occur with a non-treating mental health provider in place of the current treating provider. Non-treating mental health providers must:

- Document a referral from the treating provider for an in-person consultation, and
- Submit documentation of the visit to the insurer as well as the treating provider.

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for the in-person 6-month visit for mental health services.

Prior authorization

The same prior authorization requirements listed in this chapter apply to this policy.

Services that can be billed

When mental health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has adopted a modified list of services that may occur via audio only.

The following CPT® codes are covered when performed via audio only:

- **90791**
- **90832**
- **90834**
- **90837**
- **90839**
- **90840**
- **90847**
- **90853**

In addition, CPT® **90785** may be billed if it is appropriate for the audio-only visit but only when billed with CPT® **90791**, **90832**, **90834**, **90837**, or **90853**. See CPT® for additional requirements when billing CPT® **90785**.

Services that aren't covered

In addition to services listed in the telehealth services that aren't covered policy, audio-only services that aren't covered include:

- Services that require visual treatment of a worker,
- Mental health codes with an evaluation component, with the exception of CPT® **90791**,
- Evaluation and Management (E/M) visits,
- Audio-only services done for the convenience of the provider or worker,
- Neuropsychological testing,
- Psychological testing, *and*
- **Q3014** originating site fees.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems aren't covered.

Requirements for billing

For services delivered via audio only, bill the applicable codes as if delivering care in person.

Bill using modifier **–93** to indicate services rendered via audio only.

Providers billing for audio only services must use place of service **02** to denote the audio only visit when the worker isn't located in their home and will be reimbursed at the facility rate. Providers billing for audio only services must use place of service **10** to denote the audio only visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the provider in addition to the documentation and coding requirements for services billed:

- The date of the call, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- All medical, vocational, or return to work decisions made, *and*
- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in audio-only services.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Payment policy: Case management services

Payment limits

Psychiatrists (MD or DO), psychiatric Advanced Registered Nurse Practitioners (ARNP), or licensed clinical psychologists (PhD or PsyD) may only bill for case management services (telephone calls, team conferences, and online communications) when mental health services are authorized.

Links: For more information about payment criteria and documentation requirements for these services, see the payment policy for case management services in Chapter 10: Evaluation and Management.

Payment policy: Individual and group goal-oriented psychotherapy

Prior authorization

Group psychotherapy

Group psychotherapy treatment is only authorized in conjunction with mental health or psychotherapy treatment.

If authorized, the worker may participate in group therapy as part of the individual treatment plan.

Requirements for billing

Individual psychotherapy services

To report individual psychotherapy:

- Don't bill more than 1 unit per day, *and*
- Use the following timeframes for billing the psychotherapy codes:
  - 16-37 minutes for CPT® **90832** and **90833**.
  - 38-52 minutes for CPT® **90834** and **90836**.
  - 53 or more minutes for CPT® **90837** and **90838**.

Note: In addition to the other CPT® requirements, chart notes must document time spent performing psychotherapy. Coverage of these services is different for psychiatrists and psychiatric ARNPs than it is for clinical psychologists (see below).

Psychiatrists and psychiatric ARNPs

Psychotherapy performed with an E/M service may be billed by psychiatrists and psychiatric ARNPs when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation, *or*
- Drug management, *or*
- Writing physician orders, *or*
- Interpreting laboratory or other medical tests.

The time spent performing psychotherapy can't be included in selecting the E/M level. The provider must clearly document each service, including time spent on each service.

Psychiatrists and psychiatric ARNPs may bill the following individual goal-oriented psychotherapy CPT® billing codes without an E/M service:

- **90832**,
- **90834**,
- **90837**.

Psychiatrists and psychiatric ARNPs may bill the following CPT® billing codes when performing an evaluation and management service on the same day:

- **90833**,
- **90836**,
- **90838**.

Psychiatrists and psychiatric ARNPs bill these CPT® billing codes in addition to the code for evaluation and management services.

Clinical psychologists

Clinical psychologists may bill only the individual goal-oriented psychotherapy codes without an E/M component CPT® **90832**, **90834**, and **90837**. They can't bill psychotherapy codes with an E/M component CPT® **90833**, **90836**, or **90838** because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license in Washington State.

Master's Level Therapists

Master's Level Therapists (MLTs) may only provide individual psychotherapy without an E/M component (CPT® **90832**, **90834**, and **90837**). MLTs can't diagnose a mental health condition.

Prolonged Services

Prolonged services for psychotherapy are no longer allowed per CPT®.

Group psychotherapy services

If group psychotherapy is authorized and performed on the same day as individual goal-oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions and documentation requirements for each service.

The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers. Individual psychotherapy must occur in conjunction with group therapy.

Payment policy: Mental health consultations and evaluations

General information

When mental health services performed concurrently with one or more providers, the **attending provider** must coordinate care.

Who must perform these services to qualify for payment

Authorized mental health consultations and evaluations must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Licensed clinical psychologist (PhD or PsyD).

Prior authorization

Prior authorization is required for all mental health care referrals. This requirement includes referrals for mental health consultations and evaluations.

Links: For more information on consultations and consultation requirements, see WAC 296-20-045 and WAC 296-20-051.

Services that can be billed

When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the:

- Psychiatric diagnostic evaluation CPT® **90791**, *or*
- Psychiatric diagnostic evaluation with medical services CPT® **90792**, *or*
- Appropriate level evaluation and management (E/M) service.

Psychologists can only bill CPT® **90791** for psychiatric diagnostic evaluations.

Some **telehealth** mental health services are covered, see telehealth for mental health services in this chapter.

Services that aren't covered

Master's level therapists (MLTs) can't evaluate or consult on a mental health evaluation. MLTs must refer to a psychiatrist, psychiatric ARNP, or a psychologist for these services.

MLTs aren't authorized to provide mental health evaluations. CPT® **90791** and **90792** aren't covered for MLTs.

Requirements for billing

Once every 6 months, workers receiving **telehealth**-based mental health care must receive an in-person mental health visit to continue **telehealth**-based mental health care.

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for a consultation to satisfy the in-person 6-month telehealth visit as part of ongoing therapy.

For the purposes of mental health consultations only, the following must be included in addition to the documentation and coding requirements for services billed:

- The exam of the worker must be under the control of the provider, *and*
- The consulting provider must submit a written report documenting this service to the referring provider, and must send a copy to the insurer.

Documentation requirements

Chart notes and reports must contain documentation that justifies the level, type and extent of services billed.

Payment limits

Psychiatric diagnostic evaluation CPT® codes **90791** and **90792** are limited to 1 occurrence every 6 months, per worker, per provider.

Payment policy: Narcosynthesis and electroconvulsive therapy

Prior authorization

Narcosynthesis and electroconvulsive therapy require prior authorization.

Who must perform these services to qualify for payment

Authorized services are payable only to psychiatrists.

Services that can be billed

Use CPT® codes **90865** (narcosynthesis) and **90870** (electroconvulsive therapy).

Link: See L&I's coverage decision for electroconvulsive therapy.

Payment policy: Neuropsychological testing and evaluation

General information

Neuropsychological testing consists primarily of individually administered tests that comprehensively sample domains that are known to be sensitive to the functional integrity of the brain. See the Psychological testing and evaluation policy for details on psychological testing.

Neuropsychological testing involves administration of standardized tests, for intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensoriomotor function, emotional and personality features, and/or adaptive behavior to evaluate the worker's neurocognitive abilities. The assumption is that these processes have been altered due to a change in the worker's neurological condition as a result of their injury.

The specific tests required to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

Who must perform these services to qualify for payment

Only psychiatrists (MD or DO), or licensed clinical psychologist (PhD or PsyD) may provide neuropsychological evaluation.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform neuropsychological testing services.

Requirements for billing

Neuropsychological testing will be considered for authorization when it is medically necessary based on one or more of the following indications:

- Cognitive or behavioral deficits related to known or suspected central nervous system impairment, trauma, or neuropsychiatric disorders (such as brain hypoxia, or due to toxic or chemical exposures) , *or*
- A treatment plan is required to measure functional abilities or impairments in individuals with known or suspected central nervous system impairment, *or*
- Substance impact on cognitive impairment, *or*
- Pre-surgery or treatment-related measurements of cognitive function to determine if it's appropriate to proceed with a medical or surgical procedure (such as deep brain stimulation, epilepsy surgery, stem cell or organ transplant) that may affect brain function, *or*

- Determine through measurement of cognitive abilities if a worker's medical condition impairs their ability to comprehend and participate in treatment regiments, or to function independently after treatment, *or*
- Testing the outcomes of cognitive rehabilitative procedures, *or*
- Evaluate primary symptoms of impaired attention and concentration that can occur due to neurological or psychiatric conditions.

Note: Occupational therapists (OT) or Speech Language Pathologists (SLP) may provide standardized cognitive performance testing (CPT® **96125**) to assist in identifying the worker's baseline and treatment strategies. Formal neuropsychological testing may be referred to a psychiatrist (MD or DO) or licensed clinical psychologist (PhD or PsyD).

Neurobehavioral Status Examination

A neurobehavioral status examination (CPT® **96116** and **96121**) may be performed prior to neuropsychological testing and evaluation in order to help determine what type of tests are needed and how to administer them. This exam includes a clinical interview. A neurobehavioral status examination isn't required in order to complete a neuropsychological evaluation but is insufficient to diagnose mild cognitive impairment. Mini mental state examinations (MMSE) or MoCA cognition or other similar tests, when done without additional neurobehavioral testing, don't meet the definition of CPT® **96116** or **96121**.

Neuropsychological testing and evaluation includes separate services: the evaluation (CPT® 96132 and 96133) and test administration and scoring (CPT® 96136-96139 and 96416).

Neuropsychological Testing Evaluation

Neuropsychological testing evaluation (CPT® **96132** and **96133**) includes:

- Record review, *and*
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, *and*
- Clinical decision making, *and*
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), *and*
- Creation of a clinical report, *and*
- Medical management and treatment planning, *and*
- Interactive feedback to worker, family member(s) or caregiver(s).

Neuropsychological Test Administration & Scoring

Test administration and scoring is separately billable and includes the administration and scoring of 2 or more neuropsychological tests.

For test administration and scoring, use the following CPT® codes:

- **96136** and **96137** if performed by a qualified provider, *or*
- **96138** and **96139** if performed by a technician, *or*
- **96416** for automated testing and scoring via an electronic platform.

Time spent administering and scoring neuropsychological tests (CPT® **96138**-**96139**) can't be included in the time spent performing the neuropsychological testing evaluation service (CPT® **96132**-**96133**), such as interpretation of test results.

The qualified provider must bill and is responsible for technician supervision, test selection, data oversight, clinical interview, feedback session, interpretation and analysis, reporting and consultation.

Reviewing records and/or writing a report is included in the codes above and can't be billed separately.

Note: Additional resources for service requirements may be available from the American Medical Association, Centers for Medicare and Medicaid Services (CMS), or professional psychological associations.

Services that can be billed

The following billing codes may be used when performing neuropsychological evaluation:

CPT® code(s) and Description	Additional Information	Limit
Neurobehavioral Status Examination; **96116** (1st hour) **+96121** (each additional hour)	May be completed independent of or prior to a neuropsychological testing evaluation to help determine type of tests and how to administer them, including clinical interview. When performing independently, this test isn't sufficient to diagnose mild cognitive impairment.	Up to a 4-hour maximum. The time for this service doesn't apply to the 12-hour maximum set for CPT® codes **96136**, **96137**, **96138** and **96139** for test administration and scoring.
Neuropsychological Testing Evaluation; **96132** (1st hour) **+96133** (each additional hour)	The assumption is that the processes being examined have been altered due to a change in a neurological condition as a result of the worker's injury.	Up to a 4-hour maximum. The time for this service doesn't apply to the 12-hour maximum set for CPT® codes **96136**, **96137**, **96138** and **96139** for test administration and scoring.
Neuropsychological Test Administration and Scoring **by a qualified provider**; **96136** (1st 30 minutes) **+96137** (each additional 30 minutes)	Billed with neuropsychological testing on same or different days. Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7.	Up to a combined 12-hour maximum for test administration and scoring. **96136** or **96137** can't be billed with **96138** or **96139**.
Neuropsychological Test Administration and Scoring **by a technician**; **96138** (1st 30 minutes) **+96139** (each additional 30 minutes)	Billed with neuropsychological testing on same or different days. Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7.	Up to a combined 12-hour maximum for test administration and scoring. **96138** or **96139** can't be billed with **96136** or **96137**.

CPT® code(s) and Description	Additional Information	Limit
Automated test administration and scoring via an electronic platform; **96146**	Billed when providing a limited, single psychological or neuropsychological automated test (such as PHQ-9 or GAD-7).	Limited to 1 unit per day, per provider, per worker, regardless of the number of tests administered. Can't be billed with any other test administration and scoring codes.

Time spent performing the activities associated with each service is cumulative over the entire episode of evaluation, even if the service is spread out over multiple visits. The cumulative time for each service must be reported at the completion of the entire episode of evaluation. Don't bill using a range of dates of service if the services were spread out over multiple days.

Time calculated for each service represented by it's own CPT®, HCPCS, or local code can't be included in the time spent performing other billable services. For example, test administration (CPT® **96136-96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under neuropsychological testing evaluation (CPT® **96132-96133**).

Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or independent medical examiner (IME),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores,
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *and*
    - Test materials such as:
        - Test protocols,
        - Manuals,
        - Test items,
        - Scoring keys or algorithms, *and*
        - Any other materials considered secure by the test developer or publisher.
- Integration of sources of information (such as summary and impressions),
- Diagnosis,
- Treatment planning, *and*
- The time of each service (such as neurobehavioral status examination, neuropsychological evaluation, and test administration and scoring) provided.

Note: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

Payment policy: Pharmacological evaluation and management

Prior authorization

All mental health services require prior authorization.

Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs.

Requirements for billing

Services conducted on the same day

When a pharmacological evaluation is conducted on the same day as psychotherapy, the psychiatrist or psychiatric ARNP can bill:

- One of the add on psychotherapy codes (CPT® **90833**, **90836**, or **90838**) *and*
- Appropriate level evaluation and management (E/M) service.

Services not conducted on the same day

When a pharmacological evaluation is the only service conducted on a given day, the provider must bill the appropriate E/M code.

Payment policy: Psychological testing and evaluation

General information

Psychological testing is intended to test general psychological processes which are assumed to have an emotional, behavioral, environmental, and/or health etiology but are not directly mediated by the central nervous system as result of the worker's injury. See the Neuropsychological testing and evaluation policy for details on neuropsychological testing.

Psychological testing involves administration of several types of psychometric standardized tests for measuring emotional and interpersonal functioning, intellectual functioning, thought processes, personality and psychopathology. A mini mental state examination (MMSE) or MoCA cognition or similar tests may be appropriate but can't be the only tests performed.

The specific tests a worker requires to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

Who must perform these services to qualify for payment

Only psychiatrists (MD or DO) or licensed clinical psychologists (PhD or PsyD) may provide psychological testing.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform psychological testing services.

Requirements for billing

Psychological testing will be considered for authorization when it is medically necessary based on one or more of the following indications:

- To aid in determining psychological disorder and its severity and functional impairments to determine a psychiatric diagnosis when a mental illness is suspected, or to achieve a differential diagnosis from a range of medical or psychological disorders that present with similar symptoms,
- Measure behavioral factors that impact disease management, including but not limited to: pre-surgical evaluation, assessment of emotional or personality factors impacting physical disease management, assessment of psychological factors in chronic pain workers, or compliance to treatment regimens,
- Measure functional capacity to delineate specific cognitive, emotional or behavioral bases of functional complaints or disability,
- Measure psychological barriers and strengths to aid in treatment planning,
- Measure risk factors to determine a workers' risk of harm to self and/or others,
- Perform symptom measurement to objectively measure treatment effectiveness, and/or determine the need for referral for pharmacological treatment,
- Measure and confirm or refute clinical impressions obtained from interactions with the worker,
- Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions.

Psychiatric Diagnostic Evaluation

A psychiatric diagnostic evaluation (CPT® **90791**) may be performed prior to psychological testing and evaluation in order to help determine what type of tests are needed. This type of evaluation may also be performed as a stand-alone clinical interview in the absence of a corresponding psychological testing evaluation (CPT® **96130** or **96131**).

Psychological testing and evaluation includes separate services; the evaluation (CPT® 96130 and 96131) and test administration and scoring (CPT® 96136-96139 and 96416).

Psychological Testing Evaluation

Psychological testing evaluation (**96130** and **96131**) includes:

- Record review, and
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, and
- Clinical decision making, and
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), and
- Creation of a clinical report, and
- Medical management and treatment planning, and
- Interactive feedback to worker, family member(s) or caregiver(s).

Psychological Test Administration & Scoring

Test administration and scoring is separately billable and includes:

- Administration of 2 or more psychological tests, *and*
- Scoring of 2 or more psychological tests.

For test administration and scoring, use the following CPT® codes:

- **96136** and **96137** if performed by a qualified provider, *or*
- **96138** and **96139** if performed by a technician, *or*
- **96416** for automated testing and scoring via an electronic platform.

Time spent administering and scoring psychological tests (CPT® **96138**-**96139**) can't be included in the time spent performing the psychological testing evaluation service (CPT® **96132**-**96133)**, such as interpretation of test results.

The qualified provider must bill and is responsible for technician supervision, test selection, data oversight, interpretation and analysis, reporting and consultation.

Reviewing records and/or writing a report is included in the codes above and can't be billed separately.

Services that can be billed

The following billing codes may be used when performing neuropsychological evaluation:

CPT® code(s) and Description	Additional Information	Limit
Psychiatric Diagnostic Evaluation; **90791**	May be completed independent of or prior to psychological testing evaluation to help determine type of tests needed, including clinical interview.	1 occurrence every 6 months, per worker, per provider.
Psychological Testing Evaluation; **96130** (1st hour) **+96131** (each additional hour)	The assumption is that the processes being examined have an emotional, behavioral, environmental and/or health etiology related to the worker's injury but are not directly mediated by the central nervous system.	Up to a 4-hour maximum. The time for these services doesn't apply to the 12-hour maximum set for CPT® codes **96136**, **96137**, **96138**, and **96139** for test administration and scoring.
Psychological Test Administration and Scoring **by a qualified provider**; **96136** (1st 30 minutes) **+96137** (each additional 30 minutes)	Billed with psychological testing on same or different days. Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7.	Up to a combined 12-hour maximum for test administration and scoring. **96136** or **96137** can't be billed with **96138** or **96139**.
Psychological Test Administration and Scoring **by a technician**; **96138** (1st 30 minutes) **+96139** (each additional 30 minutes)	Billed with psychological testing on same or different days. Not appropriate when simply administering and/or scoring a PHQ-9 or GAD-7.	Up to a combined 12-hour maximum for test administration and scoring. **96138** or **96139** can't be billed with **96136** or **96137**.

CPT® code(s) and Description	Additional Information	Limit
Automated test administration and scoring via an electronic platform; **96146**	Billed when providing a limited, single psychological or neuropsychological automated test (such as PHQ-9 or GAD-7).	Limited to 1 unit per day per provider per worker, regardless of the number of tests administered. Can't be billed with any other test administration and scoring codes.

Time spent performing the activities associated with each service is cumulative over the entire episode of evaluation, even if the service is spread out over multiple visits. The cumulative time for each service must be reported at the completion of the entire episode of evaluation. Don't bill using a range of dates of service if the services were spread out over multiple days.

Time calculated for each service represented by it's own CPT®, HCPCS, or local code can't be included in the time spent performing other billable services. For example, test administration (CPT® **96136**-**96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under psychological testing evaluation (CPT® **96130**-**96131**).

Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or independent medical examiner (IME),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores, *and*
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *and*
    - Test materials such as:
        - Test protocols,
        - Manuals,
        - Test items,
        - Scoring keys or algorithms, *and*
        - Any other materials considered secure by the test developer or publisher.
- Integration of sources of information (such as summary and impressions),
- Diagnosis,
- Treatment planning.

Note: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

Payment policy: Residential facility offering treatment for mental health

General information

This policy applies to workers who require admission to a **residential facility for mental health** services. Workers covered under this policy are either filing the initial claim, or have an open and allowed claim. This includes those who:

- Have an accepted mental health condition, such as occupational posttraumatic stress disorder (PTSD), *or*
- Have mental health treatment authorized, which may include the need for treatment of substance use disorder.

For information on which insurer to bill, see Chapter 2: Information for All Providers.

For additional inpatient or outpatient facility information, see Chapter 35: Hospitals.

For mental health services and authorization requirements, see the information in this chapter. Supplemental information is defined in WAC 296-21-270.

Requirements for PTSD is defined in RCW 51.08.165. For occupational disease requirements, see RCW 51.08.142 and RCW 51.32.185 (presumptive coverage).

Claim filing

The filing of the initial L&I Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) does not require prior authorization. The insurer covers the initial visit and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. See Chapter 2: Information for All Providers for additional details on initial visits.

For workers where the facility is filing the L&I Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) **and the worker requires treatment**, the following must be submitted to the insurer:

- The ROA or PIR, *and*
- Initial evaluation of the worker, including DSM-5 diagnosis with supporting documentation to support the diagnosis and pre-screening intake, if conducted, *and*
- Request for authorization for ongoing treatment.

The recommended treatment plan and all treatment records must be submitted to the insurer for authorization of ongoing treatment.

Note: Each facility may require their own release of record form, however, the insurer's ROA/PIR requires a signature by the worker to release relevant medical records. The insurer determines 'relevant'. The ROA/PIR may be used in lieu of the facility's release of records form.

Claim status

The following are example claim statuses of workers who seek treatment at a **residential facility for mental health services**:

1. Initial claim filing, evaluation **without** treatment. In this case, the worker may seek initial evaluation from a facility without prior authorization, but may not receive a mental health diagnosis per DSM-5 or require ongoing treatment. The insurer covers the initial visit and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility are submitted within 1 year from date of service. See Chapter 2: Information for All Providers for additional details on initial visits.
2. Initial claim filing, evaluation **with** treatment. In this case, the worker may seek treatment from a facility and may require ongoing treatment per a DSM-5 diagnosis. The insurer covers the initial visit and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. Prior authorization is required before initiating treatment. See the Mental Health Services webpage, this chapter, and the prior authorization requirements below for additional details.
3. Established claim. In these cases, an L&I worker's compensation claim is open and allowed and requires prior authorization for treatment. See prior authorization requirements below for additional details.

In order to assist the worker and their providers, the insurer requires timely documentation. See documentation requirements below for additional details.

Treatment beyond the first visit and evaluation won't be paid when a claim is rejected.

Treatment

A referral from either the **attending provider (AP)** or a mental health provider (psychiatrist, psychiatric ARNP) is required prior to admission for open and allowed claims.

Prior authorization

Mental health prior authorization treatment requirements apply to claims filed through a **residential treatment facility**. Contact the insurer for prior authorization.

For workers with an open and allowed claim for accepted mental health conditions and treatment has been authorized, the following is required:

Inpatient:

- An evaluation by the facility, including a treatment plan, must be sent to the insurer for authorization **prior** to initiating treatment. The start date for treatment must be submitted as part of the evaluation.
- Initial authorization is up to 6 weeks. For treatment lasting longer than 6 weeks additional authorization is required. Contact the insurer for prior authorization. An updated treatment plan is required for additional authorization.

Ongoing outpatient treatment:

- Continuation of mental health treatment by the facility in an outpatient setting requires authorization. The facility must submit an updated treatment plan as part of the authorization request. Facilities aren't required to develop an updated treatment plan once the worker has transferred care to an AP.

Discharge:

- Upon discharge, the facility must coordinate and transfer the worker's care back to the AP and/or referring provider. If the worker does not have an AP prior to admission, the facility must help the worker identify an AP prior to discharge and then coordinate and transfer the worker's care to the identified AP. The AP is responsible for managing the overall care of the worker after discharge from a **residential facility for mental health services**. The worker has the right to choose their AP.

Payment methods

Bill the insurer usual and customary fees.

In state facilities will be paid POAC, DRG, or APC rate. See Chapter 35: Hospitals for details.

Out of state facilities will be paid at POAC rate. See Chapter 35: Hospitals for details.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a worker admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via POAC rate.

Who must perform these services to qualify for payment

Washington State **residential facilities for mental health** services must be certified and licensed by the Department of Health.

Out of state **residential facilities for mental health** services must be licensed by the state the facility is located in, and accredited by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or any other state-approved accrediting organization.

See All mental health services for additional details on who can provide mental health services.

Services that can be billed

The insurer covers the following codes with prior authorization:

- **H0035**
- **H0047-H0050**
- **H2035**
- **H2036**
- **S9480**

This is in addition to the codes found in L&I's professional provider fee schedule.

Services that aren't covered

In addition to the codes not covered on the fee schedule, the following services aren't covered:

- **H0031-H0032**
- **H0036-H0040**
- **H0046**
- **H2001**
- **H2010-H2034**
- **H2037-H2038**

Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Documentation requirements

Per Chapter 2: Information for All Providers, chart notes and any treatment plan updates, must be submitted to the insurer.

In addition to the requirements noted in Chapter 2: Information for All Providers and this chapter, all facilities must provide the insurer with the following documentation:

- Causality statement for the industrial injury or occupational disease (DSM-5 diagnosis) for initial claim filing, *and*
- The initial evaluation from a provider at the facility when the worker is admitted, *and*
- A recommended course of action for the worker, *and*
- Progress reports on a bi-weekly basis, *and*
- Discharge summary, including but not limited to, ongoing treatment plan for the worker when they return to their AP or mental health provider; assessment of worker's psychological status especially as related to reintegration in the workplace, home and community; and communication with the AP, referring provider, claim manager, assigned vocational counselor or family to support the worker's continued management of mental health condition, *and*
- The worker's full name, *and*
- L&I claim number, *and*
- Time as required per CPT® or HCPC coding, *and*
- Treatment that was provided, *and*
- Treating provider name, address and telephone number.

Don't fax the treatment plans or chart notes with bills. See Chapter 2: Information for All Providers for details on submitting chart notes and treatment plans to the insurer.

Additional information

Providers may not charge workers for copayments or deductibles. The worker may not be balance billed for any services that are claim related. See RCW 51.04.030(2) and WAC 296-20-020.

Payment policy: Telehealth for mental health services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

An in-person visit is required once every 6 months. An in-person visit is also required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- A worker files a reopening application, *or*
- A worker needs neuropsychological (CPT® **96132**, **96133**) or psychological testing (CPT® **96130**, **96131**), *or*
- A consultation is necessary to satisfy the 6-month in-person requirement.

In-person consultations may occur with a non-treating mental health provider in place of the current treating provider. Non-treating mental health providers must:

- Document a referral from the treating provider for an in-person consultation, and
- Submit documentation of the visit to the insurer as well as the treating provider.

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for the in-person 6-month visit for mental health services.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

Mental health examinations to complete a ROA or PIR filing and/or Activity Prescription Forms (even when restrictions or changes are anticipated) are covered when performed via **telehealth**. Re-opening examinations must be completed in person.

Mental health services may be payable via audio-only in certain circumstances, see the Audio-Only Mental Health Services for additional details. Telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Q3014 billing example

A worker attends an in-person Evaluation and Management (E/M) appointment at their **attending provider's** office. The **attending provider** documents all necessary information as part of this visit and bills for the E/M service. The **originating site** (**attending provider's** office) also arranges a secure and private space for the worker to participate in a consultation with their cardiologist at another location (**distant site** provider). The **originating site** provider separately documents the use of their space as part of their bill for **Q3014**.

How to bill for this scenario

The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their space for their telehealth visit with the **distant site** provider. The **distant site** provider bills for the services they provide; they can't bill **Q3014**.

For this **telehealth** visit:

- The distant site provider would bill the appropriate CPT® E/M code with modifier **–GT**.
- The originating site provider would bill **Q3014**.

Note: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Home health monitoring,
- Neuropsychological testing,
- Psychological testing, *and*
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Payment policy: Transcranial Magnetic Stimulation (TMS) for treatment-resistant depression

General information

The insurer covers transcranial magnetic stimulation (TMS) on a limited basis. Authorization for this treatment is dependent upon the conditions of coverage noted in the coverage decision for TMS therapy.

Prior authorization

Prior authorization is required before initiating TMS treatment. Each course of treatment requires separate prior authorization.

Who must perform these services to qualify for payment

TMS must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Certified technician under the supervision of one of the provider types above.

Requirements for billing

Billing of TMS codes must be in accordance with CPT® code definitions and requirements.

Evaluation and Management (E/M) service activities related to cortical mapping, motor threshold determination, and/or delivery and management of TMS aren't separately payable.

Services that can be billed

Transcranial magnetic stimulation (TMS) is covered for workers with treatment resistant major depressive disorder when the conditions of coverage are met as outlined in L&I's coverage decision.

Bill TMS using CPT® codes **90867**, **90868**, or **90869**.

If a significant separately-identifiable E/M service (which may include medication management or a psychotherapy service) is performed, then an E/M or psychotherapy code may be billed in addition to CPT® codes **90867**-**90869**. Use modifier **–25** for a separately identifiable E/M service. Use modifier **–59** for a separately identifiable psychotherapy service.

Services that aren't covered

TMS protocol that isn't FDA-approved isn't covered.

Bills for services performed without prior authorization will be denied.

Documentation requirements

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan.

Chart notes must contain documentation that justifies the level, type, and extent of services billed.

When billing a significant separately-identifiable service using either modifier **–25** or **–59**, the services must be documented separately.

Payment limits

The total number of combined sessions allowed for CPT® codes **90867**, **90868** and **90869** is 30 per course of treatment. Each course of treatment requires separate prior authorization. Additional treatment courses must meet the guidelines described in L&I's coverage decision.

CPT® **90869** may be billed up to a max of 2 units per treatment course.

Treatment related to multiple claims for the same worker is subject to split billing. See Chapter 2: Information for All Providers for more information.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for attending providers	Washington Administrative Code (WAC) 296-20-01002
Administrative rules for consultations and consultation requirements	WAC 296-20-045 WAC 296-20-051
Administrative rules for mental health services	WAC 296-21-270 WAC 296-14-300
Authorization and Reporting Requirements for Mental Health Specialists	Authorization and reporting rules on L&I's website
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 facility services (including ASCs)	Fee schedules on L&I's website
Mental health services website	Mental health services on L&I's website
Payment policies for **case management services**	Chapter 10: Evaluation and Management (E/M) Services
Payment policies for **teleconsultations and other telehealth services**	Chapter 10: Evaluation and Management (E/M) Services
Mental health services payment policies for **crime victims**	Crime Victims program on L&I's website WAC 296-31

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 18: Modifications to Home and Vehicle

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

By report: A code listed in the fee schedule as “By Report” which 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.

Residence (home) modification: A residence or home modification is a permanent change to an existing residence or a repair of a modification previously approved and paid for by the department or self-insured employer, or a modification made when constructing a new residence.

Links: For more information, see WAC 296-14-6200. For Job Modifications and Pre-Job Modifications, see Chapter 30: Vocational Services.

Payment policy: Home modifications

Prior authorization

To request prior authorization for a **consultation**, contact:

- The claim manager for State Fund claims.
- The employer or their claims representative for self-insured claims.

For **construction and design work**, pre-authorization:

- Must be done by the Assistant Director (AD) for Insurance Services for State Fund claims.
- Can't be denied without the AD's approval for self-insured claims.

Who must perform these services to qualify for payment

The **home modification** consultant must:

- Be a licensed nurse, occupational therapist, or physical therapist, *and*
- Have training or experience in both rehabilitation of catastrophic injuries and modifying homes.

Services that can be billed

Home modifications fee schedule

For this **HCPCS or local billing code**…	The **provider that can bill** is a:	And the **insurer pays for**:	With a **maximum fee** of:
8914H Home modification **construction and design**	Contractor, Architect, Construction material supplier, *and* Worker.	• Construction materials, • Labor & tax, • Permits and inspections, and • Architect plans. If the worker pays for inspections, predesign, or planning services, the worker may be reimbursed if the modification request is approved.	Each bill pays **By Report** (as billed) up to the maximum amount authorized for the home modification.
8916H Home modification **consultation**	Home modification consultant.	**Time spent** doing: • Onsite home evaluation, • Consultation, or • Required reports.	**By Report**

For this **HCPCS or local billing code**…	The **provider that can bill** is a:	And the **insurer pays for**:	With a **maximum fee** of:
8917H Home modification **mileage, lodging, bridge and ferry tolls, airfare, and car rental**	Home modification consultant.	**Mileage** **Lodging** for 1 person when the onsite visit requires: • 2 or more consecutive days, *and* • Is greater than 125 miles one-way. **Airfare** (economy) for 1 person when travel is greater than 180 miles one-way. **Car rental** (economy) when air travel is involved.	**State Rate**
0391R **Travel**	Home modification consultant.	**Travel time or wait time**	**$5.76** per unit (1 unit = 6 minutes)

Requirements for billing

To get reimbursed, you must submit a copy of receipts for:

- Materials,
- Lodging,
- Airfare, *and*
- Car rental.

Payment limits

The insurer will pay for **home modification** construction and design for only 1 residence for each catastrophically injured worker. The maximum amount payable is the current Washington State average annual wage.

Payment policy: Vehicle modifications

Prior authorization

Vehicle modifications require prior authorization based on approval by the Assistant Director of L&I's Insurance Services Program.

Link: More information about vehicle modifications is available in RCW 51.36.020(8).

Who must perform these services to qualify for payment

Consultations

The vehicle modification consultant must:

- Be a licensed occupational or physical therapist, or licensed medical professional, *and*
- Have training or experience in both rehabilitation and vehicle modification.

Services that can be billed

If the **HCPCS and local billing code** is…	Then the **provider who can bill** is:	And **the insurer pays** for:	And the **maximum fee** is:
8915H Vehicle modification	Vehicle modification supplier	**Vehicle modification**	Maximum payable for all work is **½ the current Washington State average wage.** The amount paid may be increased by no more than **$4,000.00** by written order of the Supervisor of Industrial Insurance (see Link below table).

If the **HCPCS and local billing code** is…	Then the **provider who can bill** is:	And **the insurer pays** for:	And the **maximum fee** is:
8917H Vehicle modification mileage, lodging, bridge and ferry tolls, airfare, and car rental	Vehicle modification consultants	**Mileage** **Lodging** for 1 person when the onsite visit requires: • 2 or more consecutive days, and • Is greater than 125 miles one-way. **Airfare** (economy) for 1 person when travel is greater than 180 miles one-way. **Car rental** (economy) when air travel is involved.	**State Rate**
8918H Vehicle modification consultation or driving evaluation	Vehicle modification consultants	**Time spent** doing: • Onsite – vehicle and/or driving evaluation, • Consultation, or • Required reports.	**By Report**
0391R Travel	Vehicle modification consultants	**Travel time or wait time**	**$5.76** per unit (1 unit = 6 minutes)

Requirements for billing

To get reimbursed, you must submit copies of receipts for:

- Lodging,
- Airfare, *and*
- Car rental.

Payment limits

For local billing code **8915H**, the maximum payable for all vehicle modification is 50% of the current Washington State average wage. The amount paid may be increased by no more than **$4,000.00** by written order of the Supervisor of Industrial Insurance.

Link: For more information about vehicle modification payment increases, see RCW 51.36.020(8)(b).

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for home modifications	Washington Administrative Code (WAC) 296-14-6200 through WAC 296-14-6238 available in WAC 296-14
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Contractors' questions and answers about home modifications for workers with catastrophic injuries	F252-061-000
Fact sheet on home modifications for workers with catastrophic injuries	F252-060-000
Fee schedules for all healthcare and vocational services	Fee schedules on L&I's website
Home Modification Acknowledgement of Responsibilities form	F247-003-000
Laws for definitions	Revised Code of Washington (RCW) 50.04.355
Laws for modification to residences or motor vehicles	RCW 51.36.020(7) and (8)
Laws for residence modification services	RCW 51.36.022
Laws for right to and amount	RCW 51.32.095(4) RCW 51.32.250

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 19: Naturopathic Physicians and Acupuncture Services

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Established patient: One who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

New patient: One who hasn't received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Acupuncture services

General information

Acupuncture involves the insertion of needles or lancets, with or without electrical stimulation, to directly or indirectly stimulate acupuncture points and meridians.

The insurer only covers acupuncture for allowed claims with an accepted diagnosis of a low back condition.

Note for MARFS 2024

L&I is in the process of revising this payment policy. Sign up for GovDelivery to stay informed of changes. We will notify providers via GovDelivery when this policy is revised. The updated policy will be posted on our updates and corrections page on L&I's website.

Who must perform these services to qualify for payment

Only Acupuncture, Eastern Medicine Practitioners (AEMP) and other providers who are licensed by the Department of Health to perform acupuncture may perform these services.

Prior authorization

Acupuncture requires a referral from the attending provider.

Prior authorization to perform acupuncture is not required. An initial evaluation must be performed prior to beginning treatment.

Services that can be billed

Code	Description	Payment Limits
99202-99215	**Evaluation and Management (E/M) service** for: • Initial evaluations, *or* • Follow up evaluations, *or* • Discharge visits.	See Chapter 10: Evaluation and Management Services for more information.
1582M	**Acupuncture treatment** with one or more needles, with or without electrical stimulation. Initial evaluation required prior to treatment.	**Maximum of 1 unit per day, per worker.** **Maximum of 10 treatments** over the lifetime of the claim.

Link: For more information on conditions of coverage, see WAC 296-23-238 and L&I's Acupuncture Coverage Decision.

Documentation requirements

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Chapter 2: Information for All Providers for details.

Initial evaluations must include documentation of a treatment plan and follow the documentation requirements in Chapter 10: Evaluation and Management (E/M) Services.

On the final visit, the reason for discharge of the worker must be documented.

In addition to daily chart notes, the provider must submit to the claim file validated functional instruments, including a 2-item GCPS (Graded Chronic Pain Scale) and an Oswestry Disability Index (ODI) form, to track and document the workers' pain and functional status at the following visits:

- The initial office visit/treatment, *and*
- The middle treatment (no later than visit #5), *and*
- The final treatment.

Services that aren't covered

CPT® acupuncture codes **97810-97814** aren't covered.

L&I will not authorize or pay for acupuncture treatment related to conditions other than low back pain.

Acupuncture services can't be performed via **telehealth**.

Payment policy: Naturopathic services

General information

There have been substantial changes made to naturopathic services in this version of MARFS. See the updated policy below, as well as Physical medicine services for naturopathic physicians and Telehealth for naturopathic physicians.

Dual licensures or additional certifications

Naturopaths who are also licensed in another discipline (dual-licensed) must have a separate provider account number to perform and bill for those services.

Naturopaths who hold an additional certification for services outside their typical scope of practice must ensure they've uploaded their certification information into their ProviderOne account in order to perform and bill for services related to that certification.

Providers are expected to bill their services under the correct provider number appropriately, based on the licensure scope of practice.

Link: For more information, see Chapter 2: Information for all Providers.

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker.

Medically necessary X-rays may be performed at the initial visit, without prior authorization. All subsequent x-rays require prior authorization.

Prior authorization may also be required for other services and treatments naturopaths provide. See applicable MARFS chapters for details.

Link: For more information, see WAC 296-20-03001 and WAC 296-23-205.

Services that can be billed

Naturopaths may bill services within their scope of practice and that adhere to the department's rules and policies. For more information, including service and documentation requirements and payment limits, see the appropriate policy chapter for the services being provided. These services must be billed using the appropriate CPT®, HCPCS Level II codes or local code. This includes but isn't limited to:

- Evaluation and Management (E/M) Services including; All levels of **New** and **Established patient** Evaluation and Management (E/M) Services (CPT® **99202-99215**), Outpatient prolonged services (CPT® **99417**), and Case Management services including telephone calls (CPT® **99441-99443**), team conferences (CPT® **99637** or **99212-99215**), and online communications (local code **9918M**),
- X-ray and other diagnostic services,
- Manual manipulative treatment, including craniosacral therapy, using Osteopathic Manipulative Treatment (OMT) codes (CPT® **98925-98927**),
- Injections and infusions, including dry needling (CPT® **20560**, **20561**), trigger point injections (CPT® **20552**, **20553**) and other minor office procedures,
- Behavioral Health Interventions (BHI) (Within the context of an E&M or CPT® **96156-96519**, **96127**),
- Durable Medical Equipment (DME) and miscellaneous materials and supplies, *and*
- Reports and forms appropriate for attending providers (see Chapter 27: Reports and Forms for codes).

For more information on coverage of physical medicine services, see Physical medicine services for naturopathic physicians in this chapter.

Link: For more information, see WAC 296-23-205.

Services that aren't covered

The following aren't covered for naturopaths:

- Previous Naturopathic local codes (**2130A -2134A**) for office visits and treatment,
- Consultations (CPT® **99242-99245**),
- Treatment of chronic migraine or chronic tension-type headache with manipulation/manual therapy, massage, and trigger point injections (See L&I's coverage decision),
- Colon hydrotherapy and enemas, even with appropriate training,
- Herbal supplements, minerals, botanical medicines, homeopathic remedies and other similar treatments,
- Acupuncture (local code **1582M**),
- Chiropractic manipulations (CPT® **98940-98943** or local codes **2050A-2052A**), *and*
- Mental Health Treatment.

Diagnostic ultrasound performed in the office is considered bundled into the E/M service.

Link: For additional information on covered and non-covered services, see WAC 296-23-205, WAC 296-20-03002 and WAC 296-20-03012.

Requirements for billing

Chart notes must contain documentation that justifies the level, type, and extent of services billed. Refer to the appropriate chapter for the services being provided for more detailed service and documentation requirements.

To bill the professional component of an x-ray, a written report of radiologic findings and impressions must be included in the worker's chart. See Chapter 26: Radiology Services for more information.

Some services naturopaths may provide, such as IV therapy, dry needling and biofeedback require additional training and/or certification. Providers must meet the minimum education, experience and training qualifications in order to perform these services as determined by the Department of Health (DOH).

Additional information

For more information on services that may be provided by naturopaths, see the applicable MARFS chapters. These include but are not limited to:

- Chapter 2: Information for all providers
- Chapter 6: Biofeedback, EKG, Electrodiagnostic Services, and ESWT
- Chapter 9: Durable Medical Equipment (DME)
- Chapter 10: Evaluation and Management (E/M) Services
- Chapter 16: Medication Administration and Injections
- Chapter 25: Physical Medicine Services
- Chapter 27: Reports and Forms
- Chapter 26: Radiology Services

Payment policy: Physical medicine services for naturopathic physicians

Services that can be billed

Local code **1044M** for physical medicine modalities or procedures must be billed by an attending provider type who isn't board certified/qualified in Physical Medicine and Rehabilitation (PM&R). Naturopaths are required to bill this local code for physical medicine services.

Link: For additional information on covered physical therapy services and requirements, see Chapter 25: Physical Medicine Services.

Services that aren't covered

CPT® physical medicine codes (**97001-97799**) aren't payable to naturopathic physicians.

Documentation requirements

Chart notes must contain documentation that supports billing of local code **1044M**. Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. See Chapter 25: Physical Medicine Services for complete documentation requirements.

All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Payment limits

Local code **1044M** is limited to 6 units per claim, except when the attending provider practices in a remote location where no licensed physical or occupational therapist, or physiatrist is available. After 6 units, the worker must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment.

Only 1 unit is payable per visit, regardless of the length of time the treatment is provided.

Providers who bill for physical medicine services using **1044M** may only perform low-level laser therapy in conjunction with other physical medicine services billable using this code. The insurer won't pay an additional fee for low-level laser therapy beyond the maximum fee for **1044M**. See "Payment limits" under Payment policy: Physical therapy (PT) and occupational therapy (OT) in Chapter 25 for more details.

Payment policy: Telehealth for naturopathic physicians

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required, in all cases, when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- A worker files a reopening application, *or*
- When the service to be performed requires a hands-on component, *or*
- It is the first visit of the claim, *or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of attending provider.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site and store and forward fees are covered, when applicable.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Q3014 billing example

A worker attends an in-person Evaluation and Management (E/M) appointment at their attending provider's office. The attending provider documents all necessary information as part of this visit and bills for the E/M service. The **originating site** (attending provider's office) also arranges a secure and private space for the worker to participate in a consultation with their cardiologist at another location (**distant site** provider). The **originating site** provider separately documents the use of their space as part of their bill for **Q3014**.

How to bill for this scenario

The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their space for their telehealth visit with the **distant site** provider. The **distant site** provider bills for the services they provide; they can't bill **Q3014**.

For this telehealth visit:

- The distant site provider would bill the appropriate CPT® E/M code with modifier **–GT**.
- The originating site provider would bill **Q3014**.

Note: For Evaluation and Management Services refer to Chapter 10: Evaluation and Management (E/M) Services.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only evaluation or treatment billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report except for mental health only claims), *and*
- Home health monitoring.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for naturopathic physicians	Washington Administrative Code (WAC) 296-23-205
Administrative rules for treatment requiring prior authorization	WAC 296-20-03001(1)
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers and Chapter 27: Reports and Forms
Manipulation/ Manual therapy treatment of chronic tension-type headache coverage decision	Chronic Migraine and Chronic Tension-type Headache coverage decision
Fee schedules for all healthcare services	Fee schedules on L&I's website
Payment Policies for **Evaluation and Management (E&M) and case management services**	Chapter 10: Evaluation and Management (E/M) Services
Payment Policies for **mental health services**	Chapter 17: Mental Health Services
Payment Policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Payment Policies for **Durable Medical Equipment (DME)**	Chapter 9: Durable Medical Equipment (DME)
Payment Policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services
Payment Policies for **physical medicine services**	Chapter 25: Physical Medicine Services

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 20: Nurse Case Management

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

By Report: A code listed in the fee schedule as "By Report" which 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.

Nurse case management: A collaborative process used to meet a worker's healthcare and rehabilitation needs. When in the course of a nurse case management referral, the nurse case manager (NCM):

- Works with the attending provider, worker, allied health personnel, and insurer's staff to assist in locating a provider (primarily for out-of-state claims) and/or with coordination of the prescribed treatment plan, *and*
- Organizes and facilitates timely receipt of medical and healthcare resources and identifies potential barriers to medical and/or functional recovery of the worker, *and*
- Communicates this information to the attending provider, claim manager, worker, and Occupational Nurse Consultant (ONC) or self-insured employer's designee to develop a plan for resolving or addressing the barriers.

State Rate: The reimbursement rate for travel reimbursement set by the Office of Financial Management (OFM) within the State of Washington.

Link: For the current State Rate, see the per diem tables on the OFM website.

Payment policy: Case management records and reports

Requirements for reports

Nurse case management reports must be completed monthly. Time spent writing reports is billed using the case planning code (**1222M**). See the payment policy below for additional details.

Nurse case management records must:

- Be created and maintained on each claim, *and*
- Be created when a service is rendered, *and*
- Be submitted prior to billing or within 30 days of the date of service, whichever comes first, *and*
- Present a chronological history of the worker's progress in **nurse case management** services, *and*
- Describe the service provided (including subjective and objective data) and codes billed, *and*
- Document how much time was spent providing each service.

Links: You may use the following optional reporting templates:

- Nurse Case Management Initial Care Management Plan (F245-442-000)
- Nurse Case Management Progress Report (F245-439-000)

Report elements

Initial assessment, progress, and closure reports must include all of the following information:

- Type of report (initial, progress, or closure),
- Worker name and claim number,
- Report date and reporting period,
- Worker date of birth and date of injury,
- Contact information,
- Diagnoses,
- Reason for referral,
- Current medical status,
- Recommendations for future actions,
- Actions taken and dates,
- Ability to positively impact a claim,
- Health care provider(s) name(s) and contact information,
- Psychosocial/economic issues,
- Vocational profile,
- Hours incurred to date on the referral, *and*
- Amount of time spent completing the report.

Please include the phrase “index: NCM” in the bottom corner of each page to ensure your report is properly entered into L&I’s systems.

Payment policy: Mileage and travel expenses

General information

The mileage and travel expense codes exist to reimburse nurse case managers (NCMs) for costs associated with driving, attending visits with providers and workers, and performing other necessary travel duties while completing a **nurse case management** referral.

Prior authorization

Mileage

Prior authorization is not required.

Travel expenses

For State Fund, prior authorization from an ONC is required.

For Self-Insurance, prior authorization from the insurer is required.

Failure to obtain prior authorization may result in denial of bills or recoupment of payment.

Services that can be billed

Code	Description and notes	Maximum fee
1224M	**Mileage, per mile**. 1 unit = 1 mile Mileage is paid on a portal-to-portal basis (from your office to the next address related to the referral) and does not include side trips.	**State Rate**
1225M	**Travel expenses.** Prior authorization is required. NCMs may bill for case-related travel costs resulting from parking, ferries, tolls, cabs, lodging, and airfare. An itemized receipt is required.	**By Report**

Mileage and travel expenses must be incurred while in the course of performing a **nurse case management** visit (**1221M**) or billing travel/wait time (**1223M**) related to an active referral.

Documentation requirements

Mileage

For each trip, submit an invoice to the claim file that includes:

- Worker's name,
- Claim number,
- Travel date and time,
- Starting address,
- Ending address,
- Number of miles, *and*
- Reason for the trip (such as "attend appointment with worker" or "one-on-one visit with provider").

For multiple trips made on the same date of service for the same worker, you may combine all trips into a single invoice and bill, but you must clearly note each trip separately on your invoice.

Separate documentation is required for each date of service. Do not use reports or case notes as documentation for mileage billing.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your documents are properly entered into L&I's systems.

Travel expenses

Submit an itemized receipt to the claim file when billing.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your documents are properly entered into L&I's systems.

Payment policy: Nurse case management services

General information

Nurse case management referrals are intended to help injured workers navigate the sometimes challenging and complex world of medical treatment and workers' compensation claim processes. The intent of this policy is to allow nurse case managers (NCMs) flexibility as they complete goals set collaboratively with occupational nurse consultants (ONCs).

Prior authorization

Prior authorization by the worker's claim manager and L&I's ONC or self-insured employer's designee is required for all **nurse case management** referrals.

Workers must meet one or more of the following criteria to be eligible for a referral:

- Work-related injuries not managed under the Catastrophic Project,
- Medically complex condition(s),
- Significant care coordination issues, *or*
- Barriers to successful claim resolution.

Who must perform these services to qualify for payment

Only registered nurses with case management certification can be paid for **nurse case management** referrals.

Examples of case management certification include but are not limited to:

- Certification of Disability Management Specialists (CDMS)
- Commission for Case Manager Certification (CCMC or CMC)
- Certified Rehabilitation Registered Nurse (CRRN)
- Certified Occupational Health Nurse (COHN)
- Certified Occupational Health Nurse-Specialist (COHN-S)

Note: If you're unsure whether your certification is sufficient to qualify, email the provider credentialing unit at pacmail@lni.wa.gov.

NPIs for NCMs

NCMs are required to submit a National Provider Identifier (NPI) through the ProviderOne portal. NPIs are unique 10-digit numbers used for identifying specific providers. NPIs are used by medical providers nationwide.

If you do not have an NPI number, go to the National Provider Identifier Standard section of the Centers for Medicare and Medicaid Services (CMS) website.

Services that can be billed

Nurse case managers must use the following local codes to bill for case management services, including nursing assessments:

Code	Description and notes	Maximum fee
1220M	**Phone calls.** 1 unit = 6 minutes, 10 units = 1 hour Includes calls related to scheduling appointments on behalf of a worker, performing care coordination, attempting to secure a provider, participating in a team conference over the phone, or communicating with claim parties (except for a worker's attorney) regarding the worker's case. Phone calls less than 6 minutes in duration are not billable.	**$13.02**
1221M	**Visits.** 1 unit = 6 minutes, 10 units = 1 hour Includes time spent in appointments with providers, participating in face-to-face team conferences, or when visiting a worker for case-related reasons. Visits may be performed in person or virtually, at the NCM's discretion and with the permission of the provider and/or worker. Visits less than 6 minutes in duration are not billable.	**$13.02**

Code	Description and notes	Maximum fee
1222M	**Case planning.** 1 unit = 6 minutes, 10 units = 1 hour Includes time spent reviewing claim files, writing reports, completing insurer-requested forms, performing services related to finding providers not covered by **1220M**, engaging in care coordination, or researching a worker's condition or claim. Case planning activities less than 6 minutes in duration are not billable.	**$13.02**
1223M	**Travel/wait time.** 1 unit = 6 minutes, 10 units = 1 hour Includes time spent driving, waiting for appointments, or other similar circumstances. Limited to 16 hours (160 units) per referral. Travel/wait time less than 6 minutes in duration is not billable.	**$6.52**
9918M	**Online communications.** See Chapter 10: Evaluation and Management (E/M) Services for details.	

Billing units

When billing the local codes for **nurse case management** services, use whole numbers only (don't use fractions of units) rounded to the nearest whole number.

If the billable time is…	Then bill…
6 minutes - 11 minutes	1 unit
12 minutes - 17 minutes	2 units
18 minutes - 23 minutes	3 units
24 minutes - 29 minutes	4 units
30 minutes - 35 minutes	5 units
36 minutes - 41 minutes	6 units
42 minutes - 47 minutes	7 units
48 minutes - 53 minutes	8 units
54 minutes - 59 minutes	9 units
60 minutes	10 units

Payment limits

Total hours per claim

Nurse case management services are limited to **75 total hours (750 units) per claim per NCM** for any combination of the following codes:

- Phone calls (**1220M**),
- Visits (**1221M**),
- Case planning (**1222M**), *and*
- Travel/wait time (**1223M**).

The 75-hour limit includes a maximum of **16 hours (160 units) of travel/wait time** (**1223M**).

Mileage and travel expense exception

Mileage (**1224M**) and travel expenses (**1225M**) are not included in the 75-hour limit as they are not billed in time-based units.

Report creation limits

Billable time for the creation of nurse case management reports (billed using **1222M**) is restricted to:

- Up to 2 hours (20 units) per report for initial reports, *and*
- Up to 1 hour (10 units) per report for progress and closure reports.

Services that aren't covered

Non-billable services and expenses include:

- Nurse case manager training,
- Nurse case manager certification upkeep activities and/or fees,
- Supervisory visits,
- Postage, printing, and photocopying except of medical records requested by insurer and not required to support billing,
- Telephone or fax equipment,
- Clerical activity (such as faxing, mailing, or organizing documents),
- Travel time not covered and billed under **1223M** (such as travel time to post office or fax machine),
- Email communications except those covered and billed under **9918M**,
- Services less than 6 minutes in duration,
- Fees related to legal work, such as deposition and testimony, *and*
- Any other administrative costs not specifically mentioned above.

Note: Legal fees may be charged to the requesting party, but not the claim.

Links to related topics

If you're looking for more information about…	Then see…
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Care Assessment Tool	F245-377-000
Fee schedules for all healthcare services	Fee schedules on L&I's website
General Provider Billing Manual	F245-432-000
Nurse Case Management Initial Care Management Plan	F245-442-000
Nurse Case Management Progress Report	F245-439-000
Reporting rules for ancillary providers	WAC 296-20-06101

Need more help?

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Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 21: Obesity Treatment

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Body Mass Index (BMI): BMI is a number calculated from a person's weight and height and is used as an indicator of body fatness (the higher the number, the more body fat). A BMI calculator is available on the National Institute of Health website.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Severe obesity: For the purposes of providing obesity treatment services, L&I defines severe obesity as a BMI of 35 or greater (see definition of **BMI**, above).

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Payment policy: Obesity treatment

Prior authorization

Parameters for coverage

All obesity treatment services require prior authorization.

Obesity doesn't meet the definition of an industrial injury or occupational disease. **Temporary treatment** may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

To be eligible for obesity treatment services, the worker must have **severe obesity** (a **BMI** of 35 or greater).

Requesting weight reduction services

The attending provider should contact the insurer to request a weight reduction program if the worker meets **all** of the following criteria:

- Is severely obese (**BMI**>35), *and*
- Obesity is the primary condition retarding recovery from the accepted condition, *and*
- Weight reduction is necessary to undergo required surgery, participate in physical rehabilitation, or return to work.

The attending provider who believes that the worker may qualify for weight reduction services:

- Must advise the insurer of the worker's weight and level of function prior to the injury and how it has impacted rehab and recovery, *and*
- Must submit medical justification for obesity treatment, including tests, consultations, or diagnostic studies that support the request, *and*
- May request nutrition counseling with a Certified Dietician (CD) or Certified Registered Dietician Nutritionist (RDN) when it has been determined that weight reduction nutrition counseling is appropriate for the worker.

Required: Treatment plan

Prior to receiving authorization for weight reduction services, the attending provider and worker are required to develop a **treatment plan**, which must include:

- The amount of weight the worker must lose to undergo surgery, *and*
- The estimated length of time needed for the worker to lose the weight, *and*
- A diet and exercise plan, including a weight loss goal, approved by the attending provider as safe for the worker, *and*
- Specific program or other weight loss method requested, *and*
- Attending provider's plan for monitoring weight loss, *and*
- Documented weekly weigh-ins, *and*
- Counseling and education provided by trained staff *and*
- For State Fund claims, the attending provider must sign an authorization letter generated by the Claim Manager, which serves as a memorandum of understanding between the insurer, the worker, and the attending provider.

Restrictions

A weight reduction treatment plan may include participation in a group weight loss program, but this isn't a requirement.

Weight reduction services won't include requirements to buy supplements or special foods.

Authorization

The insurer authorizes obesity treatment for **up to 90 days at a time** as long as the worker does all of the following to ensure continued compliance with the obesity treatment plan:

- Loses at least 5 pounds over the course of 6 weeks of treatment *and*
- Regularly attends weekly treatment sessions *and*
- Complies with the approved weight reduction plan, *and*
- Is evaluated by the attending provider at least every 30 days, *and*
- Sends the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

The insurer will no longer authorize obesity treatment when any one of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan (if the worker chooses to continue the weight loss program for general health, it will be at his or her own expense), *or*
- Obesity no longer interferes with recovery from the accepted condition (see Link below), *or*
- The worker isn't losing the 5 pound minimum requirement over 6 weeks of treatment *or*
- The worker isn't cooperating with the approved weight reduction services plan of care.

Link: For more information about why it is prohibited to treat an unrelated condition once it no longer retards recovery of the accepted condition, see WAC 296-20-055.

Attending provider's responsibilities

Upon approval of the obesity treatment plan, the attending provider's role is to:

- Examine the worker every 30 days to monitor and document weight loss, *and*
- Notify the insurer when:
  - The worker reaches the weight loss goal, *or*
  - Obesity no longer interferes with recovery from the accepted condition, *or*
  - The worker is no longer losing the weight needed to meet the weight loss expectations and plan of care.

Who must perform these services to qualify for payment

Nutrition counseling

Only Certified Dieticians or Certified Registered Dietician Nutritionists will be paid for nutrition counseling services.

Providers practicing in a state other than Washington that are similarly certified or licensed may apply to be considered for payment.

Services that can be billed

Nutrition counseling

Certified Dieticians and Certified Registered Dietician Nutritionists may bill for authorized services using these CPT® billing codes:

- **97802** at initial visit, with a maximum of 4 units, *and if necessary*
- **97803** for re-assessment with a maximum of 4 units per visit and a maximum of 5 visits. An additional 6 visits may be authorized if the minimum weight loss is met.

For CPT® **97802** or **97803** 1 unit of equals 15 minutes. These services may occur remotely (via **telehealth**).

Expenses for an attending provider-recommended group support setting

The **worker** will be reimbursed for attending provider-recommended group support meetings when billing using the following local codes:

- **0440A** (Weight loss program, joining fee, worker reimbursement), and
- **0441A** (Weight loss program, weekly fee, worker reimbursement).

  The worker may participate in these meetings remotely (via telehealth).

Services that aren't covered

The insurer doesn't pay the group support weight loss provider directly.

The insurer doesn't pay for:

- Surgical treatments of obesity (for example, gastric stapling, or jaw wiring),
- Drugs or medications used primarily to assist in weight loss,
- Special foods (including liquid diets),
- Supplements or vitamins,
- Educational materials (such as food content guides and cookbooks),
- Food scales or bath scales, or
- Exercise programs or exercise equipment.

Payment policy: Telehealth for obesity treatment services

General information

The insurer reimburses **telehealth** at parity with in-person appointments. Obesity treatment can be performed in person or via **telehealth**.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report), *and*
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for treating conditions unrelated to the accepted condition	Washington Administrative Code (WAC) 296-20-055
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 facility services (including obesity treatment services)	Fee schedules on L&I's website
How to **calculate BMI**	National Institute of Health'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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 22: Other Services

Effective July 1, 2024

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

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Definitions

Authorized companion: A person authorized by L&I to accompany the claimant and share their accommodations for the authorized stay.

Behavioral health interventions (BHI): Brief courses of care with a focus on improving the worker's ability to return to work by addressing psychosocial barriers that impede their recovery. These psychosocial barriers are not components of a diagnosed mental health condition; instead, they are typically the direct result of an injury, although they can also arise due to other factors.

By Report: A code listed in the fee schedule as "By Report" which 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.

Client: A worker, an individual, or a group of people that uses the professional services of an interpreter. May also be known as a patient or worker.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Lodging provider: Company, person, or group offering temporary housing, such as hotels, motels, and other temporary short-term rental locations.

Meals: Restricted to breakfast, lunch and dinner. Meals may include non-alcoholic beverages only.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Sight translation: Oral rendition of text written from one language into another language, usually done in the moment by the interpreter.

State Rate: The reimbursement rate for travel reimbursement set by the Office of Financial Management (OFM) within the State of Washington.

Link: For the current State Rate, see the per diem tables on the OFM website.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Teleinterpretation: Face-to-face services delivered by a qualified interpreter through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–8S (Health/Surgical health services coordination by a Health Services Coordinator)	
Use this modifier to indicate when a second billable HSC case note on the same day, for the same claimant, under the same claim. Bill each case note on separate lines and apply this modifier to the second line.	Payment for the second case note is made at **50%** of the fee schedule level or billed charge, whichever is less.
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Activity coaching (PGAP®)

General information

The Progressive Goal Attainment Program (PGAP®) is the standardized form of activity coaching supported by L&I. It consists of an assessment followed by up to 10 weekly individual sessions. Only L&I-approved activity coaches will be paid. A list of activity coaches can be found using the Vendor Services Lookup Tool.

Services that can be billed

Billing code	Description	Unit limit	Unit Price
1400W	Activity Coaching Initial Assessment	6 units (1 unit = 15 min)	**$46.40**
1401W	Activity Coaching Reassessment	5 units per day 10 units maximum (1 unit = 15 min)	**$44.95**
1402W	Activity Coaching Intervention	4 units per day 40 units maximum (1 unit = 15 min)	**$42.78**
1160M	PGAP® Workbook/EBook/Video	1 maximum	**$113.11**

Payment policy: Activity coaching (PGAP®) telehealth

General information

The insurer reimburses **telehealth** at parity with in-person appointments. Activity coaching (PGAP®) can be performed in person, telephonically (audio only) or via **telehealth**.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Services that can be billed

The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in person",
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Activity Coaching (PGAP®) payment policy in this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Payment policy: Activity coaching telephone calls to worker legal representatives

Who must perform these services to qualify for payment

Telephone calls are payable to approved PGAP® Activity Coaches only when they personally participate in the call.

Services that can be billed

These services are payable when providing outreach, education, and facilitating services with the worker's legal representative identified in the claim file.

The insurer will pay for telephone calls if the coach leaves a detailed message for the recipient and meets all of the documentation requirements. Telephone calls are payable regardless of when the previous or next office visit occurs.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues, *or*
- Routine requests for appointments.

Requirements for billing

Use the correct local billing codes and provide documentation as described below.

If the duration of the telephone call is…	And you are a PGAP® activity coach, then bill local code…
1-10 minutes	**1725M**
11-20 minutes	**1726M**
21-30 minutes	**1727M**

Documentation requirements

Each provider must submit documentation (either in their report or in a session note) for the telephone call that includes:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The details of the call, *and*
- All medical, vocational or return to work decisions made.

Note: See Chapter 10: Evaluation and Management Services for telephonic communication with persons other than legal representatives.

Payment policy: After-hours services

Services that can be billed

CPT® codes **99050**-**99060** will be considered for separate payment in the following circumstances:

- When the provider's office isn't regularly open during the time the service is provided, *or*
- When emergency services are provided out of the office, and these services interrupt both normal office operations and other scheduled office visits.

Documentation requirements

Medical necessity and urgency of the service must be documented in the medical records and be made available to the insurer upon request.

Payment limits

Only one code for after-hours services will be paid per worker per day. A second day can't be billed for a single episode of care that carries over from one calendar day to the next.

CPT® codes **99050**-**99060** aren't payable when billed by:

- Emergency room physicians,
- Anesthesiologists/anesthetics,
- Radiologists, *or*
- Laboratory clinical staff.

Payment policy: Behavioral health interventions (BHI)

General information

The insurer covers **behavioral health interventions (BHI)** if the attending provider has reason to believe that psychosocial factors may be affecting the worker's medical treatment or medical management of an injury. Identification of psychosocial factors and recommendation of **BHI** services can be from any claim party, but the referral must come from the attending provider. This doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or treatment.

Behavioral health intervention can take many forms. Cognitive behavioral therapy and motivational interviewing are two popular evidence-based methods.

How mental health and BHI may intersect

During **behavioral health interventions**, a provider may identify apparent symptoms of a DSM-5 diagnosable mental health condition. This may be related to the industrial injury, and in such situations, it may be appropriate to ask the attending provider to refer the worker for a mental health evaluation. See Chapter 17: Mental Health Services and the authorization and reporting requirements for mental health specialists for details.

Links: For additional details about **behavioral health interventions**, see L&I's Behavioral Health resources and Psychosocial Determinants Influencing Recovery (pages 24-27).

Who must perform these services to qualify for payment

Attending providers, consultants, psychologists, and Masters Level Therapists (MLTs) may provide **BHI** services. (see Services that can be billed for details).

An MLT must have one of the following licenses:

- Licensed Marriage and Family Therapist (LMFT), *or*
- Licensed Independent Clinical Social Worker (LICSW), *or*
- Licensed Mental Health Counselor (LMHC)

Note: When MLTs are credentialed or certified in either vocational or activity coaching, they may not provide dual services for a worker. MLTs may assist the worker with finding the appropriate provider for the other service. MLTs, vocational providers, and activity coaches all require separate L&I provider account numbers. For details, see Chapter 2: Information for All Providers.

Students and student supervision

See Chapter 2: Information for All Providers for details about students and student supervision.

Services that can be billed

CPT® Code(s)	Description and notes
96156, 96158, 96159	**Individual Behavioral Health Interventions (BHI)** No prior authorization required. 16 visits per worker. Up to 8 additional visits maximum may be allowed with prior authorization if the provider has demonstrated improvement through prior treatment and established sufficient medical necessity to the insurer in advance of the additional visits. For State Fund claims, the request is submitted to the claim manager. For Self-Insured claims, the request is submitted to the self-insured employer or their third party administrator. **Note: 96159** is an add-on code and is not included in the 16-visit maximum. **96159** must be billed with **96158**.
96127	**Brief emotional/behavioral screening and risk assessment** Not billable in addition to **behavioral health intervention (BHI)** services. Completion of these types of assessments (such as 2-item GCPS, PHQ-2, and PHQ-4) are considered to be already included within **BHI** services. 3 assessments per day, per provider, with a maximum of 6 assessments per provider, per worker. This maximum is separate to the individual therapy limit noted above.
96164, 96165, 96167, 96168	**Group or Family Behavioral Health Interventions (BHI) Therapy** No prior authorization required. 16 visits max per worker. This maximum is separate from the individual therapy limit noted above.

CPT® Code(s)	Description and notes
Bundled	**Pain Management and Brain Injury Rehabilitation** **BHI** is a bundled service when performed as part of a Brain Injury Rehabilitation Program (BIRP) or a Structured, Intensive, Multidisciplinary Program (SIMP). In these cases, **BHI** isn't separately payable. See Chapter 33: Brain Injury Rehabilitation Services and Chapter 34: Chronic Pain Management for details. L&I is in the process of reviewing SIMP and Brain Injury Rehabilitation Services. Changes may be published with 30 days' notice on the Updates and Corrections webpage.

For online communications using **9918M**, see Chapter 10: Evaluation and Management Services.

Services that aren't covered

Services beyond 16 visits per worker aren't covered. Prior authorization is required for up to 8 additional visits, as described in Services that can be billed.

Treating diagnosable mental health conditions using **BHI** therapy isn't appropriate and can't be billed. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions. If a mental health condition has been accepted or denied on a claim, BHIs aren't appropriate and can't be billed. Don't perform or bill for BHIs on claims with accepted or denied mental health conditions.

The following services aren't covered as part of **BHI**:

- **90885**
- **96130-96131**
- **96136-96137**
- **96170-96171**
- **98961-98962**

96160 isn't covered for any provider.

Requirements for billing

BHI is billed using the approved physical diagnosis or diagnoses on the claim as the condition causing the need for treatment.

If you are…	Then bill…
A psychologist or a Masters Level Therapist (MLT) such as an LMFT, LICSW, or LMHC	CPT® **96156** for assessment or re-assessment. CPT® **96158** and **96159**, as appropriate, for individual **BHI** therapy. CPT® **96164**, **96165**, **96167**, and **96168**, as appropriate, for group and family **BHI** therapy. CPT® **96127** for brief emotional/behavioral screening and risk assessments.
An attending provider or a consultant	The appropriate evaluation and management service procedure code(s). Stand-alone **BHI** follows the same limits as MLTs and psychologists above.

Link: See Chapter 10: Evaluation and Management Services for additional information.

Documentation requirements

All providers must document progress and improvement in function throughout the visits.

Attending providers and consultants

Attending providers and consultants performing **BHI** as part of an Evaluation and Management (E/M) service must use the documentation guidelines noted in Chapter 10: Evaluation and Management Services to document these services.

Stand-alone **BHI** follows the same documentation requirements below.

MLTs and psychologists

MLTs and psychologists must use the following form to document **BHI** services:

- Behavioral Health Initial Assessment form.

MLTs and psychologists must document outcomes from the following when performing an initial or re-assessment for individual **BHI** therapy:

- Patient Health Questionnaire 4 (PHQ-4)
- Two-item Graded Chronic Pain Scale (2-item GCPS)

Payment policy: Behavioral health interventions (BHI) audio only

General information

The insurer covers some **behavioral health interventions (BHI)** via audio only.

Telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

Services that must be performed in person

The same in-person requirements listed in the **BHI** telehealth policy in this chapter apply to audio-only **BHI** services.

Services that can be billed

When **BHI** are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created a local codes specific to **BHI** audio-only services.

Local Code	Description and notes
9959M	**Audio-only Individual Behavioral Health Interventions (BHI)** Interventions performed by psychologists and MLTs. Must have an established relationship with the worker, regardless of how it has been established (such as in person or via telehealth).

Audio-only should only be used if **telehealth** isn't available for the worker.

Note: Telephone calls related to but not used to render individual **BHI** treatment, see Chapter 10: Evaluation and Management Services for more information on telephone calls and other case management services.

Services that aren't covered

BHI doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or treatment. See the Behavioral Health Interventions (BHI) payment policy in this chapter for more information on how mental health and BHI may intersect.

The following aren't covered via audio only:

- Establishing **BHI** care via an initial assessment (**96156**),
- Re-assessments (**96156**),
- Individual **BHI** services billed using **96158** or **96159** with modifier **–93**. These are only billable under the local code **9959M**,
- Individual **BHI** therapy performed by attending providers within the scope of an Evaluation and Management (E/M) service. E/M services can't be performed via audio only,
- Group or family **BHI** (**96164**, **96165**, **96167**, **96168**),
- Brief emotional/behavioral assessments (**96127**), *or*
- For the convenience of the provider or worker.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems aren't covered.

Documentation requirements

The same documentation requirements listed in the Behavioral Health Interventions (BHI) payment policy in this chapter apply for audio-only **BHI** services. In addition, the documentation must include the following when the service is provided via audio only:

- The date of the call, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- A notation of the worker's originating site, *and*
- Documentation of the worker's consent to participate in audio-only services.

Chart notes (including the assessment forms for **BHI** therapy in the policy above) must contain documentation that justifies the level, type and extent of services billed.

Payment limits

The same payment limits for individual therapy listed in the Behavioral Health Interventions (BHI) payment policy in this chapter apply for audio-only **BHI** services (**9959M**).

Only 1 unit of **9959M** may be billed per day, per worker.

Payment policy: Behavioral health interventions, telehealth

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

Establishing care via **telehealth** is covered.

BHI services may be payable via audio only but not using regular **BHI** CPT® codes and modifier **–93**. See the Behavioral Health, Audio Only services for additional details. Telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a patient,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report),
- Home health monitoring,
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Behavioral Health Interventions and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in the Behavioral Health Interventions policy apply regardless of how the service is rendered to the worker.

Payment policy: Best practice provider incentives

General information

The Surgical Quality Care Program (SQCP) is a quality improvement initiative. Participating musculoskeletal surgeons are incentivized for consistently implementing occupational health best practices, which are designed to improve the outcomes for workers injured on the job.

This incentive is a result of scheduled performance reporting by L&I, which calculates surgeons' adoption of best practices.

Link: For additional information, see the Surgical Quality Care Program website.

Who must perform these services to qualify for payment

Only surgeons who are part of the SQCP may bill the Best Practices Incentive – Surgical (**1086M**).

Services that can be billed

1086M is payable during the global surgical period.

The adoption level is based on last scheduled reporting.

If the provider's adoption level is…	…then the maximum surgeon incentive is:
No adoption	$0.00
Low adoption	$157.33
Medium adoption	$233.45
High adoption	$492.28
Sustaining adoption	$532.88

Documentation requirements

SQCP providers are required to provide documentation to support their adoption of occupational health best practices. For details, see the Surgical Quality Care Program website.

Payment limits

1086M is limited to once per surgeon for the first 2 surgeons participating in SQC Program for the life of the claim. **1086M** is only payable at the first visit based on who bills first, irrespective of visit date or clinic.

Services that aren't covered

ARNPs and physician assistants aren't part of SQC Program and can't bill **1086M**.

Note: The incentive of **1086M** isn't tied to the Activity Prescription Form (APF). The APF may still be appropriate for the worker and can be billed separately using **1073M**, but it isn't a required component of **1086M**.

Payment policy: Health services coordination & surgical health services coordination

General information

Health Services Coordinators (HSCs) and Surgical Health Services Coordinators (SHSCs) assist providers, workers, and employers by:

- Assisting the worker in setting and accomplishing reactivation goals,
- Coordinating and tracking clinical referrals,
- Identifying barriers by conducting the Functional Recovery Questionnaire (FRQ),
- Tracking outcomes by capturing Pain and Function Scales,
- Referring workers to community services,
- Communicating medication issues to providers,
- Supporting return-to-work when medically possible,
- Facilitating the transition between providers, *and*
- Providing ongoing monitoring of the claim and worker's progress.

HSCs and SHSC can't make adjudicative decisions. L&I claim managers and self-insured employer representatives maintain adjudicative authority.

Who must perform these services to qualify for payment

Approved HSCs and SHSCs collaborate with providers, employers, workers, and vocational counselors within L&I's provider occupational health best practice program to improve communication and reduce disability.

HSCs and SHSCs must be approved by L&I and meet minimum qualifications. HSCs and SHSCs must have an L&I provider account number for each program they participate in.

L&I will have the sole responsibility for approving HSC/SHSC provider number applications, establishing minimum qualifications, and setting and reporting performance measures.

Links: For additional details, including minimum qualifications, HSCs and SHSCs should visit our Health Services Coordination homepage.

Information about occupational health and surgical best practices incentive programs is available online.

Services that can be billed

The attending provider must be enrolled in an L&I provider best practice program so that the HSC or SHSC can bill for services.

The following activities are billable per 6-minute unit:

- Care coordination planning (identification of barriers to recovery and planning how to resolve or overcome these barriers),
- Communicating with any parties to the claim or treatment plan, including, but not limited to, workers, providers, and employers,
- Community and clinical resource identification,
- Pain/function scales completion,
- Transfer of care documentation,
- Case conferences planning, participation, and documentation, *and*
- FRQ completion.

The following activities are bundled into the payment for health services coordination or surgical health services coordination:

- Claim file review, *and*
- Preparing documentation (such as case notes).

HSC and SHSC fee schedule

Code	Description	Program	Fee
1083M	**Surgical coordination intake (SCI)** Can be billed as a stand-alone service. Max 1 per claim every 3 years.	Surgical Quality Care Program (SQCP)	**$162.83**
1087M	**COHE health services coordination** Can be billed as a stand-alone service. Can be billed with the -8S modifier. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	COHE	**$10.02**

Code	Description	Program	Fee
1088M	**Surgical Quality Care Program health services coordination** Can be billed as a stand-alone service. Can be billed with the -8S modifier. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	Surgical Quality Care Program (SQCP)	**$10.02**

Services that aren't covered

Time spent documenting the case note and reviewing of the claim file isn't covered.

In addition, the following activities aren't payable:

- Traveling to/from a work site,
- Conducting provider orientation/education,
- General administrative meeting time,
- Responding to provider questions about best practice reporting, *and*
- Discussing best practice reporting with the Medical or Program Directors.

Requirements for billing

Providers must perform L&I HSC or SHSC standard work as defined on the care coordination webpage.

When completing a second billable case note on the same day for the same claimant, bill using the -8S modifier.

Documentation requirements

Document sharing agreement must be on file with L&I.

Approved application and attestations are required by each incentive program.

HSCs and SHSCs must utilize MAVEN's standard case note and submit required fields, including care coordination plan.

Note: Failure to comply with these requirements will result in denial or recoupment of payment by the insurer.

Payment limits

Each incentive program is limited to 16 hours of HSC or SHSC billing per claim.

Payment policy: Locum tenens

Who must perform these services to qualify for payment

A locum tenens physician must provide these services.

Link: For information about requirements for who may treat, see WAC 296-20-015.

Services that aren't covered

Modifier **–Q6** isn't covered, and the insurer won't pay for services billed under another provider's account number.

Requirements for billing

The department requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered.

Payment policy: Lodging providers

General information

Lodging providers must have an active L&I provider account number to be paid for lodging and **meals**.

Note: This policy applies to **lodging providers** only. If you are a claimant who needs reimbursement, see L&I's Expense Reimbursement webpage or contact your claim manager.

How to apply for an L&I provider account number

All **lodging providers** new to L&I and ProviderOne must apply for an L&I account through ProviderOne. Follow the step-by-step guide for Facility, Agency, Organization or Institution (FAOI) to complete your ProviderOne application.

Allow 60-90 days for application review. L&I will notify you of our decision when the review is complete.

Tips for success

- In step 1, mark 'No' on the dropdown for "All Medical Providers are federally mandated to have an NPI." **Lodging providers** aren't required to have an NPI.
- Upload a copy of your IRS W9 (wet signature required) and the Provider Agreement. Incomplete applications can't be processed and will delay payments.
- If you don't add your EFT/Direct Deposit information in ProviderOne (Step 17), L&I payments will be mailed to the 'Pay to' address.

To update an existing L&I provider account (such as changing your mailing address or billing information), log into your ProviderOne account and follow the Provider Modification Guide (F248-486-000) to make your updates.

If ownership of the business changes, you need to follow the steps above to obtain a new L&I provider account.

Link: For additional assistance, contact LNIProviderOne@Lni.wa.gov.

Expected claimant conduct

Claimants are expected to follow all **lodging provider** rules and policies. It is the expectation of the insurer that no additional visitors are to be staying in the authorized room without prior approval by the insurer.

Prior authorization

Reimbursement for lodging and **meals** requires prior authorization from the insurer. The claimant is responsible for obtaining authorization for their stay and **meals**. The **lodging provider** will be provided with a hotel voucher detailing what has been authorized upon booking.

Requirements for billing

Claim Type	Claims begin with…	To bill, you can:	To submit documentation, you can:
State Fund	A, B, C, F, G, H, J, K, L, M, N, P, X, Y or Z followed by six digits, *or* Double alpha letters (example AA) followed by five digits.	Submit a Statement for Miscellaneous Bill Form (F245-072-000) via mail to the address on the form (**Don't fax bills!**), *or* Use our free Provider Express Billing system. For more information and help with direct entry billing visit L&I's Provider Express Billing webpage.	Fax it to **360-902-4567**, *or* Mail it to: Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291
Self-Insured	S, T, or W followed by six digits, *or* Double alpha letters (example SA) followed by five digits.	Use the Self Insured Employer Look Up Tool or call **360-902-6901** for more information on where to submit your bills and documentation.	

Claim Type	Claims begin with…	To bill, you can:	To submit documentation, you can:
Crime Victims	V followed by six digits, or Double alpha letters (example VA) followed by five digits.	Submit a Statement for Miscellaneous Bill Form (F800-076-000) via mail to the address on the form or fax to **360-902-5333**, *or* Use our free Provider Express Billing system. For more information and help with direct entry billing for crime victims use the Crime Victims Direct Entry Billing Guide.	Fax it to **360-902-5333**, *or* Mail it to: Crime Victims Compensation Program PO Box 44520 Olympia, WA 98504-4520

Documentation must be submitted separately from bills. Please be sure to include the claimants' name and claim number in the upper right hand corner of each page.

Once your bill is processed, you will receive a remittance advice (RA) with your payment detailing each claimant's name, claim number, dates of service and payment amount for the bills submitted.

Lodging providers have 1 year from the date the expenses are incurred to bill.

Link: For more information, see WAC 296-20-1103, WAC 296-20-125, L&I's State Fund claims Expected payment dates webpage, and the Crime Victims Current payment schedule.

For further assistance with billing state fund claims, contact Provider Hotline at PHL@Lni.wa.gov or Provider Support and Outreach at ProviderFeedback@Lni.wa.gov. For Crime Victims claims, email CrimeVictimsProgramM@Lni.wa.gov or call **1-800-762-3716**.

Services that can be billed

Lodging

Code	Description	1 unit of service equals…	Maximum fee per unit
5936M	**Lodging provider reimbursement.** Requires authorization from the insurer prior to stay.	1 night	**State Rate** + taxes and state fees

Meals

Lodging providers may bill the insurer for up to 3 **meals** per day (breakfast, lunch, and dinner) per authorized person, only when onsite **meals** are offered and provided to the claimant and any **authorized companion** as part of approved lodging. Don't bill the insurer for **meals** not provided. See the table below for billing codes.

Code	Description	1 unit of service equals…	Maximum fee per unit
5937M	Lodging provider reimbursement (Breakfast)	1 meal per authorized person	**State Rate** (includes taxes & gratuity)
5938M	Lodging provider reimbursement (Lunch)	1 meal per authorized person	**State Rate** (includes taxes & gratuity)
5939M	Lodging provider reimbursement (Dinner)	1 meal per authorized person	**State Rate** (includes taxes & gratuity)

Current **State Rates** can be found on the Office of Financial Management's (OFM) website.

The lodging provider should bill the insurer their usual and customary charges for the meal(s) provided. Reimbursement will be at the usual and customary charge or the **State Rate**, whichever is less.

Note: For information regarding medical provider reimbursement of outpatient day program meals provided to claimants in an approved brain injury rehab program (BIRP) or structured, intensive, multidisciplinary program (SIMP), see Chapter 33: Brain Injury Rehabilitation Services or Chapter 34: Chronic Pain Management.

Parking

The insurer will reimburse the **lodging provider** for parking while in approved lodging, provided there are parking accommodations that are not free to the general public. Don't bill the insurer for parking not provided to the claimant.

Code	Description	1 unit of service equals…	Maximum fee per unit
0402A	Parking (Claimant/Lodging Provider).	1 stay	**By Report**

Fees

Taxes and state fees are payable in addition to the per diem rate for lodging. Taxes and gratuity is payable within per diem for meals.

Code	Description	1 unit of service equals…	Maximum fee per unit
5933M	Lodging provider – Late cancellation fee.	1 stay	**$102.00**

Lodging providers may bill the insurer **5933M** as a cancellation fee if the insurer or the claimant fails to provide 24-hour notice of cancellation for either an entire stay or the claimant checks out before the final day of the reservation. Per WAC 296-20-010(5), the cancellation fee is only payable if the stay was arranged as part of an independent medical examination (IME) or other department-arranged appointment. The **lodging provider** must contact the claim manager for prior approval and determination of responsibility before billing the cancellation fee. When billing, the **lodging provider** must include proof of late cancellation (such as date, time and method of cancellation). **5933M** is only payable once per scheduled stay.

The **lodging provider** may bill a claimant for a non-covered late cancellation if their established policy equally applies to all guests per WAC 296-20-010(6). L&I can't provide the worker's billing address.

Extending the claimant's stay

If the stay is extended by the insurer due to a change in the claimant's medical appointments, the insurer will reimburse for the additional lodging and **meals**, provided prior authorization has been obtained. It is the claimant's responsibility to contact the claim manager (CM) to request authorization to extend the stay.

Out-of-state lodging providers

Out-of-state **lodging providers** may be reimbursed for lodging and/or **meals** provided to Washington State claimants. The rate will be based on the location of the **lodging provider** and the U.S. General Services Administration's rates for lodging and/or **meals** for that location.

Documentation requirements

Each **lodging provider** must submit documentation along with their billing to include a folio or list of charges with:

- The date span, *and*
- The claimant's name, *and*
- L&I claim number(s), *and*
- Total charge for the date span, *and*
- Number of units (nights) stayed.

If **meals** were provided to the claimant, include an itemized list of **meals** broken out into breakfast, lunch, and dinner by date and charge.

The **lodging provider** must retain itemized receipts for no less than 1 year, and provide them to the insurer along with their bill and upon request.

Link: For more information, see RCW 19.48.020.

Services that can't be billed

The insurer won't reimburse **lodging providers** for the following:

- Complimentary **meals** (such as breakfast) supplied to the general public, *or*
- Lodging and/or **meals** paid for by the claimant or their authorized companion, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Cancellations made by the **lodging provider**, *or*
- Any expenses incurred by a worker's **authorized companion** except for **meals**, *or*
- Lodging, **meals** and/or fees outside the authorized period.

The **lodging provider** may bill the claimant directly for:

- Lodging and/or **meals**, if the claimant prefers to pay themselves, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Lodging, **meals** and/or fees outside the authorized period.

Don't bill the insurer for these services. For the purposes of this policy only, **lodging providers** are reimbursed the maximum per diem rate for **meals**. It is the responsibility of the claimant to cover costs beyond this rate.

It is up to the **lodging provider**'s discretion to accept reservations for claimants without a debit card, credit card, or cash for additional charges not covered by the insurer. Please contact the claim manager (CM) as soon as possible if this situation arises.

Link: For more information, see RCW 51.04.030(2) and WAC 296-20-020.

Payment limits

L&I reserves the right to revoke a **lodging provider**'s account number should lodging conditions not meet standards (clean, safe, etc.) in accordance with state and federal laws.

Payment policy: Provider mileage

Prior authorization

Prior authorization is required for a provider to bill for mileage.

The round trip mileage must exceed 14 miles.

Note: Reimbursement for provider mileage is limited to extremely rare circumstances.

Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **$5.90** per mile.

Payment policy: Sign language interpretation

General information

Sign language interpretation includes American Sign Language (ASL), tactile interpretation, other forms of sign language utilized in the United States, and sign languages from countries other than the United States.

The rules in this policy only apply to sign language interpreters. For spoken languages, see Chapter 14: Language Access Services for Spoken Languages.

Sign language interpreters may use **teleinterpretation** in place of in-person services when deemed appropriate by the medical provider.

Who must perform these services to quality for payment

All sign language interpreters must have an L&I provider account number. To obtain an L&I provider account number, interpreters must submit credentials using the Submission of Provider Credentials for Interpreter Services form (F245-055-000).

The following certifications from the Registry of Interpreters for the Deaf (RID) are accepted:

- Certified Deaf Interpreter (CDI),
- National Interpreter Certification (NIC), *or*
- Provisional Deaf Interpreter Certification (PDIC) up to 12 months. You must submit certification from the RID following the 12 months in order to continue providing services.

Certifications from other groups or agencies will be evaluated on a case-by-case basis.

Sign language interpreters are responsible for maintaining their credentials as required by the credentialing agency or organization. If a sign language interpreter's credentials expire or are revoked for any reason, the interpreter must immediately notify L&I of the expiration or revocation. Bills for services rendered after an interpreter's credentials expire or are revoked will be denied.

Prior authorization

Sign language interpretation doesn't require prior authorization on open claims.

Prior authorization is not required for **teleinterpretation**. However, the worker, interpreter, and provider must all agree that **teleinterpretation** is appropriate and desired for the visit. The provider will note their use of telehealth and rationale in their chart, as described in the telehealth requirements found throughout the Medical Aid Rules.

Requirements for billing

Sign language interpreters must have an active L&I provider account number. Each submitted bill must be supported by an Interpretive Services Appointment Record (ISAR), regardless of modality (in person or via **teleinterpretation**). Bills submitted without an ISAR may be denied. Sign language interpreters must submit a completed ISAR (F245-056-000) with each bill. In addition to the ISAR, attach an invoice with the following details:

- The interpreter's usual and customary fee amount, *and*
- Calculations used to determine the interpreter's usual and customary fee, including whether the fee includes an appearance fee and/or blocks of time (such as a 2-hour minimum).

If **teleinterpretation** is used, do the following:

- Include a note with the invoice indicating **teleinterpretation** was used, *and*
- On the ISAR in the signature line for the "person verifying services", write "**teleinterpretation**", then include the date of the visit and the medical or vocational provider's phone number.

Services that can be billed

Sign language interpreters may bill for the following:

- Interpretation during the **initial visit**,
- Interpretation during insurer-requested independent medical examinations (IMEs),
- No-show fees for IMEs,
- Interpretation related to the completion of a reopening application (if a claim is reopened, the insurer will determine which services are reimbursable),
- Interpretation which facilitates communication between the worker or crime victim and a healthcare or vocational provider, *and*
- Interpretation for family members or guardians of minor workers.

Sign language interpretation fee schedule

Code	Description	Payment limit and authorization information	1 unit of service equals…	Maximum fee
9976M	**Sign language interpretation** provided in person or via **teleinterpretation** to facilitate communication between a worker or crime victim and a healthcare or vocational provider. Interpretation time, wait time, and form completion time should be documented and shown as part of the calculation of the interpreter's usual and customary fee.	Doesn't require prior authorization.	1 visit. Each separate appointment for an individual worker/crime victim is considered 1 visit.	**By Report**
9996M	**Interpreter IME no-show fee.** Time spent when worker doesn't attend an insurer-requested IME.	Only 1 no-show per worker per day.	1 worker no-show at an IME.	**$60.15**

Services that aren't covered

Spoken language interpretation is covered under separate policies and isn't billable using code **9976M**.

Sign language interpreters can't bill for mileage or travel time. However, if a sign language interpreter's usual and customary fee includes a block of time (such as a 2-hour minimum), that block can include time spent traveling to or from an appointment.

Sign language interpreters can't bill other **telehealth** codes such as **Q3014**, **G2010**,or **G2250**.

No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

In addition, the following aren't covered:

- Interpretation services for treatment visits that aren't covered by the insurer (see WAC 296-20-03002),
- Interpretation services provided for a denied or closed claim, except services associated with the **initial visit**, the visit for the worker's application to reopen a claim, or for a worker receiving a pension with a treatment order,
- Interpretation services provided on rejected claims for dates of service after the date of the rejection order, except for visits authorized and requested by the insurer,
- No-show fees for any service other than an insurer-requested IME,
- Personal assistance on behalf of the worker such as scheduling appointments, translating correspondence, or making phone calls,
- Interpretation services not related to the worker's communications with healthcare or vocational providers,
- Overhead costs such as phone calls, photocopying, and preparation of bills,
- Interpretation provided by family members or friends of the worker or crime victim,
- Interpretation provided by anyone under the age of 18,
- Interpretation services rendered by interpreters who are not registered in the scheduling system or registered directly with L&I to provide out-of-state services,
- Interpretation services provide by LAPs who have had their certification revoked by a certifying authority, *and*
- Any time prior to the start of an **appointment** if the worker is not present.

Interpretation for legal counsel

Payment for interpreter services for legal purposes including but not limited to attorney appointments, legal conferences, testimony at the Board of Industrial Insurance Appeals or any court, or depositions at any level is the responsibility of the attorney or other requesting party and isn't covered by the insurer.

Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers may provide services to workers and crime victims if the provider determines it is most appropriate for their facility to employ their own interpreter. The insurer doesn't reimburse interpreters who are employed by a healthcare or vocational provider or their office. The provider is responsible for ensuring the interpreter is credentialed and provides meaningful access.

Additional information

System requirements for teleinterpretation

Teleinterpretation services require a secure interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the worker, provider, and sign language interpreter.

Security and confidentiality requirements for teleinterpretation

Providers and interpreters are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

Sign language interpreters must ensure their work environment is HIPAA compliant. This means sign language interpreters must:

- Work in a private and secure location free of distractions, *and*
- Avoid disruptive public or semi-public settings, such as outside the home, at playgrounds or outdoor areas including public spaces, and at home if distractions are (or might be) present.

Sign language interpreters must ensure that visits are not recorded by any party.

Team interpretation for sessions of 2 hours or more

If a visit is scheduled for more than 2 hours, L&I recommends that 2 or more **sign language** interpreters be present in order to reduce fatigue and facilitate clear communication. All interpreters will be paid **By Report** for the visit when billing **9976M**. Group billing isn't allowed; all interpreters must have valid L&I provider account numbers and must submit their own bills.

Payment policy: Translation services

Prior authorization

Document translation services are only paid when performed at the insurer's request. Services will be authorized before the request packet is sent to the translators.

Who must perform these services to qualify for payment

Only Department of Enterprise Services (DES) contracted translators may complete document translation requests.

Sight translation is provided by LAPs during an appointment with a **client** and a healthcare or vocational provider. Document translation services are for written materials and are only payable when requested by the insurer.

Services that can be billed

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9997M	**Document translation**, at insurer request	Over $500.00 per claim will be reviewed. Authorization will be documented on translation request packet. Only payable to agencies with a Department of Enterprise Services contract.	1 page	**By Report**

Links to related topics

If you're looking for more information about…	Then see…
Activity Coaching	Activity coaching guidelines on L&I's website
Administrative rules for "Who may treat"	Washington Administrative Code (WAC) 296-20-015
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Health Services Coordination	General information Minimum requirements Best practice incentive programs Standard work
Fee schedules for all healthcare facility services	Fee schedules on L&I's website
Vendor services lookup tool	Vendor services lookup tool 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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 23: Pathology and Laboratory Services

Effective July 1, 2024

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

Table of Contents

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–91 (Repeat clinical diagnostic laboratory test)	
Use this modifier to indicate when repeat tests are performed on the same day, by the same provider. Specifically to obtain reportable test values with separate specimens, taken at different times, when it was necessary to obtain multiple results during the course of treatment.	This modifier allows payment for the repeat procedure. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Bloodborne pathogens

Prior authorization

The insurer may pay for post exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease.

Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later.

The exposed worker must submit an accident report form before the insurer can pay for testing and treatment.

Services that can be billed

Diagnostic test or procedure

For diagnostic tests and procedures, the following CPT® codes can be billed:

- **47100**,
- **81370**-**81383**
- **86689**,
- **86701**,
- **86704**-**86705**,
- **86706**,
- **86803**-**86804**,
- **87340**,
- **87390**,
- **87521**-**87522**,
- **87901**-**87902**, *and*
- **87903**-**87904**.

Testing related procedure

For testing related procedures, the following CPT® codes can be billed:

- **78725**,
- **86360**,
- **87536**,
- **80076**,
- **90371**,
- **90746** (adult), *and*
- **99202-99215**

Link: See L&I's coverage decision about bloodborne pathogens.

Treating a reaction to testing or treatment of an exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to covered treatment for a probable exposure.

Covered test protocols

Testing schedule

Testing for hepatitis B, hepatitis C, and HIV should be done:

- At the time of exposure, *and*
- At 3, 6, and 12 months post exposure.

Hepatitis B

For hepatitis B (HBV), the following test protocols are covered:

- HbsAg (hepatitis B surface antigen),
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen),
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate for post exposure prophylaxis.

Hepatitis C

For hepatitis C (HCV), the following test protocols are covered:

- Enzyme Immunoassay (EIA),
- Recombinant Immunoblot Assay (RIBA),
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services only if HCV is an accepted condition on the claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR),
- Branched chain DNA (bDNA),
- Genotyping,
- Liver biopsy.

HIV

For HIV, 2 blood tests are needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, *and*
- Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test,
- EIA test,
- Western Blot test,
- Immunofluorescent antibody.

The following tests are covered services only if HIV is an accepted condition on the claim:

- HIV antiretroviral drug resistance testing,
- Blood count, kidney, and liver function tests,
- CD4 count,
- Viral load testing.

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. Prior authorization isn't required.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count,
- Renal and hepatic chemical function tests.

Covered bloodborne pathogen treatment regimens

Chronic hepatitis B

For chronic hepatitis B (HBV):

- Interferon alfa-2b,
- Lamivudine.

Hepatitis C

For hepatitis C (HCV) – acute:

- Mono therapy,
- Combination therapy.

HIV/AIDS

For HIV/AIDS, covered services are limited to those within the most recent guidelines issued by the US Department of Health and Human Services AIDSinfo.

Link: The US Department of Health and Human Services AIDSinfo guidelines are available online.

Payment policy: COVID-19 testing and vaccinations

Prior Authorization

Prior authorization is required for COVID-19 tests and vaccinations.

Requirements for billing

U0002 is only payable to laboratories as outlined by Centers for Medicare and Medicaid Services (CMS).

High-throughput testing may only be performed and billed by pathologists.

Services that can be billed

Vaccinations and boosters

The insurer will pay for COVID-19 vaccinations and booster vaccinations when:

- The worker is immunocompromised, *and*
- The worker is residing in a nursing home, group home, skilled nursing facility, or receiving home health at home.

Lab testing

Lab testing is covered when:

- The worker is receiving treatment or preparing for an invasive procedure that has been approved under the claim, and
- The provider requires the test, and
- The insurer authorizes the test.

Examples of procedures that may require testing in advance include:

- Approved surgeries, or
- Approved dental treatments.

Workers who reside in a nursing home, group home, skilled nursing facility, or are receiving home health at home may have lab testing for COVID-19 provided prior authorization is obtained.

Link: For updates on COVID-19 coverage and code changes, see the MARFS updates and corrections online.

Services that aren’t covered

Lab testing isn’t covered when:

- The provider doesn’t require the test, *or*
- The treatment or procedure hasn’t been approved under the claim, *or*
- The claim manager hasn’t authorized the test, *or*
- The employer has requested testing as a requirement for returning to work.

At-home testing kits aren’t covered for any reason.

Payment policy: Drug screens

Services that can be billed

The insurer will pay for:

- Drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver, *and*
- Confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

The department will pay for drug screening using the following billing codes:

- For presumptive testing billing codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

Payment limits

Billing codes **80305**, **80306**, and **80307** are payable to laboratories with a CLIA certificate of waiver.

HCPCS billing codes **G0480**, **G0481**, **G0482** and **G0483** are limited to 1 unit per day per patient encounter regardless of the CLIA status of the laboratory.

Payment policy: Non-CLIA Waived Testing

Requirements for billing

Complex or moderately complex clinical pathology procedures that aren't waived under the Clinical Laboratory Improvement Act (CLIA) must be performed in laboratories that are accredited or have a categorized status under the State Department of Health or equivalent accrediting body.

Payment limits

Payment for complex and moderately complex clinical pathology procedures won't be paid to any provider that only has a CLIA certificate of waiver or the Provider Performed Microscopic Procedure certificate.

Payment policy: Panel tests

Services that can be billed

Automated multichannel tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both. Please refer to our fee schedule for code coverage and fees.

The following tests (CPT® codes) are automated multichannel tests or panels comprised solely of automated multichannel tests:

- **80047**,
- **80048**,
- **80050,**
- **80051**,
- **80053**,
- **80061**,
- **80069**,
- **80076**,
- **82040**,
- **82247**,
- **82248**,
- **82310**,
- **82374**,
- **82435**,
- **82465**,
- **82550**,
- **82565**,
- **82947**,
- **82977**,
- **83615**,
- **84075**,
- **84100**,
- **84132**,
- **84155**,
- **84295**,
- **84450**,
- **84460**,
- **84478**,
- **84520**, *and*
- **84550**.

Additional information: How to calculate payments

Automated tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient.

Calculate the payment using the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined, *then*
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day, *then*
- Any duplicated tests are denied, *then*
- The total number of remaining unduplicated automated tests is counted.

To determine the payable fee based on the total number of unduplicated automated tests performed, see the following table:

If the number of unduplicated automated tests performed is…	Then the fee is:
1 test	Lesser of the single test or **$11.32**
2 tests	**$11.32**
3-12 tests	**$13.86**
13-16 tests	**$18.52**
17-18 tests	**$20.75**
19 tests	**$24.03**
20 tests	**$24.79**
21 tests	**$25.59**
22-23 tests	**$26.35**

Panels with automated and non-automated tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they are priced based on the:

- Automated multichannel test fee based on the number of tests, added to
- Sum of the fee(s) for the individual non-automated test(s).

For example, CPT® code **80061** is comprised of 2 automated multichannel tests and 1 non-automated test. As shown in the table below, the fee for **80061** is **$22.91**.

If the CPT® 80061 component tests is:	And the number of automated tests is…	Then the maximum fee is:
Automated: CPT® **82465** and CPT® **84478**	2	Automated: **$11.32**
Non-automated: CPT® **83718**	n/a	Non-automated: **$11.59**
Maximum payment for CPT® code **80061**:		**$22.91**

Multiple panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be **limited to the total fee allowed for the unduplicated component tests.**

The table below shows how to calculate the maximum payment when:

- **Panel codes 80050**, **80061**, and **80076** are billed with
- **Individual test codes 82977**, **83615**, **84439**, and **85025**.

Test type	CPT® panel codes				Individual tests	Test count	Max fee
	80050	**80061**	**80076**				
Automated tests	**82040**, **82247**, **82310**, **82374**, **82435**, **82565**, **82947**, **84075**, **84132**, **84155**, **84295**, **84450**, **84460**, and **84520**	**82465** and **84478**	**82248** + these duplicated tests: **82040**, **82247**, **84075**, **84155**, **84450**, and **84460**		**82977** **83615**	= 19 unduplicated automated tests (Note the fee in previous table on fees for automated tests)	**$23.68**
	84443		—	—	—	—	**$23.77**
	85025 or **85027** and **85004** or **85027** and **85007** or **85027** and **85009**		—	—	—	—	**$10.99**
	83718		—	—	—	—	**$11.59**
	—		—	—	**84439**	—	**$12.76**

Test type	CPT® panel codes				Individual tests	Test count	Max fee
	80050	**80061**	**80076**				
Non-automated tests	—		—	—	**85025** or **85027** and **85004** or **85027** and **85007** or **85027** and duplicated test **85009**	—	**$10.99**
						Maximum payment:	**$93.78**

Payment policy: Repeat tests

Requirements for billing

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) **must be taken** from separate encounters. Also, the medical necessity for repeating the test(s) **must be documented** in the patient's record.

When billing, modifier **–91** must be used to identify the repeated test(s).

Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests payment policy section of this chapter (above).

Payment limits

Tests normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

Payment policy: Specimen collection and handling

Who must perform these services to qualify for payment

The fee for billed specimen collection services is payable only to the provider who actually draws the specimen.

Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.

Services that can be billed

Specimen collection

Complex vascular injection procedures, such as arterial punctures and venisections, aren't subject to this policy and will be paid with the appropriate CPT® or HCPCS billing codes.

Travel

Travel will be paid in addition to the specimen collection fee when all of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility, or homebound patient, *and*
- The provider personally draws the specimen, *and*
- The trip is solely for collecting the specimen.

Services that aren't covered

Specimen collection

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

Travel

HCPCS code **P9604** (Travel allowance, 1 way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient, prorated trip charge) isn't covered.

Requirements for billing

Specimen collection

Use HCPCS billing codes:

- **P9612**, which is for "Catheterization for collection of specimen, single patient, all places of service," *and*
- **P9615**, which is for "Catheterization for collection of specimen(s) multiple patient(s)."

For venipuncture, use CPT® billing code **36415**.

Travel

To bill for actual mileage, use HCPCS code **P9603** (1 unit equals 1 mile).

Payment limits

Specimen collection

Costs for media, labor, and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection. Payment for performing the test is separate from the specimen collection fee.

A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:

- A throat culture, *or*
- Pap smear, *or*
- A routine capillary puncture for clotting or bleeding time.

Handling

Handling and conveyance won't be paid (for example, shipping, messenger, or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are integral to the process and are bundled into the total fee for testing service.

Travel

Travel won't be paid to nursing home or skilled nursing facility staff that performs specimen collection.

If the specimen draw is incidental to other services, no travel is payable.

Payment policy: STAT lab fees

Services that can be billed

Usual laboratory services are covered under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS codes **S3600** or **S3601**.

Requirements for billing

Tests ordered STAT should be limited only to those needed to manage the patient in a true emergency situation. Also:

- The medical record must reflect the medical necessity and urgency of the service, *and*
- The laboratory report should contain the name of the provider who ordered the STAT test(s).

Payment is limited to 1 STAT charge per episode (not once per test).

Payment limits

The STAT charge will only be paid with these tests:

- HCPCS code **G0306** (Complete CBC, auto w/diff), *or*
- HCPCS code **G0307** (Complete CBC, auto), *or*
- For presumptive testing CPT® codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

…with these CPT® billing codes:								
80047	**80184**	**81003**	**82435**	**83874**	**84520**	**85049**	**86880**	**87210**
80048	**80185**	**81005**	**82550**	**83880**	**84550**	**85378**	**86900**	**87281**
80051	**80188**	**82009**	**82565**	**84100**	**84702**	**85380**	**86901**	**87327**
80069	**80192**	**82040**	**82803**	**84132**	**84704**	**85384**	**86902**	**87400**
80076	**80194**	**82150**	**82945**	**84155**	**85004**	**85396**	**86920**	**89051**
80156	**80197**	**82247**	**82947**	**84157**	**85007**	**85610**	**86921**	
80162	**80198**	**82248**	**83615**	**84295**	**85025**	**85730**	**86922**	
80164	**81000**	**82310**	**83663**	**84450**	**85027**	**86308**	**86923**	
80170	**81001**	**82330**	**83664**	**84484**	**85032**	**86367**	**86971**	
80178	**81002**	**82374**	**83735**	**84512**	**85046**	**86403**	**87205**	

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
US Department of Health and Human Services AIDS info guidelines	National Institute of Health (NIH) website
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 services (including pathology and laboratory 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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 24: Pharmacy Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

General

Average wholesale price (AWP): A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark, which is developed independently by companies that specifically monitor drug pricing.

Initial prescription drug or "first fill": Any drug prescribed for an alleged industrial injury or occupational disease during the initial visit.

Initial visit: The first visit to a healthcare provider during which the Report of Accident (Workplace Injury, Accident or Occupational Disease) is completed and the worker files a claim for workers' compensation.

Preferred drug list (PDL)

Preferred drug list (PDL): Washington preferred drug list or "WPDL" is the list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased healthcare programs.

The following terms defined related to the PDL are utilized in this chapter:

Endorsing practitioner: A practitioner who has notified the health care authority that he or she has agreed to allow therapeutic interchange.

Preferred drug: A drug selected by the appointing authority for inclusion in the Washington preferred drug list and designated for coverage by applicable state agencies or a drug selected for coverage by applicable state agencies.

Refill: The continuation of therapy with the same drug including the renewal of a previous prescription or adjustments in dosage.

Therapeutic alternative: Drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses.

Therapeutic interchange: To dispense a preferred drug in place of a prescribed nonpreferred drug within the same therapeutic class listed on the Washington preferred drug list.

Wrap around formulary: The formulary the department uses for the drug classes that aren't part of the PDL but are part of the department's allowed drug benefit.

Note: Also see WAC 296-20-01002 for the above definitions.

Payment policy: All pharmacy services

Services that can be billed

The Outpatient Drug Formulary is a list of therapeutic classes and drugs that are covered under L&I's drug benefit. L&I uses a subset of the Washington State PDL and a wrap-around formulary for the remaining drug classes. Drugs or therapeutic classes listed on the formulary do not guarantee coverage and may be subject to specific L&I policy and determination of appropriateness for the accepted conditions.

Links: The Drug Lookup tool gives current coverage status for all non-injectable drugs, as well as a list of formulary alternatives and links to coverage policies, when applicable.

The outpatient formulary can be found online.

L&I's website has a list of policies relating to drug coverage, including limitations, criteria for coverage and treatment guidelines.

Prior authorization

If a drug requires prior authorization but approval isn't obtained before filling the prescription, the drug won't be covered by the insurer.

Non-preferred drugs

To obtain authorization for non-preferred drugs:

If the **non-preferred drug** is part of the…	And you are a **PDL endorsing provider**, then:	Or you are a **non-endorsing provider**, then:
Preferred drug list	Change to the preferred drug *or* Write DAW for non-preferred drug.	Change to the preferred drug *or* For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.

If the **non-preferred drug** is part of the…	And you are a **PDL endorsing provider**, then:	Or you are a **non-endorsing provider**, then:
Wrap-around classes	Change to the preferred drug *or* For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.	Change to the preferred drug *or* For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.

Note: The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm (Pacific Time), and the toll free contact number is 1-888-443-6798.

Links: A list of Self-Insured Employers (SIEs)/TPAs is available online.

Filling prescriptions after hours

If a pharmacy receives a prescription for a non-preferred drug when authorization can't be obtained, the pharmacist may dispense an **emergency supply** of the drug by entering a value of 6 in the DAW field. An emergency supply is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

The insurer must authorize additional coverage for the non-preferred drug.

Who must perform pharmacy services to qualify for payment

The pharmacy services fee schedule applies to pharmacy providers only. It doesn't apply to medical providers administering drugs in the office. Please see Chapter 16: Medication Administration.

Requirements for writing prescriptions

Prescription forms

Orders for over the counter drugs or non-drug items must be dispensed pursuant to a prescription from an authorized prescriber for coverage consideration.

Recordkeeping for prescriptions

Records must be maintained for audit purposes for a minimum of 5 years.

Link: For more information on recordkeeping requirements, see WAC 296-20-02005.

Requirements for billing

NCPDP payer sheet, version D.0 and 5.1

For State Fund claims, L&I currently accepts versions D.0 and 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system.

POS hours:

- 6 a.m. to midnight Sunday through Friday.
- 6 a.m. to 10 p.m. on Saturday.

Link: The current version of the NCPDP payer sheet is available online.

Payment methods

Payment for drugs and medications, including all oral over the counter drugs, will be based on these pricing methods:

If the **drug type** is…	Then the **payment method** is:
Generic	AWP less 50% (+) **$4.50** professional fee
Single or multisource brand	AWP less 10% (+) **$4.50** professional fee
Brand with generic equivalent (dispense as written only)	AWP less 10% (+) **$4.50** professional fee
Compounded prescriptions	Allowed cost of ingredients (+) **$4.50** professional fee (+) **$4.00** compounding time fee (per 15 minutes)

Pricing details

Orders for over the counter non-oral drugs or nondrug items are priced on a 40% margin.

Prescription drugs and oral or topical over the counter medications are nontaxable.

No payment will be made for repackaged drugs.

Links: For more information on tax exemptions for sales of prescription drugs, see RCW 82.08.0281. For a definition of Average Wholesale Price (AWP), see WAC 296-20-01002.

Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk non-payment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, and
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

Link: For more information, see L&I's coverage decision on compound drugs.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA-approved alternatives, such as oral generic non-steroidal anti-inflammatory drugs, muscle relaxants, tricyclic antidepressants, gabapentin and topical salicylate and capsaicin creams on the Outpatient Drug Formulary.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient. No separate payment will be made for this service:

- **99070** (Supplies and materials)

Payment policy: Emergency contraceptives and pharmacist counseling

Coverage policy

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, *and*
- The ECP and/or counseling service is sought by the worker, *and*
- The claim manager authorizes payment for the ECP and/or the counseling, *and*
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Requirements for billing

Once the Coverage policy conditions listed above have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code **S9445**.

Payment policy: Endorsing practitioner and Therapeutic Interchange Program

Requirements for writing prescriptions

Endorsing practitioners may indicate “dispense as written” or DAW on a prescription for a non-preferred drug on the PDL, and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates “substitution permitted” on a prescription for a non-preferred drug on the PDL:

- The pharmacist will interchange a preferred drug for the non-preferred drug, *and*
- A notification will be sent to the prescriber.

Additional information: When therapeutic interchange won’t occur

Therapeutic interchange won’t occur if the endorsing practitioner indicates “dispense as written” on the non-preferred prescription; if the prescription is a refill of:

- An antipsychotic,
- An antidepressant,
- An antiepileptic,
- Chemotherapy,
- An antiretroviral,
- Immunosuppressive drug,
- Immunomodulator/antiviral treatment for hepatitis,
- If the pharmacy and therapeutics committee has determined therapeutic interchange isn’t clinically appropriate for a specific drug or drug class on the Washington preferred drug list, *or*
- If the prescription is for a schedule II controlled substance.

Link: For exception criteria, see L&I’s website.

Payment policy: Infusion therapy

Prior authorization

Regardless of who is providing services, prior authorization is required for:

- Home infusion nurse services, *and*
- Drugs, *and*
- Any infusion supplies.

The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Home infusion services can be authorized independently or in conjunction with home health services.

Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the workers' allowed industrial condition.

Who must perform these services to qualify for payment

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.

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 are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

Equipment and 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.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for “Home infusion services” in Chapter 11: Home Health Services for more information.

Links: For information on home infusion therapy in general, see the Home infusion services section of Chapter 11: Home Health Services.

Billing instructions for non-pharmacy providers are detailed in the Payment policy for Injectable medications in Chapter 16: Medication Administration and Injections.

Payment policy: Initial prescription drugs or "first fills" for State Fund claims

Payment methods

L&I will pay pharmacies or reimburse workers for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance.

Payment for "first fills" will be based on L&I's fee schedule including but not limited to:

- Drug utilization review (DUR) criteria, *and*
- Preferred drug list (PDL) provisions, *and*
- Supply limit, *and*
- Formulary status.

Links: For definitions of "initial prescription drug" and "initial visit," see WAC 296-20-01002.

For billing and payment for initial prescription drugs information, see WAC 296-20-17004.

Requirements for billing

Your bill must be received by L&I within 1 year of the date of service.

For non-state fund claims, pharmacies should bill the appropriate federal or self-insured employer. If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

Link: For additional information and billing instructions, visit the Pharmacy Services website, or see the Pharmacy Prescription Billing Instructions manual.

A list of Self-Insured Employers (SIEs)/TPAs is available online.

Payment limits

L&I won't pay:

- For refills of the initial prescription before the claim is accepted, *or*
- For a new prescription written after the initial visit but before the claim is accepted, *or*
- If it is a federal or self-insured claim.

Payment policy: Opioids

Coverage policy

When treating an acute injury, generic short-acting opioids will be covered without authorization for up to 6 weeks from the date of injury.

Prior authorization

Providers must seek authorization from the insurer for opioid coverage beyond the acute phase of the injury (>6 weeks). Coverage will depend on documented use of specific best practices.

For post-surgical pain medication, contact the insurer so that post-surgical opioids can be authorized.

Link: For more information, see the department's opioid policy.

Services that aren't covered

Long-acting opioids (such as OxyContin, MS ER, MS Contin, methadone, Opana ER) aren't covered for acute post-injury or post-surgical pain.

Requirements for billing

The number of days' supply of opioids prescribed for acute and subacute pain are subject to Department of Health rules.

Prescriptions for opioids from dental providers are limited to a maximum of a 3-day supply.

Prescriptions for chronic opioids are limited to a maximum of a 28-day supply.

Payment policy: Third party billing for pharmacy services

Requirements for billing

Pharmacy services billed through a third party pharmacy biller will be paid using the pharmacy fee schedule **only when**:

- A valid L&I claim exists, *and*
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I, *and*
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

Pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement, *and*
- Allow third party pharmacy billers to route bills on their behalf, *and*
- Agree to follow L&I rules, regulations and policies, *and*
- Ensure that third party pharmacy billers use L&I's online POS system, *and*
- Review and resolve all online POS system edits using a licensed pharmacist during the dispensing episode.

Payment limits

Third party pharmacy billers **can't resolve** POS edits.

Additional information: Third Party Pharmacy Supplemental Agreements

Third Party Pharmacy Supplemental Agreements can be obtained either:

- Through the third party pharmacy biller, *or*
- By contacting L&I's Provider Credentialing (see contact info, below).

The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I.

Links: To contact L&I's Provider Credentialing, email PACMail@Lni.Wa.gov.

For more information about these agreements, refer to the Pharmacy Services website.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for pharmacy services	Washington Administrative Code (WAC) 296-20-01002 WAC 296-20-17004 WAC 296-20-03014(6) WAC 296-20-1102 WAC 296-20-02005
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Drug coverage policies	Drug coverage policies on L&I's website
PDL	Drug Formulary
Endorsing the PDL	Online registration through the Health Care Authority WA State Endorsing Practitioner Customer Service: 1-877-255-4637
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
NCPDP payer sheet current version	NCPDP payer sheet
Opioid Policy	L&I's opioid policy
Outpatient formulary	Outpatient formulary
PDL Hotline	Open Monday through Friday, 8:00 am to 5:00 pm (Pacific Time): 1-888-443-6798
Therapeutic Interchange Program exception criteria	Therapeutic Interchange Program

If you're looking for more information about…	Then see…
Third Party Pharmacy Supplemental Agreements	Third party pharmacy supplemental agreement form

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 25: Physical Medicine Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Body regions: For osteopathic manipulation treatment (OMT) services, body regions are defined as:

- Head,
- Cervical,
- Thoracic,
- Lumbar,
- Sacral,
- Pelvic,
- Rib cage,
- Abdomen and viscera regions,
- Lower and upper extremities.

Bundled codes: Procedure codes that aren't separately payable because they are accounted for and included in the payment of other procedure codes and services.

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

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Student: As part of their clinical training, a student is a person who is enrolled and participating in an accredited educational program to become a physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, or speech language pathologist. Interim permitted students who have already completed their training but aren't yet licensed can also act as students for the purposes of this chapter.

Supervising therapist: a licensed physical or occupational therapist with an active L&I provider account number who has entered into a private agreement with a student and their educational institution to provide hands on training, instruction and supervision during the clinical phase of the student's course work. A supervising therapist can only supervise a student within their discipline. They are responsible for all services provided to injured workers by their students. Physical therapist assistants and occupational therapy assistants must not act as supervising therapists.

Student supervision: The supervising therapist can only supervise one student at a time and won't treat another patient while supervising the student. The supervising therapist must maintain line-of-sight and be physically present for the entire session during treatment to provide direct instruction to the student, oversee the work, and adjust the treatment or change other patient-centered tasks while the service is being provided. Services may be single patient (student therapist to patient) or group services (student therapist to a group of patients).

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–1S (Surgical dressings for home use)	
Use this modifier to indicate when surgical dressing supplies are dispensed for home use. Bill with the appropriate HCPCS code for each dressing item.	Services with this modifier may be bundled, based on who is providing the dressings. If not bundled, payment is made at **100%** of the fee schedule level or billed charge, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–52 (Reduced services)	
Use this modifier to indicate when a service is reduced. Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. **Note**: Don't use this modifier for ASC services that require anesthesia. Instead, refer to modifiers **–73** and **–74**.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier **–95** (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

General information: Physical medicine CPT® codes billing guidance

Timed codes

Some physical medicine services (such as ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as “timed services” and are billed using “timed codes”.

Timed codes can be identified in CPT® by the code description. The definition will include words such as “each 15 minutes.”

Providers must document in the daily medical record (chart note and flow sheet, if used):

- The amount of time spent for each time based service performed, *and*
- The specific interventions or techniques performed, including:
    - Frequency and intensity (if appropriate), *and*
    - Intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (for example, flow sheets, chart notes, and reports).

The number of units you can bill is:

- Determined by the time spent performing each “timed service,” and
- Constrained by the total minutes spent performing these services on a given day.

To obtain the number of units of timed services that can be billed, add together the minutes spent performing each individual timed service and reference the table below.

Note: Documenting a range of time (for example, 8-22 minutes) for a timed service isn‘t acceptable. Providers must document the actual amount of minutes spent performing the service.

If the combined duration of all time based services **is at least**…	**and less than**…	**Then**, **when billing**, **report**:
8 minutes	23 minutes	1 unit
23 minutes	38 minutes	2 units
38 minutes	53 minutes	3 units
53 minutes	68 minutes	4 units
68 minutes	83 minutes	5 units
83 minutes	98 minutes	6 units
98 minutes	113 minutes	7 units
113 minutes	128 minutes	8 units

How to use this table

The above schedule of times doesn‘t imply that any of the first 8 minutes should be excluded from the total count. The total time of active treatment counted includes all direct treatment time. Use the table above to determine the maximum number of units that can be billed for the date of service. Begin with applying the maximum number of units to the service performed for the longest amount of time and continue assigning units to each timed service, based on length of service performed, until the maximum number of billable units has been reached. Pre and post delivery services (for example, warmup and cool down) aren’t counted in determining the treatment time. See what time counts towards timed codes. Detailed examples can be found below. below.

Examples of how to document and bill timed codes

The following examples show how the required elements of interventions can be documented and billed. These examples aren’t reflective of a complete medical record for the patient’s visit. The other elements of reporting (SOAPER) **also must be documented**.

Example 1

Procedural intervention	Specific intervention	Purpose	Treatment time
Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm2 ; 100% right forearm	Increase joint mobility	**8 minutes**
Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation	**8 minutes**
Therapeutic exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping	**10 minutes**
			Total treatment time = **26 minutes**
			Total timed intervention (treatment time spent performing timed services) = **18 minutes**

At 18 total minutes of timed services, a maximum of **1 unit** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97022** (Whirlpool) x 1 unit.

Example 2

Procedural intervention	Specific intervention	Purpose	Treatment time
Therapeutic exercise	Left leg straight leg raises x 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting	**20 minutes**
Neuromuscular reeducation	1 leg stance, 45 seconds left; 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead	**15 minutes**
Cold pack	Applied to left knee	Decrease edema	**10 minutes**
			Total treatment time = **45 minutes**
			Total timed intervention (treatment time spent performing timed services) = **35 minutes**

At 35 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97112** (Neuromuscular reeducation) x 1 unit.

Note: Cold packs are considered bundled.

Example 3

Procedural intervention	Specific intervention	Purpose	Treatment time
Manual therapy	Soft tissue mobilization to medial knee - right	Mobilization	**12 minutes**
Therapeutic exercises	Prone hip extension 10 reps x 2 sets; hamstring stretch 3 reps x 2 sets; right single leg stance 3 sets of 5 for 15 second hold	Increase strength and range of motion	**25 minutes**
Cold pack	Applied to right knee	Decrease edema	**10 minutes**
			Total treatment time = **47 minutes**
			Total timed intervention (treatment time spent performing timed services) = **37 minutes**

At 37 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercise was performed for 25 minutes, which equates to 2 units of timed service. Because no additional units of timed services are allowed, manual therapy isn't billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units

Note: Cold packs are considered bundled.

Example 4

Procedural intervention	Specific intervention	Purpose	Treatment time
Neuromuscular re-education	Squats on Airex Balance pad 10 reps x 2 sets; tandem balance on Bosu Ball 2 sets 30 seconds each; single stance on Airex Balance pad 2 sets x 5	Normalize balance for reaching overhead	**8 minutes**
Manual therapy	Soft tissue mobilization to medial knee - right	Mobilization	**12 minutes**
Therapeutic exercises	Hamstring curls 10 reps x 2 sets; short arc quads 3 sets of 5 for 5 second hold; straight leg raise 3 sets of 5 for 15 second hold	Increase strength and range of motion	**25 minutes**
Cold pack	Applied to right knee	Decrease edema	**10 minutes**
			Total treatment time = **55 minutes**
			Total timed intervention (treatment time spent performing timed services) = **45 minutes**

At 45 minutes of timed services, a maximum of **3 units** of timed services can billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercises was performed for 25 minutes, which equates to 2 units of timed service. The balance of billable units is 1 unit. Since more time was spent performing manual therapy, assign the last unit of service to manual therapy. Because no additional units of timed services are allowed, neuromuscular re-education isn't billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units
- **97140** (Manual therapy) x 1 unit

Note: Cold packs are considered bundled.

Prohibited pairs: Which CPT® codes can't be billed together

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to 1 or more patients **for the same time period**:

- Any 2 codes for "therapeutic procedures" requiring direct, one-on-one patient contact, *or*
- Any 2 codes for modalities requiring "constant attendance" and direct, one-on-one patient contact, *or*
- Any 2 codes requiring either constant attendance or direct, one-on-one patient contact, as described above (for example, any CPT® codes for a therapeutic procedure with any attended modality CPT® code), *or*
- Any code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy code (for example, CPT® code **97150** with CPT® code **97112**), *or*
- Any code for modalities requiring constant attendance with the group therapy code (for example, CPT® code **97150** with CPT® code **97035**), *or*
- An untimed evaluation or reevaluation code with any other timed or untimed codes, including constant attendance modalities, therapeutic procedures, and group therapy.

Determining what time counts towards timed codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services:

- Pre and post delivery services (for example, warmup and cool down services) aren't counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist is working directly with the patient to deliver treatment services.
- The patient should already be in the treatment area (for example, on the treatment table or mat or in the gym) and prepared to begin treatment.
- The time counted is the time the patient is treated.
- The time the patient spends not being treated because of the need for toileting or resting can't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

Link: More information about L&I's PT, OT, and massage therapy policies is available online.

Payment policy: Electrical stimulators (including TENS)

Prior authorization

These HCPCS codes for **electrical stimulator devices for home use or surgical implantation** require prior authorization:

HCPCS code	Brief description	Additional coverage information
E0745	Neuromuscular stimulator for shock	This code is covered for **muscle denervation only**.
E0747	Electrical osteogenesis stimulator, not spine	—
E0748	Electrical osteogenesis stimulator, spinal	—
E0749	Electrical osteogenesis stimulator, implanted	Authorization for this code is subject to **utilization review**.
E0760	Osteogenesis ultrasound, stimulator	This code is covered for appendicular skeleton only (**not the spine**).
E0764	Functional neuromuscular stimulator	—

Services that can be billed

For electrical stimulator devices **used in the office setting**:

- When it is within the provider's scope of practice, a provider may bill professional services for application of stimulators with the CPT® physical medicine codes.
- Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code **1044M**, which is limited to 6 units per claim. See Payment Limits in the Physical Therapy and Occupational Therapy payment policy for more information.

For electrical stimulator devices and supplies for **home use or surgical implantation**, HCPCS code **E0761** (Nonthermal electromagnetic device) is covered.

Services that aren't covered

For **use outside of medically supervised facility settings** (including home use and purchase or rental of durable medical equipment and supplies), the insurer doesn't cover:

- Transcutaneous Electrical Nerve Stimulators (TENS) units and supplies, or
- Interferential current therapy (IFC) devices, or
- Percutaneous neuromodulation therapy (PNT) devices.

Note: Use of these therapies will continue to be covered during hospitalization and in clinical settings.

For **home use or surgical implantation devices and supplies**, these HCPCS codes aren't covered:

- **E0731** (Conductive garment for TENS),
- **E0740** (Incontinence treatment system),
- **E0744** (Neuromuscular stimulator for scoliosis),
- **E0755** (Electronic salivary reflex stimulator),
- **E0762** (Transcutaneous electrical joint stimulation device system),
- **E0765** (Nerve stimulator for treatment of nausea and vomiting),
- **E0769** (Electric wound treatment device, not otherwise classified),
- **L8680** (Implantable neurostimulator electrode),
- **S8130** (Interferential current stimulator, 2 channel),
- **S8131** (Interferential current stimulator, 4 channel).

For home use or in medically supervised facility settings, CPT® code **64555** (Peripheral nerve neurostimulator) isn't covered.

Treatment of chronic migraine or chronic tension-type headache with trigger point injections or massage therapy isn't a covered benefit. See L&I's coverage decision for more details.

Payment limits

These supplies are **bundled and not payable separately for office use**:

- **A4365** (Adhesive remover wipes),
- **A4455** (Adhesive remover per ounce),
- **A4556** (Electrodes, pair),
- **A4557** (Lead wires, pair),
- **A4558** (Conductive paste or gel),
- **A5120** (Skin barrier wipes box per 50),
- **A6250** (Skin seal protect moisturizer).

Additional information: Why the insurer doesn't cover TENS

Based on extensive review of the evidence for use of Electrical Nerve Stimulation (ENS), including TENS, interferential current therapy (IFC), and percutaneous neuromodulation therapy (PNT) as treatment for acute and chronic pain, the State Health Technology Clinical Committee (HTCC) determined that ENS isn't covered for use outside of medically-supervised facilities. Purchase or rental of TENS, IFC, or PNT equipment is also not covered. For more details, see the HTCC decision paper.

Payment policy: Functional capacity evaluations (FCEs)

Prior authorization

Requires prior authorization by the claim manager.

Who must perform these services to qualify for payment

To qualify for payment, a functional capacity evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

Services that can be billed

Each provider must bill independently for their time using the following codes:

Code	Description and notes	Maximum fee
1045M	**Standard Functional Capacity Evaluation** Must involve a minimum of 3 hours of face-to-face time between all evaluating providers.	**$286.11** per unit 1 unit = 1 hour Maximum 6 units total per worker, not to exceed **$858.33**.
1098M	**Supplemental Functional Capacity Evaluation** When the Standard FCE evaluation exceeds 6 hours. This may be appropriate when: • Additional testing is required for multiple jobs with opposite physical demands, • Performing a whole body and upper extremity focused evaluation, *or* • Symptomatic neurological conditions impact testing tolerance and/or When follow up testing is indicated after completion of a Standard FCE in order for an Attending Provider or vocational provider to facilitate return to work decisions.	**$143.58** per unit 1 unit = 1 hour Maximum 6 units total per worker.

Example of billing for multiple provider evaluations

Scenario: The Occupational Therapist (OT) performed 3.2 hours of direct time and the Physical Therapist (PT) performed 0.8 hours of direct time for a Standard FCE.

OT:	3 units of **1045M**
PT:	1 unit of **1045M**
Total units billed: 4 Maximum fee of **$858.33**	

Services that can't be billed

Supplemental Functional Capacity Evaluations using **1098M** can't be billed for:

- Additional time to perform missed or forgotten testing, *or*
- Updates to an incomplete or conflicting report.

Requirements for billing

When billing, 1 hour of direct face-to-face time = 1 unit of service. If the service is 31 minutes or greater, this meets the requirement for 1 unit of service. Time accumulates regardless of the number of days the FCE is performed over.

Eligible providers must bill their usual and customary fee for Standard Functional Capacity Evaluations and Supplemental Functional Capacity Evaluations.

When the service is performed by multiple providers, each provider must bill for the amount of direct one-on-one time they spent performing the evaluation using their individual provider account number.

These services include testing, a summary of findings, and a full evaluation report. **All summary reports must be submitted within 10 days of when the service was performed and full evaluation reports within 30 days**.

Note: Ensure all documentation is submitted before billing or the bill may be denied.

Documentation requirements

Documentation for any Functional Capacity Evaluation (FCE) must include:

- Date of service,
- Worker name,
- Claim number,
- Duration of the evaluation. Each provider must also separately document the amount of direct one-on-one time they spent performing the service,
- Signature and date of all evaluators, *and*
- Completed Capacity Form (F245-434-000) for State Fund (in-state claims) or an equivalent summary of findings for out-of-state and self-insured claims.

For a Standard FCE, documentation must also include L&I's minimum evaluation elements.

For a Supplemental FCE, documentation must also include a list of all tests performed and all results of those tests.

Note: Although the department allows joint chart notes for FCEs, the documentation must clearly note who performed each service and how much time each individual provider spent providing the direct one-on-one evaluation. Include this information on both the summary of findings and full evaluation report.

Payment limits

Standard and Supplemental Functional Capacity Evaluations (**1045M** and **1098M**) may only be billed once per worker every 30 days.

Multiple providers

If the FCE is performed by multiple providers, the maximum fee applies once per worker regardless of how many providers and/or provider types performed the evaluation.

Multiple claims

If the worker has multiple claims, the maximum fee for the FCE applies once per worker regardless of the number of claims a worker may have. When this occurs, therapists must appropriately bill the portion of the visit related to each accepted claim. For more information, refer to the physical medicine split billing policy in this chapter.

Multiple days

Standard and Supplemental Functional Capacity Evaluations may be provided over multiple days. If this occurs, the bill must span the dates of service to reflect the actual dates in which the evaluation was performed. For example, if the evaluation began on January 1 and was completed on January 3, the bill will reflect the “From Date of Service” as January 1 and the “To Date of Service” as January 3.

Payment policy: Low level laser therapy (LLLT)

General information

The department has rescinded its coverage decision for low level laser therapy. This modality was previously not covered, but is now a covered benefit when performed in a clinical setting.

Services that can be billed

Physical therapy (PT) providers, occupational therapy (OT) providers, board-qualified physiatrists, and board-certified physiatrists may bill for low level laser therapy using **S8948**.

Non-board certified/qualified physical medicine attending providers may bill for low level laser therapy using local code **1044M**. See PT/OT payment limits for details on billing **1044M**.

Services that aren’t covered

Low level laser therapy must be performed in a clinical setting. Low level laser therapy isn’t covered outside of a clinical setting or for home use.

CPT® code **97037** isn’t covered.

HCPCS code **0552T** isn’t covered.

Payment limits

When billed using **S8948**, low level laser therapy is **bundled** with other physical medicine services billed with CPT® codes **97010** through **97799**. The insurer won’t pay an additional fee for low level laser therapy billed using **S8948**.

Providers who bill for physical medicine services using **1044M** may only perform low level laser therapy in conjunction with other physical medicine services billable using this code. The insurer won’t pay an additional fee for low level laser therapy beyond the maximum fee for **1044M**. See PT/OT payment limits for details on billing **1044M**.

Payment policy: Massage therapy

Who must perform these services to qualify for payment

To qualify for payment, massage therapy services must be performed by:

- A licensed massage therapist, *or*
- Other covered provider whose scope of practice includes massage techniques.

Prior authorization

Services provided by massage therapists require prior authorization after the 6th visit.

Link: For more information, see WAC 296-23-250.

Services that can be billed

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. The insurer won't pay massage therapists for additional codes.

Requirements for billing

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. Massage therapists must also use CPT® code **97124** for evaluations and reevaluations.

Massage therapists must bill their usual and customary fee and document the duration of the massage therapy treatment. Bill the appropriate units based on the length of time the service is rendered, per CPT® code description.

Documentation must support the units of service billed. Document the amount of time spent performing evaluations and reevaluations as well as the treatment. See additional information about Timed Codes for more details.

Note: Documenting a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

Progress Reports

Massage therapists are required to submit progress reports following every 6 treatment visits or after each month, whichever comes first. Documentation must include:

- an outline of the proposed treatment program, *and*
- the expected restoration goals, *and*
- the expected length of treatment, *and*
- substantiation of improvement during the most recent treatment period, such as:
    - signs of treatment progress (e.g. range of motion, sitting and standing tolerance, reduction in medication), *and/or*
    - self-reported functional outcome measures from L&I's recommended scales (such as the patient-specific functional scale).

Failure to submit a progress report after each set of 6 visits or 1 month of treatment, whichever comes first, may result in denial of bills and/or revocation of authorization for treatment.

Link: See pages 16-20 in Options for Documenting Functional Improvement in Conservative Care for more examples of appropriate functional scales.

Payment limits

Massage therapy is paid at **75%** of the maximum daily rate for PT and OT services.

The daily maximum allowable amount is **$110.98**.

Link: For more information, see WAC 296-23-250.

Services that aren't covered

These items are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices,
- Lubricants (for example, oils, lotions, emollients).

Massage therapy isn't a covered benefit for the treatment of chronic migraine or chronic tension-type headaches. See L&I's coverage decision for more details.

Payment policy: Osteopathic manipulative treatment (OMT)

Who must perform these services to qualify for payment

Only osteopathic (DO) or naturopathic (ND) physicians may bill for OMT services.

Requirements for billing

OMT includes pre and post service work (for example, cursory history and palpatory examination). The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of an E/M service in addition to OMT services on the same day.

An E/M office visit service may be billed in conjunction with OMT **only when all** of the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included with OMT, *and*
- The worker's record contains documentation supporting the level of E/M service billed, *and*
- The E/M service is billed using modifier **–25**. Without modifier **–25**, the insurer won't pay for E/M codes billed on the same day as OMT.

Payment limits

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level, type and extent of service billed. The MARFS and CPT® book describes the requirements that must be present for each level of service.

For OMT services, only 1 CPT® code is payable per treatment. This is because CPT® codes for body regions ascend in value to accommodate the additional body regions involved.

Example: If 3 **body regions** were manipulated, 1 unit of the correct CPT® code would be payable.

Services that aren't covered

CPT® code **97140** isn't covered for osteopathic physicians.

Payment policy: Physical therapy (PT) and occupational therapy (OT)

Prior authorization

No authorization is needed for less than 12 visits as long as the claim is open and allowed, treatment is for accepted conditions on the claim, and referral is from the attending provider per WAC 296-20-030.

Prior authorization is required for additional visits beyond the initial 12.

To request authorization for visits 13-24, first submit to the insurer:

- A referral for ongoing treatment,
- The initial evaluation report,
- Daily chart notes, *and*
- All progress reports.

Then fax the Physical/Occupational/Massage Therapy Provider Hotline Service Authorization Request form to the department for consideration.

For beyond 24 visits, request Utilization Review from Comagine Health directly.

Physical and Occupational therapy visits accumulate separately. Visit counts are the total number of visits per claim. New referrals, restart of therapy following surgery, or treatment of new conditions on the same claim don't start again at visit 1.

Learn more about these services on the L&I PT/OT webpage.

Who must perform these services to qualify for payment

PT services

PT services must be ordered by the worker's attending provider. The services must be provided by a:

- Licensed physical therapist, or
- Physical therapist assistant serving under a licensed physical therapist's direction, or
- Athletic trainer serving under a licensed physical therapist's direction.

For details about students performing PT services, see the Therapy student and therapy assistant payment policy.

Link: For more information, see WAC 296-23-220.

OT services

OT services must be ordered by the worker's attending provider. The services must be provided by a:

- Licensed occupational therapist, *or*
- Occupational therapy assistant serving under a licensed occupational therapist's direction.

For details about students performing OT services, see the Therapy student and therapy assistant payment policy.

Link: For more information, see WAC 296-23-230.

Physical medicine services

Physical medicine services may be provided by:

- Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation (physiatry), *or*
- Attending doctors who aren't board qualified or certified in physical medicine and rehabilitation. For non-board certified/qualified providers, special payment policies apply. (See Requirements for billing and Payment limits, below.)

Link: For more information, see WAC 296-21-290.

Who won't be paid for physical medicine services

- Exercise physiologists, *or*
- Kinesiologists, *or*
- Physical or occupational therapist aides, *or*
- Gym supervisors.

Services that can be billed

Physical and occupational therapists must use the CPT® and HCPCS codes **97161**-**97168** and **97010**-**97799**. These therapists must bill the HCPCS codes for miscellaneous materials and supplies. Some of these CPT® and HCPCS codes aren't covered or are **bundled**.

Only physiatrists and physical therapists may bill **95992**.

If more than 1 patient is treated at the same time, use CPT® code **97150**.

To report the evaluation by the physician or therapist to establish a plan of care, use CPT® codes **97161** through **97163** or **97165** through **97167**.

To revise the plan of care by reporting the evaluation of a patient who has been under a plan of care established by the physician or therapist, use CPT® codes **97164** and **97168**. CPT® codes **97164** and **97168** have no limit on how often they can be billed.

Link: For information on Surgical dressings dispensed for home use, see Chapter 28: Supplies, Materials, and Bundled Services.

For billing requirements for prosthetic and orthotic devices, see Chapter 9: Durable Medical Equipment (DME).

For information on billing for telephone calls, online communications, or team conferences, see Chapter 10: Evaluation and Management Services.

Other physical medicine services

Board qualified and board certified physiatrists bill for services using:

- CPT® codes **97010** through **97799**.

Non-board certified/qualified physical medicine attending providers may perform physical medicine modalities and procedures described in CPT® codes **97010**-**97750** if their scopes of practice and training permit it, but for these services they must bill local code **1044M**. The description for local code **1044M** is "AP provider physical medicine services".

See Payment limits for local code 1044M.

Services that aren't covered

Physical medicine CPT® codes **97033** and **97169**-**97172** aren't covered.

Cryotherapy devices with or without compression for home use aren't covered benefits. These devices used in a clinical setting are considered bundled into existing physical medicine services. For more information, please review L&I's coverage decision for Cryotherapy Devices With or Without Compression.

Non-vasopneumatic compression devices without a cryotherapy component aren't a covered benefit. For more information, please review L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component.

Documentation requirements

Progress reports are due following 12 treatment visits or every 1 month, whichever comes first. PT and OTs treating workers covered by state-fund must use the Physical Medicine Progress Report form F245-453-000 and submit this to the insurer and the attending provider. Progress reports must include functional outcome measures.

Providers can use the Documenting Functional Improvement resource to help prepare these progress reports.

Link: For more information, see WAC 296-23-220 and WAC 296-23-230.

When billing 1044M

Chart notes must contain documentation that supports billing of local code **1044M**. Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (for example, flow sheets, chart notes, and reports).

Payment limits

Physical medicine services

Non-board certified/qualified physical medicine providers won't be paid for CPT® codes **97010**-**97799**.

Local code **1044M** is limited to 6 units per claim, except when the attending provider practices in a remote location where no licensed physical or occupational therapist, or physiatrist is available. After 6 units, the patient must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment. Only 1 unit is payable per visit, regardless of the length of time the treatment is provided.

Bundled items or services

Bundled items or services include, but aren't limited to:

- Activity supplies used in work hardening, such as leather and wood,
- Application of hot or cold packs (this includes all forms of cryotherapy with or without compression. **97016** may not be used to bill for these services),
- Electrodes and gel,
- Exercise balls,
- Ice packs, ice caps, and ice collars,
- Thera-tape,
- Wound dressing materials used during an office visit and/or PT treatment.

Link: For complete lists of bundled codes, see Chapter 28: Supplies, Materials and Bundled Services.

Daily maximum for services

The daily maximum allowable fee for PT and OT services is **$147.97**.

If PT, OT, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type. See Massage Therapy Payment Limits above for the daily maximum fee that applies to massage therapists.

When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **97161**-**97168**, **95992**, and **97010**-**97799**.

If the worker receives PT or OT services for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

The daily maximum allowable fee doesn't apply to:

- Speech language pathologists, *or*
- Physicians board certified in Physical Medicine, *or*
- Functional capacity evaluations (FCEs), *or*
- Work rehabilitation services, *or*
- Work evaluations, *or*
- Job modification/pre-job accommodation consultation services.

Links: For more information, see WAC 296-23-220 and WAC 296-23-230.

Split Billing – Unrelated Conditions

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition:

- Therapists must appropriately bill L&I only for the portion of the visit related to the accepted claim.
- Treatment rendered for a condition unrelated to an accepted L&I claim may be billed to a secondary insurer, if appropriate.

Only send chart notes related to the accepted L&I claim to the insurer, since the employer doesn't have the right to see information about an unrelated condition.

Link: Chapter 2: Information for All Providers

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to 1 unit per day. Refer to CPT® and HCPCS to determine whether a service is timed or untimed.

Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Payment policy: Powered traction therapy

Services that can be billed

Powered traction devices are covered as a physical medicine modality.

Payment limits

The insurer won't pay any additional cost when powered devices are used.

Additional information: Why the insurer won't pay additional cost when powered devices are used

Published literature hasn't substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. See L&I's coverage decision for more details.

Payment policy: Telehealth for physical medicine services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See Services that must be performed in person for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

The insurer prefers that Physical Therapy and Occupational Therapy services be provided in person.

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*

- A worker files a reopening application, *or*
- When the service to be performed requires a hands-on component.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Speech, physical, and occupational therapists as well as their assistants and students may conduct services via **telehealth**.

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site and store and forward fees are covered, when applicable.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Store and Forward

G2250 is covered for worker-to-provider store and forward of images or video recordings, including interpretation and follow up when it isn't part of a visit. Follow up must occur within 24 business hours of receiving the images or video recordings, and follow up may occur by phone, **telehealth**, or in-person, and isn't separately payable. **G2250** isn't covered if the worker provides the image or video recording as follow-up from a visit in the prior 7 days, nor if the provider's evaluation of the image or video recording leads to a visit within the next 24 hours or soonest available appointment. Providers are required to document their interpretation of the image or video recording. Chart notes that don't state the interpretation by the provider are insufficient.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only evaluation or treatment billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report),
- Home health monitoring,
- **G2010** for store and forward (use **G2250**),
- Work rehabilitation, *and*
- Functional Capacity Evaluations (FCE).

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the distant site provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker. In addition to those limits, physical medicine services conducted by **telehealth** are limited to 2 hours per day per worker, regardless of the service provided.

Payment policy: Therapy student and therapy assistant student supervision

General information

L&I has adopted a modified version of Medicare Part B's policy on physical and occupational therapy students. L&I considers supervised students an extension of their supervising therapist.

Please refer to the Definitions section at the beginning of this chapter to see the definitions of **student**, **supervising therapist**, and **student supervision**.

Services that can be billed

Supervising therapists will direct all care provided by their **students** to injured workers and must bill for these services under the **supervising therapist's** provider account number.

All billed services must meet the billing and documentation requirements applicable to the **supervising therapist**.

Services that aren't covered

Any service provided by a **student** that is unsupervised (including in skilled nursing facilities) isn't payable.

Students can't independently:

- Make clinical judgements,
- Provide evaluations, re-evaluations or assessments, *or*
- Develop, manage, or deliver services.

Any service that deviates from the requirements outlined in Medical Aid Rules and Fee Schedules isn't covered.

Two-way audio/visual direct supervision isn't covered (modifier –**FR**).

Requirements for billing

All documentation must identify both the **supervising therapist** and the **student** and must be signed by both parties.

All services must be billed by the **supervising therapist** under their provider account number and must comply with supervision and documentation requirements for physical medicine services.

Supervising therapist responsibilities

Supervising therapists are responsible for all services provided to injured workers by their **students**. This means they must:

- Ensure that the work **students** perform does not exceed their education, skills, and abilities, nor the **supervising therapist's** scope of practice,
- Provide **supervision** to the **student** regardless of what setting care is being rendered in (clinic, hospital, or skilled nursing facility),
- Ensure that all documentation requirements are met,
- Co-sign all documentation for services rendered to injured workers, *and*
- Keep a copy of the private agreement between them and the **student** in accordance with WAC 296-20-02005.

Payment limits

Students won't be directly reimbursed for their time or services.

Link: For more information, see WAC 296-20-015.

Payment policy: Work rehabilitation (WR)

General information

Work rehabilitation (WR) is a special individualized program to assist a worker in meeting the demands of a specific job using progressive exercise, work simulation tasks, and education. It consists of two intensity levels: work rehabilitation – conditioning (WRC) and work rehabilitation – hardening (WRH).

For general program details, visit our work rehabilitation website. You can also find specific information about the program in our work rehabilitation standards.

Prior authorization

Initial evaluations

Initial evaluations for work rehabilitation program eligibility don't require prior authorization.

Work rehabilitation programs

Work rehabilitation programs require a referral from the worker's attending provider (AP). For State Fund, utilization review (UR) is also required. For self-insurance, the self-insured employer's representative grants prior authorization.

Additional services

Providing separate and additional rehabilitation outpatient physical therapy (PT) or occupational therapy (OT) services to the worker while they're participating in a work rehabilitation program is atypical and must be authorized by the insurer. Documentation must support the clinical necessity of additional services.

Program extensions

The insurer must authorize program extensions in advance. Extensions are based on documentation of progress and the worker's ability to benefit from a program extension. Program extensions apply to **1023M**, **1024M**, **97545**, and **97546**. To request a program extension:

- For State Fund claims, use Secure Access Washington (SAW) to email therapy@lni.wa.gov. Don't send confidential worker information via email. You may also fax the Therapy Services unit at **360-902-5035**.
- For self-insured claims, contact the self-insured employer or their representative.

Who must perform these services to qualify for payment

Only L&I-approved work rehabilitation providers will be paid for work rehabilitation services.

Link: Visit our website to apply to become a work rehabilitation provider.

Services that can be billed

Work rehabilitation evaluation

Service	Code	Details
WR evaluation	**1001M**	Work rehabilitation – evaluation and plan of care. 1 unit = 1 hour Doesn't require prior authorization.

Work rehabilitation – conditioning (WRC)

Service	Code	Details
WRC program, first 2 hours	**1023M**	Work rehabilitation – conditioning, first 2 hours of treatment per day. 1 unit = 1 hour Requires prior authorization. A minimum of 2 hours of treatment per day (2 units) is required; see below for details.
WRC program, each additional hour	**1024M**	Work rehabilitation – conditioning, each additional hour of treatment per day. 1 unit = 1 hour Requires prior authorization.

Work rehabilitation – hardening (WRH)

Service	Code	Details
WRH program, first 2 hours	**97545**	Work rehabilitation – hardening, first 2 hours of treatment per day. 1 unit = 2 hours Requires prior authorization. A minimum of 2 hours of treatment per day (1 unit) is required; see below for details.
WRH program, each additional hour	**97546**	Work rehabilitation – hardening, each additional hour of treatment per day. 1 unit = 1 hour Requires prior authorization.

Requirements for billing

Billing portions of an hour using 1001M

Each unit of **1001M** equals 1 hour of evaluation services. If the worker completes less than 38 minutes of a given hour, round down to the nearest whole number unit. If the worker completes 38 or more minutes, round up to the nearest whole number unit. For example, if the worker is evaluated for 2 hours and 47 minutes, the provider would bill 3 units of **1001M**.

Billing less than 2 hours of treatment in a day with CPT® 97545 or 1023M

Services provided for less than 2 hours of total program time (2 units of **1023M** or 1 unit of **97545**) on any day don't meet the work rehabilitation program standards and can't be billed using WR codes. The services must be billed with other physical medicine codes. Failure to complete at least 2 hours of a WR program should be counted as an absence when determining worker compliance with the program.

Billing portions of an additional hour using CPT® 97546 or 1024M

After completion of the requirements for **97545** or **1023M**, each additional hour is billed using **97546** or local code **1024M**. A full hour is billed as 1 unit at your usual and customary rate, but if the worker completes less than 38 minutes of an hour of program work:

- The charged amount for the incomplete hour of service must be prorated, *and*
- You must bill a line of **97546** or **1024M** at the prorated rate with modifier **–52**.

Example: Worker completes 4 hours and 25 minutes of WRH treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged amount	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	**–52**	42% of usual and customary (completed 25 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the number of hours they perform. Both PT and OT providers may bill for the same date of service.

Examples of billing for services in multidisciplinary programs

Example 1: Standard treatment (Work rehab – Hardening)

Scenario: The OT performs treatment that lasts 4 hours. On the same day, the worker is also treated by the PT for 2 hours.

The providers could bill for the 6 hours of services in the following ways:

Billing example A		
PT:	1 unit **97545**	2 hours
OT:	4 units **97546**	4 hours
Total hours billed:		**6 hours**

Billing example B		
PT:	2 units **97546**	2 hours
OT:	1 unit **97545** + 2 units **97546**	2 hours 2 hours
Total hours billed:		**6 hours**

Example 2: Standard treatment (Work rehab – Conditioning)

Scenario: The OT performs 1 hour of treatment for a worker. A PT provider then performs an additional 2 hours of treatment.

The providers could bill for the 3 hours of services in the following ways:

Billing example A		
PT:	1 unit **1023M** + 1 unit **1024M**	1 hour 1 hour
OT:	1 unit **1023M**	1 hour
Total hours billed:		**3 hours**

Billing example B		
PT:	2 units **1023M**	2 hours
OT:	1 unit **1024M**	1 hour
Total hours billed:		**3 hours**

Example 3: Reduced treatment hours (Work rehab – Conditioning)

Scenario: The PT performs 2 hours of treatment with the worker. The OT performs an additional 1.5 hours of treatment.

The providers could bill for the 3.5 hours of services in the following ways:

Billing example A		
PT:	2 units **1023M**	2 hours
OT:	1 unit **1024M**	1 hour
	1 unit **1024M** (prorated) with modifier **–52**	30 minutes
Total hours billed:		**3.5 hours**

Billing example B		
PT:	1 unit **1023M**	1 hour
	1 unit **1024M**	1 hour
OT:	1 unit **1023M**	1 hour
	1 unit **1024M** (prorated) with modifier **–52**	30 minutes
Total hours billed:		**3.5 hours**

Documentation requirements

Documentation for both WRC and WRH must meet the requirements listed in the Work Rehabilitation Standards. For additional documentation requirements, see Chapter 2: Information for All Providers.

A report is required when billing **1001M**. This report must include any results of tests or measurements performed and/or document the worker's progress through the program.

If a worker fails to complete the minimum treatment duration for WRC or WRH on a given day, this should be documented as an absence from the program for that day. Services will need to be billed using other CPT® physical medicine codes; billing and documentation requirements for these codes can be found in other sections of this chapter.

Payment limits

Providers may only bill for the time that services are performed while the worker is in the clinic participating in their program. The reimbursement rates of CPT® **97545** and **97546** and local codes **1023M** and **1024M** account for the fact that some work occurs outside of the time the worker is present (for example, creation of the initial plan of care or documentation of worker progress).

Code	Description	Daily unit limit	Program unit limit	Notes
1001M	Evaluation	None	6 units	
1023M	Work conditioning, first 2 hours	2 units (2 hours)	80 units	Minimum of 2 units per day.
1024M	Work conditioning, each additional hour	2 units (2 hours)	80 units	Add-on code. Won't be paid as a standalone procedure. Must be billed with **1023M**.
97545	Work hardening program, first 2 hours	1 unit (2 hours)	40 units	Minimum of 1 unit per day.
97546	Work hardening, each additional hour	6 units (6 hours)	240 units	Add-on code. Won't be paid as a standalone procedure. Must be billed with CPT® **97545**.

Payment policy: Wound care

Prior authorization

Electrical stimulation for chronic wounds

If electrical stimulation for chronic wounds is requested for use on an outpatient basis, prior authorization is required using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy, *and*
- In addition to electrical stimulation, standard wound care must continue.

Note: In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Services that can be billed

Debridement

Therapists must bill CPT® **97597**, **97598**, or **97602** when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies sent home with the patient for self-care may be billed with HCPCS codes appended with local modifier **–1S**.

Link: For more information on billing with local modifier **–1S**, see the Surgical dressings for home use section (Requirements for billing and Payment limits) of Chapter 28: Supplies, Materials, and Bundled Services.

Electrical stimulation for chronic wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is covered for the following chronic wound indications:

- Stage III and IV pressure ulcers,
- Arterial ulcers,
- Diabetic ulcers,
- Venous stasis ulcers.

To bill for electrical stimulation for chronic wounds, use HCPCS code **G0281**.

Link: For more information, see the Electrical Stimulation for Chronic Wounds coverage decision.

Requirements for billing

Debridement

When performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool), therapists must bill CPT® **97597**, **97598**, or **97602**.

Electrical stimulation for chronic wounds

In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Payment limits

Debridement

Wound dressings and supplies used in the office are bundled and aren't payable separately.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules (Washington state laws) for physical medicine	Washington Administrative Code (WAC) 296-21-290
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Electrical stimulation for chronic wounds	Electrical stimulation for chronic wounds
Fee schedules for all healthcare professional services	Fee schedules on L&I's website
Keeping of records	WAC 296-20-02005
Massage therapy administrative rules	WAC 296-23-250
Occupational therapy administrative rules	WAC 296-23-230
Physical Medicine Progress Report Form	Form F245-453-000
Physical therapy administrative rules	WAC 296-23-220
Powered traction devices for intervertebral decompression	Powered traction devices for intervertebral decompression
L&I's general policies and rules for **PT**, **OT**, and **massage therapy**	PT, OT, and massage rules on L&I's website
Payment policies for **supplies, materials, and bundled services**	Chapter 28: Supplies, Materials, and Bundled Services
TENS coverage decision	State Health Technology Clinical Committee (HTCC) published TENS decision
Work rehabilitation program at L&I	**Program reviewer**: therapy@lni.wa.gov Work hardening rules on L&I's website

L&I's coverage decision for Chronic Migraine and Chronic Tension-type Headaches	Chronic migraine headache coverage decision
L&I's coverage decision for low level laser therapy	Low level laser therapy coverage decision
L&I's coverage decision for Cryotherapy Devices with or without Compression	Cryotherapy devices with or without compression coverage decision
L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component	Non-vasopneumatic devices without cryotherapy component coverage decision

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 26: Radiology Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Full spine study: A full spine study is a radiologic exam of the entire spine: anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic, and lumbar spine).

Incomplete full spine study: An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–7N (Services in conjunction with an IME)	
Use this modifier to indicate when services are requested for an IME.	This modifier doesn't affect payment but is necessary to describe the service performed.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.

Use	Payment Information
–TC (Technical component)	
Use this modifier to indicate when only the technical component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's technical component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the technical component (**–TC**) rate for each specific radiology service performed or billed charge, whichever is less.
–UN (2 patients served)	
Use this modifier to indicate when 2 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UP (3 patients served)	
Use this modifier to indicate when 3 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UQ (4 patients served)	
Use this modifier to indicate when 4 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UR (5 patients served)	
Use this modifier to indicate when 5 patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–US (6 or more patients served)	
Use this modifier to indicate when 6 or more patients are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Contrast material

Requirements for billing

Use the following HCPCS codes to bill for contrast material:

- Low osmolar contrast material (LOCM): **Q9951**, **Q9965** - **Q9967**
- High contrast osmolar material (HOCM): **Q9958** - **Q9964**

For LOCM and HOCM, bill 1 unit per ml.

Providers may use either HOCM or LOCM. The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart.

Separate payment will be made for contrast material for imaging studies.

Payment limits

HCPCS codes for LOCM and HOCM are paid at a flat rate based on the AWP per ml.

Payment policy: Noninvasive cardiac imaging for coronary artery disease

Services that can be billed

Certain noninvasive cardiac imaging technologies for coronary artery disease are covered with conditions. See L&I's coverage decision for details.

Cardiac magnetic resonance angiography (CMRA)

Cardiac magnetic resonance angiography is covered with conditions. See L&I's coverage decision for details.

Payment policy: Nuclear medicine

Payment limits

The standard multiple surgery policy applies to the following radiology CPT® codes for nuclear medicine services:

- **78306**,
- **78802**, *and*
- **78803**.

The multiple procedure reduction will be applied when these codes are billed:

- With other codes subject to the standard multiple surgery policy, *and*
- For the same patient:
    - On the same day by the same provider, *or*
    - By more than 1 provider of the same specialty in the same group practice.

Link: For more information about the standard multiple surgery payment policy, refer to Chapter 29: Surgery Services.

Payment policy: Portable radiology services

Services that can be billed

Portable X-ray services are only payable when furnished in the worker's place of residence, which includes:

- The workers' home,
- Assisted living, adult family, or boarding home, *and*
- Skilled Nursing Facilities.

All tests must be performed under the general supervision of a physician and are limited to:

- Skeletal films involving:
  - Extremities,
  - Pelvis,
  - Vertebral column, *or*
  - Skull,
- Chest or abdominal films that don't involve the use of contrast media, *and*
- Diagnostic mammograms.

HCPCS codes for transportation of portable X-ray equipment **R0070** (1 patient) or **R0075** (multiple patients), and set up of portable X-ray equipment **Q0092**, may be paid in addition to the appropriate CPT® radiology code(s).

Link: For more information on service and documentation requirements for X-rays see the X-ray services policy in this chapter.

Services that aren't covered

Don't bill **R0070**, **R0075**, **R0076** or **Q0092** for portable X-rays or EKGs performed in a location other than the workers' place of residence.

There are no codes for transportation of portable ultrasound equipment. This is not a covered benefit.

Payment limits

Set up of portable X-ray equipment using HCPCS code **Q0092** is only payable when performed in a workers' place of residence and not for routine purposes or the convenience of the provider or worker. Refer to the HCPCS code book for more details.

Use HCPCS code **R0070** or **R0075** only when the equipment was not stored in the location the service was performed. **R0075** will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table. For transportation of portable X-ray services:

If the **number of patients served** is…	Then the appropriate **HCPCS code** to bill is…	Along with this billing code **modifier**:	The **maximum fee**, effective July 1, 2023 is:
1	**R0070**	—	**$200.47**
2	**R0075**	**–UN**	**$100.24**
3	**R0075**	**–UP**	**$66.83**
4	**R0075**	**–UQ**	**$50.10**
5	**R0075**	**–UR**	**$40.09**
6 or more	**R0075**	**–US**	**$32.92**

Payment policy: Radiology consultation services

General Information

Radiology consultation services include requests for secondary interpretive opinions by a different radiologist. These are performed at the request of the attending provider or insurer.

Who must perform these services to qualify for payment

Second opinion radiology consultations must be performed by:

- Radiologists, *or*
- Approved chiropractic radiology consultants who are a Diplomat of the American Chiropractic Board of Radiology.

Services that aren't covered

CPT® code **76140** isn't covered.

Requirements for billing

Providers who perform radiology consultation services must bill the specific radiology CPT® code with modifier **–26**.

Documentation requirements

Attending providers who request second opinion radiology consultation 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?

The consulting provider must follow all reporting and documentation requirements for the professional service, including justification of the level, type, and extent of the services billed. See the reporting requirements policy in this chapter for more details.

Documentation such as "X-rays are negative" or "X-rays are normal" don't fulfill the reporting requirements and the insurer **won't pay** for the professional component in these circumstances.

Payment limits

Payment for radiology consultation services will be made at the professional component (modifier **–26**) rate for each specific radiology service performed.

Payment policy: Radiology reporting requirements

General information

Global radiology services include both a **technical component** (producing the study) and a **professional component** (interpreting the imaging study). When billing for radiology services globally the reporting requirements for both the technical (**–TC**) and professional (**–26**) components must be met.

Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

Documentation requirements

Technical component (modifier–TC)

Any provider who is billing separately for the technical component (**–TC**) is required to submit documentation to the insurer. The documentation must include the following:

- Patient name, age, sex, *and*
- Date of study, *and*
- Name of ordering provider, *and*
- The name of the location of where the service was performed (e.g., the provider's office, a hospital, etc.), *and*
- The anatomic location of the procedure, including laterality as applicable, and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- A description of any contrast media or pharmaceutical used, including route of administration and dose, when applicable, *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable).

Note: The technical component (modifier **—TC**) must be billed by the provider who actually performed the service or the provider who supervised the technician performing the service. Copying an imaging report into the chart note isn't enough to support billing the technical component (modifier **—TC**) or a global imaging service.

Professional component (modifier –26)

Documentation (charting of justification, findings, diagnoses, and test result integration) for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier **–26** or as part of the global service.

Any provider who produces and interprets their own imaging studies, and any radiologist who over reads imaging studies must produce a report of radiology findings to bill for the professional component.

The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, *and*
- Date of study, *and*
- The anatomic location of the procedure, including laterality as applicable, and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- Brief sentence summarizing history and/or reason for the study, such as:
    - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
    - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description or listing of, imaging findings:
    - Advanced imaging reports should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
    - Radiology reports on plain films of skeletal structures should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*
    - Radiology reports on chest plain films should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*
- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the report. For example:
    - For a skeletal plain film report with imaging findings of normal osseous density and contours and no joint abnormalities, the impression could be: "No evidence of fracture, dislocation, or gross osseous pathology."

- For a skeletal plain film report with imaging findings of reduced bone density and thinned cortices, the impression could be: “Osteoporosis, compatible with the patient’s age.”
- For a chest report with imaging findings of vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be: “Emphysema.”

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes. Examples include:

- “Imaging rules out fracture, so rehab can proceed.”
- “Flexion/extension plain films indicate hypermobility at C5/C6, and spinal manipulation will avoid that region.”

Requirements for billing

Use HCPCS modifiers **–RT** (right side) and **–LT** (left side) with CPT® codes **70010**-**79999** to identify duplicate procedures performed on opposite sides of the body.

Use modifier **–TC** when only the **technical component** of a radiology service is performed.

Use modifier **–26** when only the **professional component** of a radiology service is performed.

Do not use modifier **–TC** or **–26** for **global radiology services** when both the technical and professional components are performed by the same provider.

Note: All professional interpretations (modifier –**26**) must be billed by the provider who actually performed the service.

Payment limits

Documentation such as "X-rays are negative" or "X-rays are normal" don’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances.

The technical component (**–TC**) or global radiology service is only payable once per study.

The professional component (**–26**) may be billed, under their individual provider number, only when a provider has performed an independent interpretation of the study.

Payment policy: Ultrasound

Who must perform these services to qualify for payment

Providers and/or technicians performing ultrasounds must have the appropriate licensure per Department of Health requirements.

Facilities billing for the technical component must have an L&I provider ID and provide documentation to support the service rendered.

Providers performing the professional component (modifier **–26**) must bill under their individual L&I provider ID.

Services that can be billed

Refer to the fee schedule for codes covered by the insurer. Refer to CPT® for additional guidelines.

The use of ultrasounds for treatment such as guided needle placement and for quick assessments in emergency departments are separately reimbursable services.

Services that aren’t covered

Office-based ultrasounds

Office based ultrasounds used for evaluation and diagnosis are considered bundled into the evaluation and management (E/M) service and can’t be billed separately. No separate payment will be made for these services.

Transportation of portable equipment

HCPCS codes **Q0092**, **R0070** and **R0075** aren’t payable for mobile ultrasound services.

Requirements for billing

Technical component (modifier –TC)

The following documentation is required for the technical component of an ultrasound study:

- Patient name, age, sex,
- Date and time of ultrasound exam,
- Name of ordering provider,
- The anatomic location of the procedure, including laterality as applicable, and type of procedure,

- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Specific ultrasound examination performed, including all joint spaces and structures examined,
- Output display standard (thermal index & mechanical),
- Address where study took place (for mobile providers).

Professional component (modifier –26)

The following documentation is required for the professional component of an ultrasound study:

- Patient's name, age, sex, *and*
- Date of study, *and*
- Indication for exam, *and*
- Relevant clinical information, including indication for the exam and/or relevant ICD-10 code, *and*
- The specific method use for endocavity techniques, if performed, *and*
- A description of the studies and/or procedures performed, *and*
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable, *and*
- Anatomic measurements, if taken, *and*
- A description of examination findings, *and*
- Impression, conclusion, or summary statement, *and*
- Specific diagnosis, if appropriate, *and*
- Recommendation for follow-up, if necessary, *and*
- Accounting of any failure to include standard views or other necessary components, if necessary, *and*
- Statement of comparison of relevant imaging studies if reviewed, *and*
- Details on any provider-to-provider communication if there are delays which may have an adverse effect on the patient's outcome.

Payment limits

CPT® codes **76881** and **76882** are limited to **1 unit per extremity per day.**

76881 and **76882** aren't payable in conjunction with each other when performed on the same anatomical region on the same date of service. Refer to CPT® for additional restrictions and requirements.

Payment policy: X-ray services

General Information

Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

Custody

X-rays must be retained for 10 years.

Links: For more information on custody requirements, see WAC 296-20-121 and WAC 296-23-140.

Services that can be billed

Incomplete full spine studies

- For a single view bill **72081**.
- For 2 or 3 views bill **72082**.
- For 4 or 5 views bill **72083**.
- For 6 or more views bill **72084**.

Link: See definitions of **fully spine study** and **incomplete full spine study** at the beginning of this chapter.

Services that aren't covered

Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion X-ray, vertebral motion analysis and spinal X-ray digitization.

DSV isn't a covered benefit. Don't bill CPT® code **76496** for these services.

Link: For more information about DSV, see the L&I's coverage decision.

Requirements for billing

Most radiology services include both a technical component (**–TC**) for producing the study and a professional component (**–26**) for interpreting the imaging study. When billing for radiology services, the reporting requirements for the component(s) billed must be met. See the Radiology reporting requirements policy in this chapter for more information.

Attending provider documentation

Attending providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain, or
- PA and lateral chest films to determine cause for dyspnea.

Repeat X-rays

Per WAC 296-20-121, the insurer won't pay for excessive or unnecessary X-rays.

Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Billing code modifiers –RT and –LT

HCPCS modifiers **–RT** (right side) and **–LT** (left side) don't affect payment. Use these modifiers with CPT® radiology codes **70010**-**79999** to identify duplicate procedures performed on opposite sides of the body.

Payment limits

Number of views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exam of the cervical spine are payable as outlined below:

If the **CPT® code** is…	Then it is **payable**:
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or 5 cervical views
72052	Once, 6 or more views, regardless of the number of cervical views it takes to complete the series

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for X-ray custody requirements	Washington Administrative Code (WAC) 296-20-121 WAC 296-23-140
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Payment policies for **physical medicine services**	Chapter 25: Physical Medicine Services
Payment policies for **surgery**	Chapter 29: Surgical Services
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Dynamic Spinal Visualization coverage decision	Dynamic spinal visualization coverage decision

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 27: Reports and Forms

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

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.

Job analysis (JA): A JA is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Job description: A job description is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

Job offer: A job offer is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis.

Link: For more information about Job offers, see RCW 51.32.090(4).

Payment policy: Copies of medical records

Who must perform these services to qualify for payment

Only providers who have provided healthcare services to the worker may bill HCPCS codes **S9981** or **S9982**.

Services that can be billed

All records to support billed services must be provided to the department, at no cost. If the insurer requests records from a healthcare provider that are for services not provided under the claim, the insurer will pay for the requested records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury.

Providers may bill for CDs/DVDs of medical records requested by the insurer using HCPCS code **S9981**. Payment will be made per complete record requested by the insurer.

Providers may bill for paper copies of medical records requested by the insurer using HCPCS code **S9982**. Payment will be made per copied page.

L&I may request records before, during, or after the delivery of services to ensure workers receive proper and necessary medical care and to ensure provider compliance with the department's MARFS. The provider must submit the requested records within 30 calendar days from receipt of the request. Failure to do so may result in denial or recoupment of bill payment(s).

Note: Requested records must be submitted within 30 days. Failure to submit records in a timely manner may result in denial or recoupment of bills.

Payment limits

Payment for **S9981** and **S9982** includes all costs, including postage.

S9981 and **S9982** aren't payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Links: For more information, see WAC 296-20-02005 and WAC 296-20-02010.

Payment policy: Reports and forms

Services that can be billed

To bill for special reports or forms required by the insurer, providers should use the CPT® or local billing codes listed in the following table. The fees listed in the table below include postage for sending documents to the insurer. When required, the insurer will send special reports and forms.

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
60-Day Report	**99080**	**$52.91**	60-day reports aren't required unless requested by the insurer or if legible comprehensive chart notes are submitted and include the required information per WAC 296-20-06101. Not payable for records required to support billing, for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Limit of 1 per provider per 60 days per claim.

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Special Report	**99080**	**$52.91**	**Must be requested by insurer or vocational counselor.** **For reports created by provider.** Not payable for records or reports required to support billing or for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Don't use this code for forms or reports with assigned codes. Limit of 1 per day. Bill this code for starring a work history form.
Department of Transportation (DOT) Medical Examination & Certification	**99499**	**By Report**	Bill this code for completing a DOT Medical Examination and completing the certification form. Must be conducted by a licensed "medical examiner" with the Federal Motor Carrier Safety Administration (FMCSA). MD, DO, ND, ARNP, PA eligible in Washington State. Prior authorization required.
AP Final Report	**1026M**	**$30.40**	**May be requested by insurer or submitted by attending provider.** Payable only to attending provider. Limit of 1 per day.
Loss of Earning Power (LEP)	**1027M**	**$23.01**	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per day.

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Report of Accident (ROA) Workplace Injury, or Occupational Disease for State Fund claims	**1040M**		MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim. For additional information, see Chapter 2: Information for All Providers.
		$46.01	**When submitted within 5 business days after first treatment date**
		$36.01	**When submitted 6-8 business days after first treatment date**
		$26.01	**When submitted 9 or more business days after first treatment date**

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Provider's Initial Report (PIR) – for Self Insured claims	**1040M**		MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim. For additional information, see Chapter 2: Information for All Providers.
		$46.01	**When submitted within 5 business days after first treatment date**
		$36.01	**When submitted 6-8 business days after first treatment date**
		$26.01	**When submitted 9 or more business days after first treatment date**
Application to Reopen Claim	**1041M**	**$59.81**	MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.
Occupational Disease History Report	**1055M**	**$223.21**	**Must be requested by insurer.** Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s). Visit our website for instructions.

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Attending Provider Review of Independent Medical Exam (IME)	**1063M**	**$46.02**	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per request. Attending provider must respond to request using letter sent by claim manager. Not payable to a Master Level Therapist (MLT).
Attending Provider Supplemental Review of IME with written report	**1065M**	**$34.51**	**Must be requested by insurer.** Payable only to attending provider when submitting a separate report of IME review. This report expands upon the provider's response from **1063M**. Limit of 1 per request.
Provider Review of Video Materials with written report	**1066M**	**By Report**	**Must be requested by insurer.** Payable once per provider per day. Report must include actual time spent reviewing the video materials. Report should include findings and observations gained from the review. Won't pay in addition to CPT® code **99080** or local codes **1104M** or **1198M**.

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Activity Prescription Form (APF)	**1073M**	**$59.81**	Submit the Activity Prescription Form (APF): • With the Report of Accident when there are work related physical restrictions, or • When documenting a change in the worker's medical status or capacities. Limits: A provider may submit up to 6 APFs per worker within the first 60 days of the initial visit date and then up to 4 times per 60 days thereafter. The insurer will review and allow or deny any APFs submitted over the limits listed above. Providers will be paid for properly completed APFs requested by the insurer, even if the provider has already reached the limit by self-generating prior APFs. Payable once per provider per worker per day.

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
AP response to VRC/Employer request about RTW	**1074M**	**$36.81**	Responding to written communication with vocational counselors (VRC) and employers such as questionnaires. 1074M is not payable when performed on the same day as a team conference, office visit, or online communication with a VRC or employer. Not payable to an MLT. A copy of the written communication must be sent to the insurer.
Subacute Opioid Request Form for Pain without Documentation	**1076M**	**$36.81**	Use this code if submitting the Subacute Opioid Request Form but results of screenings are documented in the medical record. (See WAC 296-20-03056.)
Subacute Opioid Request Form for Pain with Documentation	**1077M**	**$69.03**	Use this code if submitting the Subacute Opioid Request Form and copies of all required screenings (urine drug test, risk of opioid addiction, current or former substance use disorder and depression, if indicated) for increased reimbursement. (See WAC 296-20-03056.)
Opioid Request Form for Chronic Pain	**1078M**	**$36.81**	Use this code if submitting the Chronic Opioid Request Form. (See WAC 296-20-03057 and WAC 296-20-03058.)

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Review of FCE Reports/ Summary	**1097M**	**$59.81**	**Must be requested by insurer, employer, or vocational counselor.** Payable to attending provider, IME examiner, or consultant. Limit of 1 per day per provider per worker.

Links: More information on reports and forms listed above is provided in WAC 296-20-06101.

Many L&I forms are available and can be downloaded from L&I's website and all reports and forms may be requested from the Provider Hotline by emailing PHL@Lni.wa.gov.

Documentation requirements

In addition to the specific reports and forms requirements in the above table, documentation must include all required elements including, the name and title of the person completing it (either with a hand-written signature, signature stamp or electronic signature) and the date it was completed. These are required even if the report or form doesn't have a field for it.

Links: See Chapter 2: Information for All Providers and WAC 296-20-01002 for more information on documentation requirements.

Payment policy: Review of job offers, job analyses, and job descriptions

General information

Job analyses and **job descriptions** identify the physical requirements of a potential job for the worker.

The medical provider reviews the **JA** or **job description(s)** to determine whether the worker can perform a specific job. The provider sends the insurer (and vocational provider, if applicable) a response, indicating whether the worker can perform the job described, or if not, specifying any modifications needed to enable the worker to do the job.

Prior authorization

Prior authorization is required for review of **JAs** and **job descriptions** if not requested by the insurer, employer or vocational provider.

Who must perform these services to qualify for payment

Job offers

Attending providers must review the physical requirements documented in the **job description** or **job analysis** of any **job offer** submitted by the employer of record and determine whether the worker can perform that job.

JAs and job descriptions

Attending providers, Independent Medical Examiners and consulting physicians will be paid for review of **job descriptions** or **JAs**.

A **job description/JA** review may be performed at the request of the employer, the insurer, Vocational Rehabilitation Counselor (VRC), or Third Party Administrator (TPA). This service is payable in addition to other services performed on the same day. The provider must send a copy of each **job description** or **job analysis** reviewed to the insurer.

Note: Reviews requested by other persons (for example, attorneys or workers) won't be paid.

Services that can be billed

If the **report or form** is…	Then bill using this **CPT® or local billing code**:	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Review of Job Descriptions or JA	**1038M**	**$59.81**	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Isn't payable to IME examiner on the same day as the IME is performed. Not payable to MLTs.
Review of Job Descriptions or JA, each additional review	**1028M**	**$44.87**	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. For IME examiners on day of exam: may be billed for each additional **JA** after the first 2. For IME examiners after the day of exam: may be billed for each additional **JA** after the initial (initial is billed using **1038M**).

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for information in this chapter	Washington Administrative Code (WAC) 296-20-06101 WAC 296-20-097 WAC 296-20-03056 WAC 296-20-03057 WAC 296-20-03058
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 services	Fee schedules on L&I's website
L&I forms	L&I's website
Penalty for failing to file accident reports and assist injured workers	RCW 51.48.060
Penalty adjusted for inflation	RCW 51.48.095

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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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 28: Supplies, Materials, and Bundled Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Acquisition cost: The acquisition cost equals:

- Wholesale cost of the item, *and*
- Shipping and handling if applicable, *and*
- Sales tax.

By report: A code listed in the fee schedule as "By Report" which 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 full legal definition of By Report, see WAC 296-20-01002.

Bundled codes: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Pharmacy and DME providers can bill HCPCS codes listed as bundled on the fee schedules because, for these provider types, there's not an office visit or a procedure into which supplies and/or equipment can be bundled.

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

Itemized invoice: An invoice for a supply item that includes acquisition cost.

Primary surgical dressings: Therapeutic or protective coverings directly applied to wounds or lesions on the skin or caused by an opening on the skin. These dressings include items such as:

- Telfa,
- Adhesive strips for wound closure, *and*
- Petroleum gauze.

Secondary surgical dressings: Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. These dressings include items such as:

- Adhesive tape,
- Roll gauze,
- Binders, *and*
- Disposable compression material.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–1S (Surgical dressings for home use)	
Use this modifier to indicate when surgical dressing supplies are dispensed for home use. Bill with the appropriate HCPCS code for each dressing item.	Services with this modifier may be bundled, based on who is providing the dressings. If not bundled, payment is made at **100%** of the fee schedule level or billed charge, whichever is less.
–NU (New purchased DME)	
Use this modifier to indicate when the DME dispensed is being purchased and doesn't need to be returned to the supplier. **Note**: DME codes that are applicable to purchasing are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–NU** rate for each specific DME provided or billed charge, whichever is less.
–RR (Rented DME)	
Use this modifier to indicate when the DME dispensed will be rented and returned to the supplier. **Note**: DME codes that are applicable to rental are listed in the L&I Professional Services Fee Schedules	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–RR** rate for each specific DME provided or billed charge, whichever is less.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Acquisition cost and itemized invoices

General information

This policy describes what **acquisition cost** means, how it's calculated, and when charges for **supplies** are reimbursed at this rate. It also describes when an **itemized invoice** is required.

This policy doesn't apply to hospital bills. For the hospital **acquisition cost** policy, see Chapter 35: Hospitals.

Definition of acquisition cost

The **acquisition cost** equals:

- Wholesale cost of the item, *and*
- Shipping and handling if applicable, *and*
- Sales tax.

Services that can be billed

Providers are reimbursed at **acquisition cost** for supply codes that:

- Are listed as **By Report** in the Fee Schedule, *and*
- Cost $150 or more.

The following table summarizes the various ways the insurer pays for **supplies**:

	If the supply has a fee listed in the Fee Schedule…	If the supply is listed as "By Report" in the Fee Schedule…	If the supply is listed as "Bundled" in the Fee Schedule…
You bill less than $150 for the item…	**Itemized invoice** not required. Submit standard documentation. Payment is made at the amount billed or the maximum fee, whichever is less.	**Itemized invoice** not required. Submit standard documentation. Payment is made at 80% of the amount billed.	You won't be paid for this item separately from the associated service(s).

	If the supply has a fee listed in the Fee Schedule…	If the supply is listed as "By Report" in the Fee Schedule…	If the supply is listed as "Bundled" in the Fee Schedule…
You bill $150 or more for the item…	**Itemized invoice** required. Submit with standard documentation. Payment is made at the amount billed or the maximum fee, whichever is less.	**Itemized invoice** required. Submit with standard documentation. Payment is made at **acquisition cost**.	You won't be paid for this item separately from the associated service(s).

Requirements for billing

The **acquisition cost** must be billed as one charge. Sales tax and shipping and handling charges aren't paid separately and must be included in the total cost for the supply.

Documentation requirements

All supplies require documentation to support their purchase regardless of cost. See Chapter 2: Information for All Providers for details.

As described in the table above, an **itemized invoice** showing **acquisition cost** must be submitted with bills for all **supplies** that:

- Cost more than $150, *and*
- Aren't listed as **Bundled** in the Fee Schedule.

Providers must keep invoices for all **supplies** in their office files for a minimum of 5 years. A provider must submit a copy of the itemized invoice to the insurer when required (see table above) and/or upon request. Failure to produce an **itemized invoice** when required may result in bill denial or recoupment.

Payment policy: Casting materials

Services that can be billed

Bill for casting materials with HCPCS codes **Q4001**-**Q4051**.

Services that aren’t covered

No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider’s practice expense.

Payment policy: Catheterization

Services that can be billed

Separate payment is allowed for placement of a temporary indwelling catheter when treatment is:

- Performed in a provider's office, *and*
- Used to treat a temporary obstruction.

Link: For more information about catheterization to obtain specimen(s) for lab tests, see the Specimen collection and handling payment policy in Chapter 23: Pathology and Laboratory Services.

Payment limits

Separate payment isn't allowed when placement of a temporary indwelling catheter is performed:

- On the same day as a major surgical procedure, *or*
- During the postoperative period of a major surgical procedure that has a follow up period.

Payment policy: Miscellaneous supplies

Services that can be billed

HCPCS billing code **E1399** can be billed for a miscellaneous supply that meets both of these criteria:

- The supply (or DME item) doesn't have a valid HCPCS code assigned, *and*
- The item must be appropriate relative to the covered injury or type of treatment being received by the worker.

Services that aren't covered

The insurer won't pay CPT® code **99070**, which represents miscellaneous **supplies** and materials provided by the provider.

Requirements for billing

All bills for **E1399** items must have:

- Either the **–NU** or **–RR** modifier, *and*
- A description must be on the paper bill or in the remarks section of the electronic bill.

These specific miscellaneous **supplies** must be billed using HCPCS code **E1399**:

- Therapy putty and tubing, *and*
- Anti-vibration gloves.

Payment policy: Services and supplies

General information

Services and **supplies** must be medically necessary and must be prescribed by an approved provider for the direct treatment of an accepted condition.

Supplies include, but aren't limited to:

- Drugs administered in a provider's office,
- Medical and surgical supplies, *and*
- Prefabricated orthotics.

Providers must bill specific HCPCS or local codes for **supplies** and materials provided during an office visit or with other office services.

For covered medical and surgical **supplies** that pay **By Report**, providers must bill their usual and customary fees. To find out which codes pay **By Report**, see the Medical and Surgical Supplies section of the Professional Services Fee Schedule.

Links: For more information on billing usual and customary fees, see WAC 296-20-010(2).

Services that aren't covered

The insurer won't pay CPT® **99070**, which represents miscellaneous **supplies** and materials provided by the provider.

Payment limits

Under the fee schedules, some services and supply items are considered **Bundled** into the cost of other services (associated office visits or procedures) and won't be paid separately. These include:

- **Supplies** used in the course of an office visit, *and*
- Fitting fees, which are **Bundled** into the office visit or into the cost of any DME.

For medical and surgical **supplies** that pay **By Report** (except **E1399**), see Payment policy: Acquisition cost and itemized invoices.

To see which billing codes are **Bundled**, see L&I's Professional Services Fee Schedule; in the dollar value column, such items show the word **Bundled** (instead of a dollar amount).

Payment policy: Supply codes, bundled

General information

In the following table, the items listed are used as orthotics/prosthetics and may be paid separately **for permanent conditions** if they are provided in the physician's office.

If the condition is **acute or temporary**, these items aren't considered prosthetics.

For example:

- Foley catheters and accessories for permanent incontinence or ostomy **supplies** for permanent conditions may be paid separately when provided in the physician's office, *and*
- The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction wouldn't be paid separately because it is treating a temporary problem, *and*
- If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthetic/orthotic and would be paid separately.

HCPCS supply codes

This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4327	Fem urinary collect dev cup
A4328	Fem urinary collect pouch
A4335	Incontinence supply
A4338	Indwelling catheter latex
A4340	Indwelling catheter special
A4344	Cath indw foley 2 way silicn
A4346	Cath indw foley 3 way
A4356	Ext ureth clmp or compr dvc
A4357	Bedside drainage bag
A4358	Urinary leg or abdomen bag
A4361	Ostomy face plate
A4362	Solid skin barrier
A4364	Adhesive, liquid or equal

This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4366	Ostomy vent
A4367	Ostomy belt
A4368	Ostomy filter
A4369	Skin barrier liquid per oz
A4371	Skin barrier powder per oz
A4372	Skin barrier solid 4x4 equiv
A4373	Skin barrier with flange
A4375	Drainable plastic pch w fcpl
A4376	Drainable rubber pch w fcplt
A4377	Drainable plstic pch w/o fp
A4378	Drainable rubber pch w/o fp
A4379	Urinary plastic pouch w fcpl
A4380	Urinary rubber pouch w fcplt
A4381	Urinary plastic pouch w/o fp
A4382	Urinary hvy plstc pch w/o fp
A4383	Urinary rubber pouch w/o fp
A4384	Ostomy faceplt/silicone ring
A4385	Ost skn barrier sld ext wear
A4387	Ost clsd pouch w att st barr
A4388	Drainable pch w ex wear barr
A4389	Drainable pch w st wear barr
A4390	Drainable pch ex wear convex
A4391	Urinary pouch w ex wear barr
A4392	Urinary pouch w st wear barr
A4393	Urine pch w ex wear bar conv
A4394	Ostomy pouch liq deodorant
A4395	Ostomy pouch solid deodorant
A4398	Ostomy irrigation bag

This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4399	Ostomy irrig cone/cath w brs
A4400	Ostomy irrigation set
A4402	Lubricant per ounce
A4404	Ostomy ring each
A4405	Nonpectin based ostomy paste
A4406	Pectin based ostomy paste
A4407	Ext wear ost skn barr <=4sq
A4408	Ext wear ost skn barr >4sq
A4409	Ost skn barr w flng <=4 sq I
A4410	Ost skn barr w flng >4sq
A4413	2 pc drainable ost pouch
A4414	Ostomy sknbarr w/o conv<=4sq in
A4415	Ostomy skn barr w/o conv >4 sqi
A4416	Ost pch clsd w barrier/filtr
A4417	Ost pch w bar/bltinconv/fltr
A4418	Ost pch clsd w/o bar w filtr
A4419	Ost pch for bar w flange/flt
A4420	Ost pch clsd for bar w lk fl
A4421	Ostomy supply misc
A4422	Ost pouch absorbent material
A4423	Ost pch for bar w lk fl/fltr
A4424	Ost pch drain w bar & filter
A4425	Ost pch drain for barrier fl
A4426	Ost pch drain 2 piece system
A4427	Ost pch drain/barr lk flng/f
A4428	Urine ost pouch w faucet/tap
A4429	Urine ost pouch w bltinconv
A4430	Ost urine pch w b/bltin conv

This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4431	Ost pch urine w barrier/tapv
A4432	Os pch urine w bar/fange/tap
A4433	Urine ost pch bar w lock fln
A4434	Ost pch urine w lock flng/ft
A5051	Pouch clsd w barr attached
A5052	Clsd ostomy pouch w/o barr
A5053	Clsd ostomy pouch faceplate
A5054	Clsd ostomy pouch w/flange
A5055	Stoma cap
A5061	Pouch drainable w barrier at
A5062	Drnble ostomy pouch w/o barr
A5063	Drain ostomy pouch w/flange
A5071	Urinary pouch w/barrier
A5072	Urinary pouch w/o barrier
A5073	Urinary pouch on barr w/flng
A5081	Stoma plug or seal, any type
A5082	Continent stoma catheter
A5083	Stoma absorptive cover
A5093	Ostomy accessory convex inse
A5102	Bedside drain btl w/wo tube
A5105	Urinary suspensory
A5112	Urinary leg bag
A5113	Latex leg strap
A5114	Foam/fabric leg strap
A5121	Solid skin barrier 6x6
A5122	Solid skin barrier 8x8
A5126	Disk/foam pad +or- adhesive
A5131	Appliance cleaner

Payment policy: Surgical dressings dispensed for home use

Requirements for billing

Providers must bill the appropriate HCPCS code for each dressing item, along with the local billing code modifier **–1S** for each item.

Payment limits

Primary surgical dressings and **secondary surgical dressings** dispensed for home use are payable at **acquisition cost** when all of these conditions are met:

- They are dispensed to a patient for home care of a wound, *and*
- They are medically necessary, *and*
- The wound is due to an accepted work related condition.

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. Separate payment isn't allowed.

Items such as elastic stockings, support hose, and pressure garments aren't **secondary surgical dressings** and must be billed with the appropriate HCPCS code.

Surgical dressing **supplies** and codes billed without the local modifier **–1S** are considered **Bundled** and won't be paid.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and is not separately payable, even to **DME** suppliers. For details on coverage of pneumatic compression devices, see Chapter 9: Durable Medical Equipment.

Payment policy: Surgical trays and supplies used in the physician's office

Payment limits

L&I follows CMS's policy of bundling HCPCS codes for surgical trays and **supplies** used in a physician's office. Surgical trays and **supplies** won't be paid separately.

Special note: Surgical dressings and other items dispensed for home use

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier **–1S**.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for topics relevant to this chapter	Washington Administrative Code (WAC) 296-20-1102 WAC 296-20-01002
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 facility services (including ASCs)	Fee schedules on L&I's website
Payment policies for **catheterization to obtain specimens for lab tests**	Chapter 23: Pathology and Laboratory Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **hospital acquisition cost policy**	Chapter 35: Hospitals

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 29: Surgery Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Certified or accredited facility or office: L&I defines a certified or accredited facility or office that has certification or accreditation from 1 of the following organizations:

- Medicare (CMS – Centers for Medicare and Medicaid Services),
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
- Accreditation Association for Ambulatory Health Care (AAAHC),
- American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF),
- American Osteopathic Association (AOA),
- Commission on Accreditation of Rehabilitation Facilities (CARF).

When services are performed in a facility setting, the insurer makes 2 payments:

- One to the professional provider, and
- One to the facility.

Payment to the facility includes resource costs, such as:

- Labor,
- Medical supplies, and
- Medical equipment.

Endoscopy: For the purpose of these payment policies, “endoscopy” will be used to refer to any invasive procedure performed with the use of a fiber optic scope or other similar instrument.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–24 (Unrelated evaluation and management (E/M) services by the same physician during a postoperative period)	
Use this modifier to indicate when an E/M service is performed during a postoperative period that was unrelated to the surgical procedure.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–50 (Bilateral surgery)	
Use this modifier to indicate when a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each side of the body the procedure was performed. Apply the modifier to the second line.	The total payment is made at **150%** of the global surgery fee schedule amount for the procedure as follows: • **100%** of the global surgery fee for the procedure on the first line. • **50%** of the global surgery fee for the procedure on the second line.

Use	Payment Information
–51 (Multiple surgeries)	
Use this modifier to indicate when multiple procedures were performed at the same operative session by the same individual. Providers must bill using separate line items for each procedure performed. Apply the modifier to all line items but the primary procedure. If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.	The total payment equals the sum of: • **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, *plus* • **50%** of the maximum allowable fee for the subsequent procedure(s) with the next highest values according to the fee schedule.
Surgical package modifiers When providing less than the global surgical package, providers should use modifiers **–54**, **–55**, or **–56**. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider for each portion of the global surgery service.	
–54 (Surgical care only)	
Use this modifier to indicate when the physician performs a surgical procedure but another physician provides preoperative and/or postoperative management.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–54** column of the Professional Provider Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.

Use	Payment Information
–55 (Postoperative management only)	
Use this modifier to indicate when the physician performs the postoperative management but another physician has performed the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–55** column of the Professional Provider Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–56 (Preoperative management only)	
Use this modifier to indicate when the physician performs the preoperative care and evaluation but another physician performs the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–56** column of the Professional Provider Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–57 (Decision for surgery)	
Use this modifier to indicate that an Evaluation and Management (E/M) service resulted in the initial decision to perform the surgery.	This modifier doesn't affect payment but is necessary to describe the service performed.
–62 (Two surgeons)	
Use this modifier to indicate when 2 primary surgeons (usually with different specialties) performed distinct part(s) of the same procedure. Both surgeons must submit separate operative reports describing their specific roles.	Payment is made for each surgeon at **62.5%** of the global surgical fee or billed charge, whichever is less. No payment is made for an assistant in these cases.

Use	Payment Information
–66 (Team surgery)	
Use this modifier to indicate when a highly complex procedure is carried out by a surgical team. This requires the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Each surgeon must submit separate operative reports describing their specific roles.	Procedures with this modifier are reviewed and priced on an individual basis (by report).
Assistant surgeon modifiers Physicians who assist the primary physician in surgery should use modifiers **–80**, **–81**, or **–82**, depending on the medical necessity. The insurer doesn't recognize modifier **–AS**. Refer to the assistant surgeon indicator in the Professional Provider Fee Schedule to determine if assistant surgeon fees are payable. If the fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in the surgeon's report to receive payment.	
–80 (Assistant surgeon)	
Use this modifier to indicate when the physician assisted on a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–81 (Minimum assistant surgeon)	
Use this modifier to indicate when the physician only assisted on part of a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–82 (Assistant surgeon (when qualified resident surgeon not available))	
Use this modifier to indicate when the physician assisted on a surgery when a qualified resident surgeon was not available to assist the primary surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.

Use	Payment Information
–FT (Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.)	
Use this modifier to indicate when a critical care E/M visit is furnished within the postoperative period but is unrelated to the surgery.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–SU (Procedure performed in physician's office)	
This modifier isn't recognized by the insurer.	Facility fees are not payable for procedures performed in a physician's office. Services with this modifier will be **denied**.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Autologous chondrocyte implant (ACI)

Services that aren't covered

Autologous chondrocyte implants aren't covered. For details, see L&I's coverage decision.

Payment policy: Angioscopy

Payment limits

Payment for angioscopies CPT® code **35400** is limited to only 1 unit based on its complete code description encompassing multiple vessels.

Note: The work involved with varying numbers of vessels is incorporated in the RVUs.

Payment policy: Bilateral surgeries

Requirements for billing

Bilateral surgeries should be billed as 2 line items:

- Modifier **–50** must be applied to the second line item, *and*
- The second line item is paid at the lesser of the billed charge, or 50% of the fee schedule maximum.

Bilateral surgeries are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.

Link: To see if modifier **–50** is valid with the procedure performed, check the Professional Services Fee Schedule.

Example 1: Billing for bilateral surgeries

Line item	CPT® code (and modifier)	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	**64721**	**$842.72**	—	**$842.72**(1)
2	**64721-50**	**$842.72**	**$421.36**(2)	**$421.36**
			Total allowed amount in non-facility setting:	**$1,264.08**(3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

Example 2: Billing for bilateral surgeries and multiple procedures

Line item	CPT® code (and modifier)	Max payment (non-facility setting)	Bilateral policy applied	Multiple procedure policy applied	Allowed amount
1	**63042**	**$2,368.61**	—	—	**$2,368.61** (1)
2	**63042-50**	**$2,368.61**	**$1,134.31** (2)	—	**$1,134.31**
				Subtotal:	**$3,552.92** (3)
3	**22612-51**	**$2,879.64**	—	**$1,439.82**(4)	**$1,439.82**
				Total allowed amount in non-facility setting:	**$4,992.74**(5)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.

(4) The third line item billed with modifier **–51** is paid at 50% of the maximum payment.

(5) Represents total allowable amount.

Payment policy: Bone growth stimulators

Prior authorization

These HCPCS (billing) codes for bone growth stimulators require prior authorization:

- **E0747** (Osteogenesis stimulator, electrical, noninvasive, other than spinal application), and
- **E0748** (Osteogenesis stimulator, electrical, noninvasive, spinal application), and
- **E0749** (Osteogenesis stimulator, electrical (surgically implanted)), and
- **E0760** (Osteogenesis stimulator, low intensity ultrasound, noninvasive).

The insurer, with prior authorization, pays for bone growth stimulators for specific conditions when medically necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, *and*
- Implanted electrical stimulators that supply a direct current to the bone.

Payment policy: Bone morphogenic protein (BMP)

Prior authorization

The insurer may cover the use of bone morphogenic protein 7 (rhBMP-7) as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. The insurer may also cover the use of rhBMP-2 for primary anterior open or laparoscopic lumbar fusion at one level between L4 and S1, or revision lumbar fusion on a compromised injured worker for whom autologous bone and bone marrow harvest aren't feasible or not expected to result in fusion.

All of the guidelines for bone morphogenic protein treatment must be met before the insurer will authorize the procedures. In addition, lumbar fusion guidelines must be met.

Services that aren't covered

Bone morphogenic protein-2 (rhBMP-2) isn't covered for use in long bone nonunion fractures.

Bone morphogenic protein-7 (rhBMP-7) isn't covered for use in lumbar fusion.

BMP isn't covered for use in cervical spinal fusion or any other indication.

Payment policy: Closure of enterostomy

Payment limits

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy.

CPT® code **44139** will be denied if it is billed with CPT® code **44625** or **44626**.

Payment policy: Endoscopy procedures

Endoscopy family groupings

Endoscopy procedures are grouped into clinically related families. Each **endoscopy** family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an **endoscopy** family is listed in the Endo Base column in the Professional Services Fee Schedule.

How multiple endoscopy procedures pay

When multiple **endoscopy** procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- The **endoscopy** procedure with the highest dollar value is 100% of the fee schedule value, *then*
- For subsequent **endoscopy** procedures, payment is the difference between the family member and the base fee (see Example 1, below), *then*
- When the maximum fee for the family member is less than the maximum base fee, the payment is $0.00 for the family member (see Example 2, below), *then*
- No additional payment is made for a base procedure when a family member is billed.

Once payment for all **endoscopy** procedures is calculated, each family is defined as an endoscopic group.

If more than 1 endoscopic group or other non-**endoscopy** procedure is billed for the same worker on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4, below).

Multiple endoscopies that aren't related (each is a separate and unrelated procedure) are priced as follows:

- 100% of fee schedule value for each unrelated procedure, *then*
- Apply the standard multiple surgery policy.

Payment limits

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless:

- A documented, separately identifiable service is provided, and
- Modifier **–25** is used.

Example 1: Billing for 2 endoscopy procedures in the same family

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	29805	**$877.51**	**$0.00** (2)	—
1	29820	**$996.87**	**$119.36** (4)	**$119.36** (5)
2	29824	**$1,264.98**	**$11,264.98** (3)	**$1,264.98** (5)
			Total allowed amount in non-facility setting:	**$1,384.34** (6)

(1) Base code listed is reference only (not included on bill form).

(2) Payment isn't allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same **endoscopy** family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Amount allowed under the **endoscopy** policy.

(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only 1 family of endoscopic procedures was billed.

Example 2: Billing for endoscopy family member with fee less than base procedure

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	43235	**$545.22**	—	—
1	43241	**$256.71**	**$0.00** (3)	
2	43243	**$426.46**	**$426.46** (2)	**$426.46** (4)
			Total allowed amount in non-facility setting:	**$426.46** (5)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an **endoscopy** family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the **endoscopy** policy.

(5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

Example 3: Billing for 2 surgical procedures billed with an endoscopic group (highest fee)

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	**11402**	**$326.29**	—	**$163.15** (5)
2	**11406**	**$597.40**	—	**$298.70** (5)
Base (1)	**29830**	**$858.91**	—	—
3	**29835**	**$956.08**	**$97.17** (3)	**$97.17** (4)
4	**29838**	**$1,114.43**	**$1,114.43** (2)	**$1,114.43**(4)
Total allowed amount in non-facility setting:				**$1.673.45** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued **endoscopy** procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued **endoscopy** procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or **endoscopy** group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: Billing for 1 surgical procedure (highest fee) billed with an endoscopic group

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	23412	**$1,582.27**		**$1,582.27** (4)
Base (1)	29805	**$877.51**		
2	29820	**$996.87**	**$119.36** (3)	**$59.68** (5)
3	29824	**$1,264.98**	**$1,264.98** (2)	**$632.49** (5)
Total allowed amount in non-facility setting:				**$2,274.44** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued **endoscopy** procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued **endoscopy** procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or **endoscopy** group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Payment policy: Epidural adhesiolysis

Services that can be billed

Epidural adhesiolysis is covered under certain conditions. For details, see L&I's coverage decision.

Payment policy: Fractional ablative laser

Prior authorization

Fractional ablative laser fenestration of burn and traumatic scars requires prior authorization.

Services that can be billed

0479T and **0480T** are covered for fractional ablative laser fenestration of burn and traumatic scars where deemed medically necessary by the insurer to treat scarring that impairs the worker's function. Authorization will be given only for treatment of scarring that resulted from the industrial injury, or treatment thereof.

Services that aren't covered

Fractional ablative laser isn't covered for cosmetic purposes only.

Payment limits

0479T is limited to a max of 1 unit per day per claim.

0480T is limited to a max of 40 units per day per claim.

Payment policy: Global surgery

Global surgery follow up periods

Many surgeries have a follow up period during which charges for normal post-operative care are bundled into the global surgery fee.

The global surgery follow up period for each surgery is listed in the Follow Up column in the Professional Services Fee Schedule.

A new post-operative period begins with the subsequent procedure.

What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless modifier **–24**, **–57** or **–FT** are appropriately used:

- E/M codes:
  - **99211**-**99215**,
  - **99231**-**99239**,
  - **99291**-**99292**,
  - **99304**-**99310**,
  - **99315**-**99316**,
  - **99347**-**99350**,
- Ophthalmological codes: **92012**-**92014**

The following services and supplies **are included** in the global surgery follow up period and are considered bundled into the surgical fee:

- The operation itself, *and*
- Pre-operative visits, in or out of the hospital, beginning on the day before the surgery, *and*
- Services by the primary surgeon, in or out of the hospital, during the post-operative period, *and*
- The following services:
  - Dressing changes, *and*
  - Local incisional care and removal of operative packs, *and*
  - Removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, *and*

  - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric, and rectal tubes, *and*
  - Change and removal of tracheostomy tubes, *and*
  - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

What isn't included in the follow up period

The following services and supplies aren't included in the global surgery follow up period:

- Casting materials aren't part of the global surgery policy and are paid separately, *and*
- The initial consultation or evaluation by the surgeon to determine the need for surgery, *and*
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care, *and*
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications, *and*
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery, *and*
- Diagnostic tests and procedures, including diagnostic radiological procedures, *and*
- Distinct surgical procedures during the post-operative period which aren't reoperations or treatment for complications, *and*
- Treatment for post-operative complications which requires a return trip to the operating room, *and*
- Immunotherapy management for organ transplants, *and*
- Critical care services (CPT® codes **99291** and **99292**) unrelated to the surgery where a seriously injured or burned worker is critically ill and requires constant attendance of the provider, *and*
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

Who must perform these services to qualify for payment

The follow up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the worker; identified by modifiers **–54**, **–55**, and **–56**,),
- Assistant surgeon (identified by modifiers **–80**, **–81**, and **–82**),
- 2 surgeons (identified by modifier **–62**),
- Team surgeons (identified by modifier **–66**),
- Anesthesiologists and CRNAs.

Documentation of services

Providers (to include providers participating in multiple and team surgeries) must submit documentation in workers' individual operative reports to verify the level, type, and extent of surgical services. Surgeons using an assistant surgeon must document the name and actions of the assistant surgeon.

Payment limits

Professional inpatient services (CPT® codes **99221**-**99223**) are only payable during the follow up period if they are performed on an emergency basis.

Example: They aren't payable for scheduled hospital admissions.

Codes that are considered bundled aren't payable during the global surgery follow up period.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is bundled into the surgical service fee and isn't separately payable, even to DME suppliers. For details on coverage of pneumatic compression devices, see Chapter 9: Durable Medical Equipment.

Payment policy: Lumbar Intervertebral Artificial Disc Replacement

Services that aren’t covered

Lumbar intervertebral artificial disc replacements aren’t covered. For more information, see L&I’s coverage decision.

Payment policy: Meniscal allograft transplantation

Services that can be billed

Meniscal allograft transplantation is covered under certain conditions. For details, see L&I's coverage decision.

Payment policy: Microsurgery

Services that can be billed

CPT® code **69990** is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

Payment limits

CPT® code **69990** isn't payable when:

- Using magnifying loupes or other corrected vision devices, *or*
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), *or*
- Another code describes the same procedure being done with an operative microscope.

Example: CPT® code **69990** can't be billed with CPT® code **31536** because CPT® code **31536** describes the same procedure using an operating microscope.

Payment policy: Minor surgical procedures

Services that can be billed

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the post-operative period and modifier **–24** is used, or
- The provider who performs the procedure also reports a significant, separately identifiable service on the same date and modifier **–25** is used (also see Requirements for billing, below, and using CPT® billing code modifier **–25** in Chapter 10).

Services that aren't covered

Modifier **–57**, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

Requirements for billing

When billing with modifier **–25**, the insurer follows CPT® guidelines for the billing of an E/M service on the same day as performing a minor surgical procedure. An E/M service isn't considered a significant, separately identifiable service if the evaluation is related to the procedure. In this case, the evaluation is considered part of the preoperative and/or postoperative care and is therefore bundled into the payment for the minor surgical procedure.

However, if the evaluation is related to another condition, an E/M service may be billed.

Example: A worker is seen for a work related scalp laceration in which the provider determined sutures are needed but the worker also reports dizziness. The evaluation of the scalp laceration is considered inclusive of the preoperative service work for the laceration repair and therefore is included in the billing of the surgical code.

The evaluation of the worker's dizziness is considered a significant, separately identifiable service, and

- Modifier **–25** must be used, and
- Appropriate documentation is required describing both the minor surgical procedure and the E/M service

Payment limits

Modifier **–57** is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

Payment policy: Pre, intra, or post-operative services

Services that can be billed

The insurer will allow separate payment when different providers perform the pre-operative, intra-operative, or post-operative components of the surgery. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

Requirements for billing

When different providers perform pre-operative, intra-operative, or post-operative components of the surgery, modifiers (**–54**, **–55**, or **–56**) must be used.

If different providers perform different components of the surgery (pre, intra, or post-operative care), the global surgery policy applies to each provider.

Example: If the surgeon performing the operation transfers the worker to another provider for the post-operative care, the same global surgery policy, including the restrictions in the follow up day period, applies to both providers.

Payment policy: Procedures performed in a physician's office

Services that can be billed

Procedures performed in a provider's office are paid at non-facility rates that include office expenses.

Services that aren't covered

Services billed with modifier **–SU** aren't covered.

Requirements for billing

Providers' offices must meet ASC requirements to qualify for separate facility payments.

Link: For information about these requirements, see WAC 296-23B.

Payment policy: Registered nurses as surgical assistants

Who must perform these services to qualify for payment

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of their valid and current registered nurse license, *and*
- A letter granting onsite hospital privileges for each institution where surgical assistant services will be performed.

Payment policy: Skin Cell Substitutes

Services that can be billed

The insurer covers certain HCPCS codes for skin cell substitutes. For the current list of covered codes, see the Professional Services Fee Schedule.

Payment policy: Standard multiple surgeries

How multiple surgeries pay

When multiple surgeries are performed on the same worker at the same operative session or on the same day, the total payment equals the sum of:

- 100% of the global fee schedule value for the procedure or procedure group with the highest value, according to the fee schedule, and
- 50% of the global fee schedule value for the second through fifth procedures with the next highest values, according to the fee schedule.

When different types of surgical procedures are performed on the worker on the same day, the payment policies will always be applied in the following sequence:

- Multiple **endoscopy** procedures, *then*
- Other modifier policies, *then*
- Standard multiple surgery policy.

Requirements for billing

All surgical procedure codes subject to the standard multiple surgery policy must be billed as a separate line item.

For additional instructions on billing bilateral procedures, see the payment policy on bilateral procedures earlier in this chapter.

Payment policy: Stem cell therapy for musculoskeletal conditions

Services that aren't covered

Stem cell therapy for musculoskeletal conditions isn't covered. For details, see L&I's coverage decision.

Payment policy: Tobacco Cessation Treatment for Surgical Care

Services that can be billed

The department has published a coverage decision for Tobacco Cessation Treatment for Surgical Care.

Requirements for billing

CPT® codes **99406** and **99407** may be billed for tobacco cessation counseling.

Billing for each claim is limited to a maximum of 8 units of any combination of the 2 codes.

Payment policy: Unlisted Surgical Procedures

General information

Some covered procedures don't have a specific code or payment level listed in the fee schedule. Thus, the provider must list the most similar procedure code or codes to the services performed including units of service in their surgical report.

Requirements for billing

When reporting such a service, the appropriate unlisted procedure code must be billed.

The insurer also requires:

- Within the surgical report, supporting documentation including a full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using the established procedure codes. Modifiers must be included.
- The provider must also list the most similar procedure code or codes to the services performed including units of service.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Ambulatory Surgery Center (ASC) payment	Washington Administrative Code (WAC) 296-23B
Ambulatory Surgery Center **Fee Schedule**	Fee schedules on L&I's website
Autologous chondrocyte implant (ACI)	Autologous chondrocyte implant coverage decision
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bone growth stimulators	Bone growth stimulators coverage decision
Bone morphogenic protein (BMP)	Bone morphogenic protein coverage decision
Condition and Treatment Index	Condition and treatment index on L&I's website
Epidural adhesiolysis	Epidural adhesiolysis coverage decision
Medical treatment guideline for Lumbar fusion arthrodesis	Lumbar fusion arthrodesis treatment guidelines
Meniscal allograft transplantation	Meniscal allograft transplantation coverage decision
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Tobacco Cessation Treatment for Surgical Care	Tobacco cessation treatment for surgical care coverage decision

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 30: Vocational Services

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

By report: A code listed in the fee schedule as "By Report" which 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.

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Remote: Vocational services provided by a qualified vocational rehabilitation counselor via audio only or face-to-face through a real-time, two-way, audio video connection.

Registration fee: Any fee charged by a school to process student applications and establish a student record system.

Telehealth: Face-to-face services delivered by a qualified provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Worker or **student:** An individual who has an L&I claim number and qualifies for workers' compensation retraining benefits. For the purposes of this policy, the terms worker and student are used interchangeably.

Withdrawal or **termination date**: The earliest of any of the following dates:

- The date the school recorded the student's last day of attendance, or
- The date a student is terminated for violation of published school policy, or
- The date a student is terminated for failing to meet performance requirements, or
- The date the student notifies the school in writing that they will withdraw.

Vocational rehabilitation counselors (VRC) or **provider**: The term "provider" in the above definitions includes vocational rehabilitation counselors.

Payment policy: Billing by referral type

Prior authorization

All vocational services require prior authorization.

Vocational services are authorized by referral type. The State Fund uses 6 referral types:

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

Each referral is a separate authorization for services.

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.

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.

Note: The firm must assign a VRC upon referral.

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

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)	**$10.55**
0801V	Vocational recovery services (intern)	**$8.99**
0802V	Vocational recovery services exception (VRC)	**$10.55**
0803V	Vocational recovery services exception (intern)	**$8.99**

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0810V	Assessment services (VRC)	**$10.55**
0811V	Assessment services (Intern)	**$8.99**
0812V	Assessment services exception (VRC)	**$10.55**
0813V	Assessment services exception (intern)	**$8.99**

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)	**$10.55**
0823V	Pre-job or job modification consultation (VRC)	**$10.55**
0824V	Pre-job or job modification consultation (Intern)	**$8.99**

Plan development

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0830V	Plan development services (VRC)	**$10.55**
0831V	Plan development services (Intern)	**$8.99**

Plan implementation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0840V	Plan implementation services (VRC)	**$10.55**
0841V	Plan implementation services (Intern)	**$8.99**
0842V	Plan implementation services exception (VRC)	**$10.55**
0843V	Plan implementation services exception (intern)	**$8.99**

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.

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)	**$12.62**

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)	**$10.55**
0809V	Stand-alone job analysis (intern)	**$8.99**
0378R	Stand-alone job analysis (non-VRC)	**$10.45**

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
0389R	Pre-job or job modification consultation, 1 unit = 6 minutes	**$12.71** per 6 minutes
0390R	Vocational evaluation, 1 unit = 6 minutes	**$10.45** per 6 minutes

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.

When a worker has 2 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 3 (or more) claims, the vocational evaluation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received.

Payment policy: Fee caps for vocational services

Fee cap policy for referrals

Vocational services are subject to fee caps. 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**	**$7,421.96**
Assessment referral cap, per referral	**0810V**, **0811V**	**$7,421.96**
Plan development referral cap, per referral	**0830V**, **0831V**	**$7,096.53**
Plan implementation referral cap, per referral	**0840V**, **0841V**	**$8,045.40**
Stand-alone job analysis referral cap, per referral	**0808V**, **0809V**, **0378R**	**$541.23**

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 of a subsequent evaluation under another referral type.

If the **description** of the service is…	Then the **applicable codes** are:	And the **maximum fee** per claim is:
Vocational evaluation services	**0821V**, **0390R**	**$1,552.91**

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, there are exception codes for VRCs and for interns, with an additional fee cap of **$1,034.51.**

Code	Description	Maximum fee
0802V	Vocational recovery services exception (VRC)	**$10.55** per 6 minutes
0803V	Vocational recovery services exception (intern)	**$8.99** per 6 minutes

AWA referrals

For AWA referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$1,034.51**.

Code	Description	Maximum fee
0812V	Assessment services exception (VRC)	**$10.55** per 6 minutes
0813V	Assessment services exception (intern)	**$8.99** per 6 minutes

Plan implementation referrals

For plan implementation referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$2,391.02**.

Code	Description	Maximum fee
0842V	Plan implementation services exception (VRC)	**$10.55** per 6 minutes
0843V	Plan implementation services exception (intern)	**$8.99** per 6 minutes

Fee cap considerations

When nearing 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.

The vocational provider may request a new referral when they are nearing 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 utilizing the remaining referral funds.

- 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.

If both the original fee cap and the fee cap exception are spent, and a new referral isn't granted, 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 utilizing the remaining referral funds.

Flat rate policy for 30-day progress reports

There is a **$50** flat rate for each 30-day progress report. Progress report fees don'tcount 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 1 progress report per referral every 30 days.

To bill for more than 1 progress report for the same referral on the same invoice, use separate line items of 1 unit and $50 each for each date of service. If you bill for more than 1 report on the same line, all but 1 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 1 claim, progress reports should be billed under that claim.

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

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.

Telehealth

When the consultant is unable to go onto the worksite, **telehealth** may be used as an alternative method to complete the consultation. Qualified PT or OT providers may have to be licensed in the state where the worker is receiving **telehealth** services, per that state's licensing requirements.

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** Vocational Rehabilitation Provider	Discussing/consulting about modifications to a job. This may include: • 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. • Discussing available L&I benefits to include stay at work, preferred worker, and job modification with the employer, worker, and/or attending provider. • Communication with others about modifying a job to include the worker, employer, health-care providers, vocational provider, insurer, and/or vendor. • Documenting findings and recommendations, • Instruction in work practices (such as body mechanics, ergonomic principles), • Obtaining bids, • Completing and submitting the Job Modification/Pre-job Assistance Application and any associated follow up, and • Assisting an employer with accessing return to work incentives.	**$10.55** per 6 minutes

Code	Description	Activities	Maximum fee
0824V	**Pre-job or job modification consultation** Vocational Rehabilitation Provider Intern	Same as above	**$8.99** per 6 minutes
0389R	**Pre-job or job modification consultation, analysis of physical demands** OT, PT, Ergonomic Specialist	Same as above Analyzing job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only).	**$12.71** 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.	**$5.76** 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. 1 unit=1 mile	**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**

Authorized equipment vendors

The following codes can be billed by equipment vendors:

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

Obtaining equipment from consultants

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, *and*
- They agree to send insurer a PDF picture of the final product.

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. However, self-insured employers may pay any pre-job accommodation expenses for injured workers who no longer work for them.

Links: Additional information regarding Job Modifications and Pre-Job Accommodations is available online.

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

Link: More information on Option 2 vocational services is available online.

Limits

Interns can't provide Option 2 vocational services.

Option 2 vocational services must be provided within 5 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.

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. State Fund claims require form F280-063-000 and self-insured claims require form F280-064-000.

Billing

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

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

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)	**$10.55**
R0398	Option 2 job placement services (VRC)	**$10.55**

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

Payment policy: Quality Assurance

General information

Quality assurance activities: For the State Fund, vocational firms must perform quality assurance (QA) activities to comply with WAC 296-19A-210.

Services that can be billed

Payment is allowed for QA activities regarding claims listed on the department-provided, randomized list of claims. QA activities include, but aren't limited to:

- Following the department's validation guidance and reporting requirements while completing department-provided validation template(s).
- Discussing validation results with the vocational rehabilitation counselor assigned to the claim to reinforce quality work and to support continued improvement.

Limits

A vocational firm's everyday business operations aren't considered quality assurance activities. The activities outlined in WAC 296-19A-340 are considered overhead and the department won't pay for these services.

Aggregate data collection and reporting aren't payable. For the purposes of this policy, data in this context refers to numbers. Specific examples include QA elements published by the department such as the number of:

- Open vocational recovery referrals.
- Engagement activities for a worker.
- Meetings with identified claim parties.

Payment policy: Remote services

General Information

Remote services may be appropriate where vocational services can be completed effectively via audio only or audio-visual platform.

Services that should be performed in person

In alignment with the worker-centric model, **remote** services are an option, but in some situations these aren't possible or aren't preferred by the worker. In-person services should be provided when:

- The vocational provider has determined the worker isn't a candidate for **remote** services, either generally or for a specific service, *or*
- The worker doesn't want to participate remotely**.**

In-person services are particularly important for:

- Job analyses,
- Plan development rights and responsibilities,
- Initial meetings with the worker.

Originating Site Fee (Q3014)

Vocational providers may be reimbursed an **originating site** fee (**Q3014**) for allowing use of their office space to workers who need a **telehealth** visit with a medical provider.

When billing the **originating site** fee, no other service can be provided to the same worker by the vocational provider. When a vocational provider bills **Q3014** on the same day they render in-person services to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The vocational provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person services that occurred on the same day. When **Q3014** is the only code billed, documentation is still required to support the service.

Q3014 isn't covered when:

- **Remote** services performed via telephone, *or*
- The **originating site** vocational provider performs another service during the workers' **telehealth** service with a medical provider (such as a team conference), *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The services are provided via audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** or **remote** related services.

Services that aren't covered

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems aren't covered.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** or **remote** appointment.

For **remote** services delivered, bill the applicable codes as if delivering care in person.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the distant site provider in addition to the documentation requirements for the vocational services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **remote** services with an audio and visual connection. This must be noted for each such visit and isn't required for audio only connections.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Payment policy: School billing, cancellation, and refund

General information

Schools and training programs are L&I-approved training providers that equip **workers** with the knowledge, skills, and abilities they need to be successful in the workforce. Approved providers are either accredited, licensed, or otherwise meet L&I provider requirements.

Workers must have an authorized vocational training plan.

A training provider must have an L&I provider account to be paid for services. Resources for billing are available on the insurer's website.

Prior authorization

Prior authorization is required to bill for **student** application fees and/or placement tests (code **0388R**). This authorization can be granted before a training plan has been approved.

An L&I-approved training plan is required before training begins. This training plan documents the allowed dollar limits, date spans, and billing codes for each vendor. The authorized expenses must be either on an encumbrance form (F245-454-000 for an Option 1 training plan) or on an authorization letter (for an Option 2 plan). See Resources for Training Providers.

Who must perform these services to qualify for payment

To be paid for services, a training provider must have an L&I provider account and prior authorization from L&I.

To maintain status as an approved training provider, schools must:

- Have an admission policy allowing all qualified members of the general population to be candidates for admission, *and*
- Maintain documentation on **student** completion and placement rates, *and*
- Maintain credentials. Accredited or licensed training providers must maintain their accreditation or licensure status per WAC 296-19A-590. Non-accredited or unlicensed training providers must reapply every two years per WAC 296-19A-550. Failure to maintain credentials may result in termination of the provider number (WAC **296-19A**), *and*
- Comply with all federal, state, and local regulations, and other requirements governing their education and business operations, *and*
- Ensure services provided are respectful, equitable, and responsive to diverse cultural beliefs, practices, preferred languages, and communication needs, *and*
- Ensure access to spoken and sign language according to Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA). Interpretation services for an injured **worker** or a crime victim are covered by L&I and don't require prior authorization. For further details, see Chapter 2: Information for All Providers.

For additional guidance, see Schools and Training Programs (wa.gov).

Note: To become an approved L&I training provider, schools must submit an application and be accredited, licensed, or otherwise meet L&I provider requirements. To apply for an L&I provider account, see Become a Training Provider.

Changes to a billing address, tax ID, etc. could require a different L&I provider number and could cause bills to be delayed or denied. See Become a Training Provider or contact SchoolOversightProgram@Lni.Wa.Gov for assistance.

Services that can be billed

With documentation and prior authorization, the insurer covers the following codes:

- Fees for **student** applications and placement tests (**0388R**). This code can be authorized before the training plan has been approved.

Under an approved training plan, the insurer covers the following codes:

- Tuition and fees (training, exams, licensing) (**R0310**)
- Books, supplies, and equipment (**R0312**)

Note: Childcare providers must be licensed.

When to bill the insurer

Billing must fall within the date spans and allowed amounts as listed in the approved training plan (either the Encumbrance form or the Option 2 Authorization Letter).

Tuition must be billed by quarter or semester. For schools without quarters or semesters, billing can't exceed 90-day increments.

Example

A $6,000 training plan starting 9/5/2023 and ending 1/1/2024 should be billed as follows:

- 9/5/2023 – 11/20/2023: $3,000
- 11/21/2023 – 1/1/2024: $3,000

Make sure your billing dates are within the approved plan dates, or it may cause payment delays or denials.

For additional billing guidance, see Resources for Training Providers.

Refund requirements

At a minimum, schools must use the refund and cancellation policies outlined below unless the school is governed by a higher statutory authority. For example, community and technical colleges are governed by different laws and also defer to federal laws regarding financial aid. The insurer may approve refund policies whose terms are more favorable to **students** than the following established minimums.

The process

Refunds must be calculated using the official date of **withdrawal or termination**.

Refunds require the L&I claim number, the billing codes, dates of service, the original bill ICN, and the refund amount. For details, see Getting a Payment Adjusted and complete the Refunding Money form (F245-043-000).

Refunds are only payable for bills submitted to the insurer.

Refunds must be submitted within thirty calendar days of the **student's** official date of **withdrawal or termination**. See RCW 51.48.260 and WAC 296-19A-390.

If training ends before a student begins classes

If the applicant isn't accepted, the school may keep money billed for applications and placement tests under code **0388R**. The school must refund all money billed under codes **R0310** and **R0312.**

If the school cancels a class before it starts, the school must refund all money billed for the class under codes **R0310** and **R0312**.

If a training is terminated after signing the enrollment contract and before the **student** begins classes, the school may retain an established **registration fee** equal to 10% of the total tuition cost, or $100, whichever is less.

If training ends after the student begins classes

The school may retain the **registration fee**, plus a percentage of the total tuition as described in the table below.

The percentage will be applied within the date span that includes the official date of **withdrawal or termination**. Authorized dates are listed on the Encumbrance Form or Authorization Letter.

For example, if a student completes 4 weeks within a 10-week date span (40% of the scheduled training), the school may bill no more than 50% of the tuition for that date span.

When the student **completes this amount of training**…	Then the school may **retain no more than this percentage of tuition**:
1 week or up to 10%, whichever is less	10%
More than 1 week but less than 25%	25%
25% up to 50%	50%
More than 50%	100%

Services that aren't covered

The following services aren't covered:

- Schools using a monthly subscription service, *or*
- Hourly tutoring.

Requirements for billing

The insurer will only pay bills that fall within the dollar limits and date spans identified in the approved training plan. For further assistance, see Resources for Training Providers.

All charges for tuition must be submitted to the insurer.

Schools can't charge **workers** or VRCs for tuition. Bills must be submitted to the insurer.

Documentation

L&I may request records regarding the **worker's** training. Records may include a course catalog with prices and policies, signed enrollment agreement, documentation of a **student's** attendance dates, or other information needed to evaluate the **student's** progress or attendance.

Upon request, schools are required to submit records or information on the **student's** progress to L&I or vocational counselors at no cost.

Payment limits

Schools must bill the insurer based on their usual and customary fees.

When questions arise about the cost of training (such as tuition, fees, supplies, etc.), L&I will base decisions on the catalog relevant when the plan was approved. This catalog must include total cost of the program including tuition, fees, supplies, etc. Licensed schools must maintain a current catalog with costs on file with the school's credentialing body.

Schools can't:

- Bill the worker more than any other **student** for the same program, *or*
- Charge **workers** or VRCs directly for tuition, *or*
- Bill the **worker** or VRC for amounts above the approved training plan cost. See RCW 51.04.030(2) and WAC 296-20-020.

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: A list of SIE/TPAs is available online.

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**.

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 vocational provider's L&I provider account number 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.

Payment limits

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

Payment policy: Travel, wait time, and mileage

General information

L&I supports in-person meetings to encourage effective engagement, collaborative problem solving, and delivery of quality vocational services. Travel, wait time, and mileage charges aren't included in the fee cap for any referral type.

The vocational provider may bill mileage, round trip, from their primary branch office to their in-state or border city 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 1 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 1 claim

If traveling for more than 1 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 2 claims, bill half to each claim.
- For 3 or more claims split the charges accordingly (3 claims = by thirds, 4 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 C, and then back to their primary branch office. VRC will bill a third of the total time and mileage under each referral.

Prior authorization

Reimbursement for lodging and airfare requires prior authorization from L&I. The VRC is responsible for obtaining authorization from the Vocational Services Specialist (VSS) for their travel in advance.

Extension of stay

If the stay is extended for the VRC referral needs, L&I will reimburse for the additional lodging provided prior authorization has been obtained. It is the VRC's responsibility to contact the VSS to request authorization to extend the stay.

Services that can be billed

Code	Description	Maximum fee
0891V	Travel/wait time (VRC or forensic VRC) 1 unit = 6 minutes Includes time spent driving, waiting for appointments, or other similar circumstances.	**$5.29** per 6 minutes
0892V	Travel/wait time (intern) 1 unit = 6 minutes Includes time spent driving, waiting for appointments, or other similar circumstances.	**$5.29** per 6 minutes
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) Requires documentation with a receipt in case file.	**By Report**
0897V	Hotel charges (VRC, intern or forensic VRC)	**State rate**

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
0391R	Travel/wait (non-VRC), 1 unit = 6 minutes	**$5.76** per 6 minutes
0392R	Mileage (non-VRC), 1 unit = 1 mile	**State rate**
0393R	Ferry charges (non-VRC) Requires documentation with a receipt in case file.	**State rate**

Services that aren't covered

L&I won't reimburse for the following:

- Meals, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Cancellations made by the **lodging provider**, *or*
- Lodging and/or fees outside the authorized period.

Documentation requirements

Documentation must be submitted separately from bills. Please include the phrase "**index: VOC"** in the bottom right corner of each page to ensure documentation is entered properly in L&I's systems.

Please submit a copy of the hotel invoice and airfare receipt for documentation. L&I will reimburse up to the US General Services Administration rates for out of state travel, and up to the Office of Financial Management travel reimbursement for in-state travel.

Documentation must contain:

- A copy of the itemized receipt, *and*
- The travel date span, *and*
- The claimant's name, *and*
- L&I claim number(s), *and*
- Total charge for the date span, *and*
- Number of units (nights) stayed.

Payment policy: Additional requirements for all vocational services providers

Documentation requirements

For bills submitted to the department, see WAC 296-19A-360 for documentation requirements.

Inappropriate referral: ADMA billing

Vocational firms must assign a referral to a vocational counselor within 24 hours. After the assignment is made, the counselor may have reason to decline. The use of the ADMA outcome, *firm declines referral*, should be rare and determined as quickly as possible within 14 days of the referral assignment.

Examples of when a firm may need to use the ADMA outcome code include:

- Conflict of interest, or
- Higher level of specialization is necessary.

A maximum of 3 professional hours may be billed for reviewing the file and preparing a brief rationale after the referral is assigned to a counselor. The counselor assignment is critical to avoiding delays in payment

Prior to entering an ADMA outcome, the firm needs to call the unit vocational services specialist to discuss the reasons for declining the referral. If the ADMA code is still appropriate, the firm must enter the outcome code and send the rationale using an EVOC message.

The ADMA outcome code shouldn't be used by firms to selectively decline referrals in favor of less complicated cases or to manage capacity. Firms must be proactive in managing counselor caseload and notify L&I if the volume of referrals needs to be adjusted.

Preferred worker certification for workers who choose Option 2

Vocational providers must consider assisting a worker covered by the State Fund 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 granted by legal order.

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.

Other VRC requests to attending providers 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 accommodation reviews,
- Proposed work rehabilitation 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, by **telehealth**, 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.
    - 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 **$342.55** for VRC and/or intern time.

Code	Description	Maximum fee
0844V	Resume services (VRC)	**$10.55** per 6 minutes
0845V	Resume services (intern)	**$8.99** 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) that aren't billable include:

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

Time spent on any administrative and clerical activity also isn't billable including:

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

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. 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 isn't covered during a vocational recovery referral.

Test administration billing

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 appropriate group testing for 3 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.

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*
- The vocational provider's L&I provider number 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 L&I 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 an initial plan on a claim with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers shouldn't 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 another provider.

When more than 1 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*
- 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.

Split billing across multiple referrals

When a worker has 2 or more open time loss claims, the insurer may make a separate referral for each claim. In cases where the insurer makes 2 (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 2 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 8 units under each claim.
- A provider has 2 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 4 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 3 (or more) claims requiring time loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received. 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 1 claim and referral, the billing must be split equally among the claims.

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

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.

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

Answers to the following common questions can be found in various WACs:

- 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

The insurer must be notified immediately by both the firm and the L&I provider number (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.

Change in status responsibilities apply to both State Fund and Self-Insurance vocational providers. Forms for reporting change in status are available on L&I's website.

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

Failure to report change in status

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.

Approved plan services that occur prior to plan start date

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

- Tuition and fees (training, exams, licensing) (billing code **R0310**), *and*
- Books, equipment, supplies, other (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:
  - 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 may reimburse for food including grocery and restaurant purchases made while the worker is participating in an approved plan with authorized board and lodging.

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).

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.

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

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

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for corrective action for failure to notify about changes in status	Washington Administrative Code (WAC) 296-19A-270
Administrative rules for vocational services	WAC 296-19A
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 and vocational services	Fee schedules on L&I's website
Job modifications and pre-job accommodations policies	Job modifications on L&I's website Pre-job accommodations on L&I's website
L&I's Claim and Account Center	Claim and Account Center
Quality assurance by vocational firms	Quality Assurance by Vocational Firms
Schools and training programs	Resources for Training Providers on L&I's website
Statement for Miscellaneous Services	F245-072-000 on L&I's website
Option 2 Vocational Services	WAC 296-19A-631, 633, 635, 637 Option 2 details on L&I's website Self-Insured Option 2 Vocational Services Summary State Fund Option 2 Vocational Services Summary
Services that aren't covered	WAC 296-19A-340
Statement for Retraining and Job Modification Services form	F245-030-000 on L&I's website

If you're looking for more information about…	Then see…
Notify L&I of changes in status	Email Private Sector Rehab Services PSRS@LNI.WA.GOV
Vocational Provider and Firm Application	F252-088-000 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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 31: Washington RBRVS Payment System

Effective July 1, 2024

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

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Relative value units (RVUs): Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

- The work,
- Practice expense, *and*
- Liability insurance (malpractice expense).

A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

Link: A list of current RVUs can be accessed on Medicare's website.

Resource-based relative value scale (RBRVS): RBRVS is a payment method used by many healthcare insurers to develop fee schedules for services and procedures provided by healthcare professionals. Each fee is based on the relative value of resources required to deliver a service or procedure.

This chapter includes details on the RBRVS, which L&I uses to pay for most professional services. These services have a fee schedule indicator (FSI) of R in L&I's Professional Services Fee Schedule.

Payment policy: Basis for calculating RBRVS payment levels

Payment methods

Fee development

RBRVS fee schedule allowances are based on:

- Relative value units (**RVUs**),
- Geographic adjustment factors for Washington State, *and*
- A conversion factor

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted **RVU** (see **RVU** geographic adjustments, below).

The maximum fee for a procedure is obtained by multiplying the adjusted **RVUs** by the conversion factor. The maximum fees are published as dollar values in the Professional Services Fee Schedule.

The conversion factor has the same value for all services priced according to the **RBRVS**. L&I may annually adjust the conversion factor.

Links: The conversion factor is published in WAC 296-20-135, and the process for adjusting the conversion factor is defined in WAC 296-20-132.

RVU geographic adjustments

The state agencies geographically adjust the **RVUs** for each of these components based on the costs for Washington State.

The Washington State geographic adjustment factors for July 1, 2024 are:

- 101.3% of the work component **RVU**,
- 107.8% of the practice expense **RVU**, *and*
- 78.5% of the malpractice **RVU**.

Calculation for maximum fees

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor, then
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth, then
3. Multiply the rounded sum by L&I's RBRVS conversion factor, and finally
4. Round to the nearest penny.

Note: 2 state agencies, L&I and Health Care Authority (HCA), use a common set of **RVUs** and geographic adjustment factors for procedures, but use different conversion factors.

Place of service payment differential

Based on where the service was performed, the insurer will pay professional services at the **RBRVS** rates for:

- Facility settings (such as hospitals and ASCs), *and*
- Non-facility settings.

The place of service payment differential is based on CMS's payment policy.

Link: The maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

Requirements for billing

Due to the site of service payment differential (see above), it is important to include a valid 2-digit place of service code on your bill.

Payment policy: Facility setting services paid at the RBRVS rate

Payment methods

When services are performed in a facility setting, the insurer makes 2 payments:

- 1 to the professional provider, *and*
- 1 to the facility.

The payment to the facility includes resource costs such as:

- Labor,
- Medical supplies, *and*
- Medical equipment.

Note: To avoid duplicate payment of resource costs, these costs are excluded from the **RBRVS** rates for professional services in facility settings.

Requirements for billing

Remember to include a valid 2-digit place of service code (POS) on your bill. Bills without a place of service code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

Professional services billed with the following place of service codes will be paid at the rate for **facility settings**:

If the **place of service description** is…	Then bill using this **2-digit place of service code**:
Ambulance (air or water)	42
Ambulance (land)	41
Ambulatory surgery center	24
Birthing center	25
Comprehensive inpatient rehabilitation facility	61

If the **place of service description** is…	Then bill using this **2-digit place of service code**:
Comprehensive outpatient rehabilitation facility	62
Emergency room hospital	23
Hospice	34
Indian health service free standing facility	05
Indian health service provider based facility	06
Inpatient hospital	21
Inpatient psychiatric facility	51
Military treatment facility	26
Outpatient hospital	22
Psychiatric facility partial hospitalization	52
Psychiatric residential treatment center	56
Skilled nursing facility	31
Telehealth provider other than in patient's home	02
Tribal 638 free standing facility	07
Tribal 638 provider based facility	08
Other unlisted facility	99
(Place of service code not supplied)	(none)

Payment policy: Non-facility setting services paid at the RBRVS rate

Payment methods

When services are provided in non-facility settings, the professional provider typically bears the costs of:

- Labor,
- Medical supplies, *and*
- Medical equipment

These costs are included in the **RBRVS** rate for non-facility settings.

Professional services will be paid at the **RBRVS** rate for non-facility settings when the insurer doesn't make a separate payment to a facility.

When the insurer doesn't make a separate payment directly to the provider of the professional service, the facility will be paid for the service at the **RBRVS** rate for non-facility settings.

Requirements for billing

Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

Professional services billed with the following place of service codes will be paid at the rate for **non-facility settings**:

If the **place of service description** is…	Then bill using this **2-digit place of service code**:
Assisted living facility	13
Community mental health center	53
Correctional facility	09
Custodial care facility	33
End stage renal disease treatment facility	65
Federally qualified health center	50

If the **place of service description** is…	Then bill using this **2-digit place of service code**:
Group home	14
Home	12
Homeless shelter	04
Independent clinic	49
Independent laboratory	81
Intermediate care facility/individuals with intellectual disabilities	54
Mass immunization center	60
Mobile unit	15
Nonresidential substance abuse treatment center	57
Nursing facility	32
Office	11
Pharmacy	01
Residential substance abuse treatment center	55
Rural health clinic	72
School	03
State or local public health clinic	71
Telehealth provided in patient's home	10
Temporary lodging	16
Urgent care facility	20
Walk in retail health clinic	17

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for the conversion factor	Washington Administrative Code (WAC) 296-20-132 WAC 296-20-135
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
A list of the current RVUs used in calculating the insurer's conversion factor	RVUs on the CMS 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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 32: Ambulatory Surgery Centers (ASCs)

Effective July 1, 2024

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

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Modifiers

The CPT®, HCPCS, and/or local code modifiers which apply to this chapter (but aren't limited to) are:

Use	Payment Information
–50 (Bilateral surgery)	
Use this modifier to indicate when a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each side of the body the procedure was performed. Apply the modifier to the second line.	The total payment is made at **150%** of the global surgery fee schedule amount for the procedure as follows: • **100%** of the global surgery fee for the procedure on the first line. • **50%** of the global surgery fee for the procedure on the second line.
–51 (Multiple surgeries)	
Use this modifier to indicate when multiple procedures were performed at the same operative session by the same individual. Providers must bill using separate line items for each procedure performed. Apply the modifier to all line items but the primary procedure. If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.	The total payment equals the sum of: • **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, *plus* • **50%** of the maximum allowable fee for the subsequent procedure(s) with the next highest values according to the fee schedule.
–52 (Reduced services)	
Use this modifier to indicate when a service is reduced. Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. **Note**: Don't use this modifier for ASC services that require anesthesia. Instead, refer to modifiers **–73** and **–74**.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–73 (Discontinued procedures prior to the administration of anesthesia)	
Use this modifier to indicate when a physician cancels a surgical procedure due to the onset of medical complications or extenuating circumstances subsequent to the patient's preparation (including sedation), but prior to the administration of anesthesia (local, regional block(s) or general). For use in ASC only.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.
–74 (Discontinued procedures after administration of anesthesia)	
Use this modifier to indicate when a physician terminates a surgical procedure due to the onset of medical complications or extenuating circumstances after the administration of anesthesia (local, regional block(s) or general) or after the procedure was started. For use in ASC only.	This modifier doesn't affect payment but is necessary to describe the service performed.
–99 (Multiple modifiers)	
Use this modifier to indicate when more than 2 modifiers affect payment. For billing purposes only, include only this modifier with the service(s) performed on the billing form, along with any modifiers not affecting payment. In the remarks section of the billing form, include the individual descriptive modifiers that affect payment.	This modifier doesn't affect payment but is necessary to accommodate all modifiers billed. Payment is based on the policy associated with each individual modifier that describes the actual services performed.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: All ASC services

Prior authorization

Procedures not on L&I's ASC fee schedule require prior authorization. Specifically:

- Under certain conditions, the director, the director's designee, or self-insurer, at their sole discretion, may determine that a procedure not listed on L&I's ASC fee schedule may be authorized in an ASC.
    - For example, this may occur when a procedure could be harmful to a particular worker unless performed in an ASC.
- The healthcare provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. Requests for coverage under these special circumstances require prior authorization. The written request must contain:
    - A description of the proposed procedure with associated CPT® or HCPCS procedure codes, *and*
    - The reason for the request, *and*
    - The potential risks and expected benefits, *and*
    - The estimated cost of the procedure.
- The healthcare provider must provide any additional information about the procedure requested by the insurer.

What facilities qualify for payment

To qualify for payment for ASC services, an ASC must:

- Be licensed by the state(s) in which it operates, unless that state doesn't require licensure, *or*
- Have at least 1 of the following credentials:
    - Medicare (CMS) Certification as an ASC, *or*
    - Accreditation as an ASC by a nationally recognized agency acknowledged by CMS, and
- Have an active ASC provider account with L&I.

Services that can be billed

L&I uses the CMS list of procedure codes covered in an ASC, plus additional procedures determined to be appropriate.

L&I's rates for ASC procedures are based on a modified version of the current system developed by CMS for ASC services. L&I expanded the CMS list by adding some procedures CMS identified as excluded procedures.

Link: All procedures covered in an ASC are listed online in the fee schedule.

Services that aren't covered

Procedure codes not listed in L&I's ASC fee schedule aren't covered in an ASC.

Additional information: Who to contact to become accredited or Medicare certified as an ASC

For national accreditation, contact:

- Accreditation Association for Ambulatory Health Care
- American Osteopathic Association
- Commission on Accreditation of Rehabilitation Facilities
- The Joint Commission
- QUAD A

For Medicare certification, contact:

Department of Health, **Office of Health Care Survey**
Facilities and Services Licensing
PO BOX 47874
Olympia, WA 98504-7874
360-236-4983

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for ASC payment policies	Washington Administrative Code (WAC) 296-23B
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 facility services (including ASCs)	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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 33: Brain Injury Rehabilitation Services

Effective July 1, 2024

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

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Definitions

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:

Use	Payment Information
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Brain injury rehabilitation services

Prior authorization

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment.

State Fund claims

To determine whether or not to authorize post-acute brain injury rehabilitation for a claim, both an occupational nurse consultant (ONC) and L&I claim manager will review the claim separately. (See Approval criteria, below.)

The Provider Hotline can't authorize brain injury treatment; however, the Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

Self-insured claims

Contact the SIE or TPA for authorization (see Approval criteria, below).

Link: Contact information for the SIE or TPA is available via L&I's self-insured lookup tool.

Approval criteria

Before a worker can receive treatment, all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim,
- The brain injury is related to the industrial injury or is retarding recovery,
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program,
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury, *and*
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Who must perform these services to qualify for payment

Only providers approved by the department can provide post-acute brain injury rehabilitation services for workers.

Providers must maintain CARF accreditation in Outpatient Medical Rehabilitation Program – Interdisciplinary with Brain Injury Specialty designation and provide the Department of Labor and Industries (L&I) with documentation of satisfactory recertification including the latest CARF Accreditation Report. This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account will be inactivated if CARF accreditation expires or this information is not received from the provider. It is the provider's responsibility to notify L&I when an accreditation visit is delayed.

Qualifying programs

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation,
- Treatment, *and*
- Follow up.

When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to:

Department of Labor and Industries

Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Specific L&I provider account number required

Providers will be issued a provider-specific ID number (separate from any provider ID they may already have with L&I) which will enable payment via the brain injury program billing codes. Providers billing for individual services and therapies don't need to obtain a special provider account number.

Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at 1-800-848-0811 or by emailing PHL@lni.wa.gov.

Services that can be billed

Nonhospital based programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs:

Local code	Description	Maximum fee
8950H	Comprehensive brain injury evaluation	**$5,119.15**
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,161.25**
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$808.78**

Hospital based programs

The following revenue codes and payment amounts for hospital-based outpatient post-acute brain injury rehabilitation treatment programs:

Local rev code	Description	Maximum fee
0014	Comprehensive brain injury evaluation	**$5,119.15**
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,161.25**
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$808.78**

Meals

L&I will reimburse the brain injury provider for 1 meal per day provided there is an onsite meal offered to the worker, and the worker is participating in more than 4 hours of treatment that day. Don't bill L&I for meals not provided to or paid by the worker.

Code	Description	1 unit of service equals…	Maximum fee per unit
5934M	Outpatient Day Program - Lunch	1 meal per authorized person	**State Rate** (includes taxes & gratuity)

Current **State Rates** can be found on the Office of Financial Management's (OFM) website.

The brain injury provider should bill L&I their usual and customary charges for the meal provided. Reimbursement will be at your usual and customary charge or the **State Rate**, whichever is less. For more information about billing for meals, see Chapter 22: Other Services.

Services that aren't covered

Brain injury rehabilitation program services performed in the worker's home aren't covered.

Requirements for billing

For State Fund claims billing, providers participating in the Brain Injury Program must bill for brain rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. (See who must perform these services to qualify for payment, above.)

Comprehensive brain injury evaluation requirements

A comprehensive brain injury evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in depth analysis of the worker's cognitive, psychological, emotional, social, physical status and functioning. It should also include the review of the workers' medical records, assessment of any important associated conditions that may hinder recovery, identification of the worker's family and support resources, and identification of factors that may affect participation. The evaluation must be provided by a multidisciplinary team that includes all of the following:

- Medical physician,
- Psychologist,
- Neuropsychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist, and
- Speech therapist

Additional medical consultations are referred through the program's physician. For State Fund claims, each consultation may be billed under the provider account number of the consulting physician. Services must be preauthorized by an L&I claim manager or the self-insured employer.

Documentation requirements

The following documentation is required of providers when billing for evaluation and/or treatment services within the post-acute brain injury rehabilitation program:

- Daily record of a workers' attendance, activities, treatments and progress
- All test results and scoring
- Documentation of interviews with family, *and*
- Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program.

Progress reports must be sent to the insurer regularly, including all preadmission and discharge reports.

Payment limits

Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation, may be performed in any combination depending on the worker's condition, and **can't be billed separately**:

- Neuropsychological Diagnostic Interview(s), testing, and scoring,
- Initial consultation and exam with the program's physician,
- Occupational and Physical Therapy evaluations,
- Vocational Rehabilitation evaluation,
- Speech and language evaluation, *and*
- Comprehensive report.

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is **considered part of the provider's administrative overhead**. It includes but isn't limited to:

- Obtaining and reviewing the workers' historical medical records,
- Interviewing family members, if applicable,
- Phone contact and letters to other providers or community support services,
- Writing the final report, *and*
- Office supplies and materials required for service(s) delivery.

Treatment

These therapies, treatments, and/or services are included in the Brain Injury Program maximum fee schedule amount for the full day or half-day brain injury rehabilitation treatment and **can't be billed separately**:

- Psychotherapy,
- Behavioral modification,
- Behavioral Health Interventions, see Chapter 22: Other Services for more details,
- Individual or group therapy counseling,
- Physical therapy and occupational therapy,
- Speech and language therapy,
- Nursing and health education and pharmacology management,
- Activities of daily living management,
- Recreational therapy (including group outings),
- Vocational counseling, *and*
- Follow up interviews with the worker or family, which may include home visits and phone contacts.

Ancillary work, materials, and preparation that may be necessary to carry out Brain Injury Program functions and services are considered part of the provider's administrative overhead and **aren't payable separately**. These include, but aren't limited to:

- Daily charting of patient progress and attendance,
- Report preparation,
- Case management services,
- Coordination of care,
- Team conferences and interdisciplinary staffing, *or*
- Educational materials (for example, workbooks and tapes).

Follow up care is included in the cost of the full day or half-day program. This includes, but isn't limited to:

- Telephone calls,
- Home visits, *and*
- Therapy assessments.

Payment policy: Telehealth for brain injury rehabilitation services

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

Post-acute brain injury rehabilitation, full day (**8951H,** rev code 0015) and half-day (**8952H,** rev code 0016) are covered via **telehealth**.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Services that aren't covered

Telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only evaluation or treatment billed using modifier **–93** (audio only).

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report),
- Home health monitoring,
- **G2010** and **G2250** Store and forward, *and*
- Comprehensive brain injury evaluations (**8950H**, rev code **0014**).

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Do not bill using the **–GT** modifier to indicate **telehealth** for local codes.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
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 facility 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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 34: Chronic Pain Management

Effective July 1, 2024

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

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Distant site: The location of the provider who performs telehealth services. This provider isn't at the originating site with the worker.

Important associated conditions: Medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

State Rate: The reimbursement rate for travel reimbursement set by the Office of Financial Management (OFM) within the State of Washington.

Link: For the current **State Rate**, see the per diem tables on the OFM website.

SIMP (structured intensive multidisciplinary program): A chronic pain management program with the following 4 components:

- **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
- **Intensive** means the Treatment Phase is delivered on a daily basis, 6 to 8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
- **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare professionals with expertise in pain management in at least the areas of medicine, psychology, and physical therapy or occupational therapy. The **SIMP** may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits, *and*
- **Program** means an interdisciplinary pain rehabilitation program that provides outcome focused, coordinated, goal oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Telehealth: Face-to-face services delivered by a qualified medical provider through a real-time, two-way, audio video connection. These services aren't appropriate without a video connection.

Treatment plan: An individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

Valid tests and instruments: Those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Structured, intensive, multidisciplinary program (SIMP)

General requirements

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP**.

Prior authorization is required for all workers to participate in a **SIMP** for functional recovery from chronic pain. See details about prior authorization requirements later in this Payment policy section.

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

Program design: Phases of an approved SIMP

An approved **SIMP** has 3 phases:

- Evaluation Phase,
- Treatment Phase, and
- Follow up Phase.

See below for details about each of these 3 phases.

1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes **treatment plan** development and a report. Only 1 evaluation is allowed per authorization but it can be conducted over 1 to 2 days.

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*
- Review of medical records and reports, including diagnostic tests and previous efforts at pain management, *and*
- Assessment of any **important associated conditions** that may hinder recovery, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease, *and*
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs. This must include checking the Prescription Monitoring Program Database *and*
- Psychological and social assessment by a licensed clinical psychologist using **valid tests and instruments**, *and*
- Identification of the worker's family and support resources, *and*
- Identification of the worker's reasons and motivation for participation and improvement, *and*
- Identification of factors that may affect participation in the program, *and*
- Assessment of pain and function using **valid tests and instruments**; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
    - Activities of Daily Living (ADLs),
    - Range of Motion (ROM),
    - Strength,
    - Stamina, *and*
    - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the **SIMP** vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for **SIMP** workers section of this chapter), *and*

- A summary report of the evaluation and a preliminary recommended **treatment plan**. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6 to 8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the **treatment plan**, *and*
- **Education and skill development** on the factors that contribute to pain, responses to pain, and effective pain management, *and*
- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using **valid tests and instruments** consistent with those at evaluation, *and*
- **Ongoing assessment** of **important associated conditions**, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment. This must include checking the Prescription Monitoring Program Database. *and*
- **Performance** of real or simulated work or daily functional tasks, *and*
- **SIMP vocational services**: these may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and* a discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase.
- At time of discharge, the SIMP physician must call the attending provider to discuss the workers treatment in the program, progress, barriers, and discharge plan. *and*

- **A summary report** at the conclusion of the Treatment Phase that addresses all the following questions:
  - To what extent did the worker meet his or her treatment goals?
  - What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?
  - What changes if any, have occurred in the worker's pain level and functional capacity as measured by **valid tests and instruments** (consistent with the tools used during evaluation)?
  - What changes if any, have occurred in the worker's ability to manage pain?
  - What is the status of the worker's readiness to return to work or daily activities?
  - What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
  - How much and what kind of follow up care does the worker need?

3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), or
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

- Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.
- Non face-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems,
- What was done during the Follow up Phase,
- What resulted from the follow up care, and
- Measures of pain and function using **valid tests and instruments** (consistent with the tools used during the SIMP program)

This summary report must be submitted at the 1, 3, and 6 month marks; if applicable.

Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with **valid tests and instruments**, *and*
- Evaluating whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase, *and*

- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing **important associated conditions** and psychological status especially as related to reintegration in the workplace, home, and community, *and*
- Assessing what kind of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist, *and*
- Adjusting the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*
- Teaching new techniques or skills that weren't part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain, *and*
- Making recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources, *and*
- Holding case conferences with the:
- Interdisciplinary team of clinicians, *and/or*
- Worker's attending provider, *and/or*

- Other individuals closely involved with the worker's care and functional recovery.

Follow up Phase special considerations

When determining what follow up services the worker needs, **SIMP** providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a **SIMP** provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the **SIMP** provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*
- If a **SIMP** provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

Link: More information about Helping Workers Get Back to Work is available online.

Prior authorization

General referral and prior authorization requirements

All **SIMP** services require prior authorization by the claim manager and a referral from the worker's attending provider. An occupational nurse consultant, claim manager, or insurer-assigned vocational counselor may recommend a **SIMP** for the worker, but only the attending provider can make a referral.

Note: Only the attending provider can refer a worker for a **SIMP**.

SIMP referral

SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the attending provider refers a worker to a **SIMP**, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the **SIMP** provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the **SIMP** provider recommends the worker move on to the Treatment Phase, the **SIMP** provider must provide the insurer with a report and **treatment plan** as described under the Evaluation Phase, *or if the worker*
- **Doesn't meet the requirements**, the **SIMP** provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*
  - The goals the worker must meet before he or she can return and participate in the program, *also*
  - If the worker is found to have **important associated conditions** during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the **SIMP** provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

SIMP provider requirements

To provide chronic pain management program services to eligible workers, **SIMP** service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see Definitions at the beginning of this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, *and*
- Communicate with providers who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's attending provider, *and*
- Inform the claim manager if the worker:
  - Stops services prematurely,
  - Has unexpected adverse occurrences, or
  - Doesn't meet the worker requirements.
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*
- Provide the insurer with the required documentation in a timely manner (Evaluation Summary Report, all daily chart notes, Treatment Phase Summary Report including the discharge care plan, Follow up visit notes, and Follow Up Summary Report).
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.
- Provide the Department with the SIMP organization structure annually.
- Notify the Department in writing of key organization changes within 30 days.
- New programs must provide the Department contact information with the provider application and be available to provide additional information, as needed.
  - For applicable programs, the Department must be notified of substantial material changes to the program description in writing within 30 days.

Providers must maintain CARF accreditation and provide the Department with documentation of satisfactory recertification including the latest CARF Accreditation Report.

This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account will be inactivated if CARF accreditation expires or this information isn't received from the provider. It is the provider's responsibility to notify the Department when an accreditation visit is delayed.

For any existing SIMP provider wanting to add a new site to the SIMP program, they must provide the L&I's Provider Accounts and Credentialing unit with a copy of the completed *CARF OCForm_Relocation_Expansion_Elimination* to be added to your provider account file.

Worker requirements

An injured worker must make a good faith effort to participate and comply with the **treatment plan** prescribed for him or her by the **SIMP** provider. To complete a **SIMP** successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her **treatment plan**, *and*
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her **treatment plan**, *and*
- Agree to be evaluated and comply with treatment prescribed for any **important associated conditions** that hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease), *and*
- Attend each day and each session that is part of his or her **treatment plan**. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward **treatment plan** goals, *and*
- Cooperate and comply with his or her **treatment plan**, *and*
- Not pose a threat or risk to himself or herself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

Services that can be billed

SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table. The fee schedule applies to injured workers only in an outpatient program:

Description	Local code	Duration / limits	Units of service	Maximum fee
SIMP Evaluation Services	**2010M**	1 evaluation per authorization, which may be conducted over 1 to 2 days.	Bill only 1 unit for evaluation even if conducted over 2 days	**$1,329.96**

Description	Local code	Duration / limits	Units of service	Maximum fee
SIMP Treatment Services, each 6-8 hour day	**2011M**	Not to exceed 20 treatment days (6-8 hours per day).	1 day equals 1 unit of service	**$851.87** per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community	**2014M**	Not to exceed 4 hours per day and not to exceed 24 hours total (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.79** per minute (**$107.40** per hour)
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community	**2015M**	Not to exceed 40 hours (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.40** per minute (**$84.00** per hour)

Description	Local code	Duration / limits	Units of service	Maximum fee
Outpatient Day Program - Lunch for meal reimbursement	**5934M**	Worker must be onsite for treatment of more than 4 hours. Prior authorization required. Don't bill for meals not provided to or paid for by the worker.	1 meal per authorized person	**State Rate** (includes taxes & gratuity)
Mileage for traveling to and from the worker's community	**0392R**	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

Requirements for billing

Outpatient chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form (F245-127-000).

Billing for partial days for the treatment phase

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the worker was scheduled for less than 8 hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill **$851.87** x 25% = **$212.97**

Payment limits

SIMP evaluation services

Only 1 evaluation per authorization is allowed, which may be conducted over the course of 1 to 2 days. If the evaluation is conducted over a 2 day period, bill only 1 unit and span the dates.

SIMP treatment services

These services can't exceed 20 treatment days (6-8 hours per day).

SIMP follow up services

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Face-to-face services (local code **2014M**) can't:

- Exceed 4 hours per day, *and*
- 24 hours total.

Note: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit.

Payment policy: Telehealth for chronic pain management

General information

The insurer reimburses **telehealth** at parity with in-person appointments.

Objective medical findings are required for time-loss and other claim adjudication decisions. In-person visits are preferred for gathering objective medical findings; however, **telehealth** may be an appropriate alternative in certain situations where objective medical findings can be gathered via a two-way audio and visual connection.

The provider is expected to make arrangements for in-person evaluation and intervention for certain circumstances. See below for additional information.

Telehealth services must occur either from a medical or vocational **origination site** or the worker's home. Services may not be delivered from either the employer's worksite or any location owned or controlled by the employer that isn't operated by a Medical Provider Network practitioner. The employer or their designee may not direct or require the worker to use a specific medical provider.

A medical or vocational **origination site** may be:

- A clinic, *or*
- A hospital, *or*
- A nursing home, *or*
- An adult family home.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services. Only vocational rehabilitation counselors are exempt from this requirement.

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status.

System requirements

Telehealth services require an interactive telecommunication system consisting of special two-way audio and video equipment that permits real time consultation between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fee is covered, when applicable.

SIMP treatment services (**2011M**) and follow up face-to-face services (**2014M**) are covered via **telehealth**.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use **HCPCS** code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a worker,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report),
- Home health monitoring,
- **G2010** and **G2250** Store and forward, *and*
- SIMP evaluation services (**2010M**).

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

SIMP follow up that doesn't occur face-to-face (**2015M**) is covered via audio only under the regular local code, based on its description. It wouldn't be appropriate to use this code for SIMP follow up via **telehealth**.

Other than **2015M**, telephone calls aren't an appropriate replacement for in-person or **telehealth** services. The insurer won't pay for audio-only evaluation or treatment billed using modifier **–93** (audio only).

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Don't bill using the modifier **–GT** to indicate **telehealth** for local codes.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

If treatment is to continue via **telehealth**, the evaluation report must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

Chart notes must contain documentation that justifies the level, type and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker. In addition to those limits, physical medicine services including exercise and work rehabilitation activities conducted via **telehealth** are limited to 2 hours per day per worker.

Payment policy: Vocational services for SIMP workers

Prior authorization

Vocational referrals

Prior to authorizing participation in a **SIMP**, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

- Is working, *or*
- Is scheduled to return to work, *or*
- Has been found employable or not likely to benefit from vocational services.

Requirements for a Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with **SIMP** treatment and the claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the **outcomes** listed in the Return to Work Action Plan **must be included** with the Treatment Phase summary report.

If a vocational counselor is assigned, he or she will work with the **SIMP** vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

Note: Don't forget to include the outcomes from the Return to Work Action Plan in your Treatment Phase Summary Report.

Return to Work Action Plan roles and responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the **SIMP** vocational counselor, the attending provider, and the worker are involved.

The specific roles and responsibilities of each are as follows:

The SIMP vocational counselor will:

- Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
- Present the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the **SIMP** recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.

The insurer assigned vocational counselor will:

- Co-develop the Return to Work Action Plan with the **SIMP** vocational counselor, *and*
- Attend the chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
- Negotiate with the attending provider when the initial Return to Work Action Plan isn't approved in order to resolve the attending providers concerns, *and*
- Obtain the worker's signature on the Return to Work Action Plan, *and*
- Communicate with the **SIMP** vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
- Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

The attending provider will:

- Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
- Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.

The worker will:

- Participate in the selection of a return to work goal, *and*
- Review and sign the final Return to Work Action Plan, *and*
- Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

Link: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules supporting **SIMP** payment policies	Washington Administrative Code (WAC) 296-20-125
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Crime Victims Compensation Program contact information	**Phone**: 1-800-762-3716 (toll free) **Fax**: 1-360-902-5333 Crime Victims on L&I's website
Fee schedules for all healthcare services	Fee schedules on L&I's website
Return to work: "Helping Workers Return to Work"	Helping Workers Return to Work on L&I's website
Self-insured claims authorization from the self-insured employer (SIE) or their third party administrator (TPA)	Contact list of SIE/TPAs on L&I's website
Worker refuses to cooperate with care plan: Legal issues defined in Washington state laws	Revised Code of Washington (RCW) 51.32.110

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 35: Hospitals

Effective July 1, 2024

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

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Payment policy: All hospitals

Payment methods

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury.

For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance.

Links: Hospital payment policies established by L&I are reflected in the Hospital Billing Instructions (call L&I's Provider Hotline at 1-800-848-0811 for a current copy) and in WAC 296-20, WAC 296-21, WAC 296-23, and WAC 296-23A.

Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a **UB-04** billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a patient admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via a Percent of Allowed Charges (POAC) rate. For information about POAC rates for outpatient hospital visits, see the State Fund payment methods section for outpatient hospitals later in this chapter.

L&I follows CMS in regards to hospital admissions in the course of an encounter at another site for E/M services. Refer to Chapter 10: Evaluation and Management Services "Services that can be billed" for more information.

Payment limits

No copayments or deductibles from workers are required or allowed.

Payments won't exceed allowed billed charges.

Payment policy: Hospital acquisition cost policy

Payment methods

Items covered under the hospital acquisition cost policy will be paid using a hospital-specific POAC rate.

Nonhospital facilities will be paid a statewide average POAC rate.

Payment policy: Inpatient hospital acute care

Self-insured employer payment methods

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital-specific POAC rates for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program payment methods

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using hospital-specific POAC rates for all hospitals (see WAC 296-30-090).

State Fund provider network coverage requirements

Services from both network and non-network providers can be covered:

- If done in an emergency room at an acute care hospital, or
- If done prior to discharge for a patient who was directly hospitalized from an initial emergency room visit.

Links: For more information about the network, see WAC 296-20-01010(3).

For information on who may treat, see WAC 296-20-015(1).

State Fund payment methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

- An All Patient Refined Diagnosis Related Group (APR DRG) system. L&I currently uses APR DRG Grouper version 38. For exclusions and exceptions, see WAC 296-23A-0470, *or*
- A statewide per diem rate for those APR DRGs that have low volume, *or*
- A POAC rate for hospitals excluded from the APR DRG system.

Link: The current APR DRG Assignment List is available online.

Payment methods for hospital types or locations

Hospital types or locations…	**Payment method** for inpatient hospital acute care services is:
Hospitals not in Washington State, including psychiatric facilities and HMOs	Paid by an out of state POAC rate. The POAC rates are 65.49% for hospitals within the United States and 100% for hospitals outside the United States.
Hospitals in Washington State that are excluded: • Children's hospitals, • Health Maintenance Organizations (HMOs), • Military hospitals, • Veterans Administration facilities, • State psychiatric facilities, • Tribal-owned facilities located on tribal land.	Paid 100% of allowed charges.
Hospitals not in Washington State that are excluded: • Children's hospitals, • Military hospitals, • Veterans Administration facilities	Paid 100% of allowed charges.

Hospital types or locations…	**Payment method** for inpatient hospital acute care services is:
Hospitals in Washington State that are major teaching hospitals: • Harborview Medical Center, • University of Washington Medical Center. *OR* All other Washington hospitals	Paid on a per case basis for admissions falling within designated APR DRGs. For low volume APR DRGs, Washington hospitals are paid using the statewide per diem rates for the designated APR DRG categories below: • Chemical dependency, • Psychiatric, • Rehabilitation, • Medical, • Surgical.

Hospital inpatient acute care rates

The APR DRG Assignment List with APR DRG codes, descriptions, relative weights for each severity of illness category and average length of stay can be viewed on L&I's fee schedule page.

For information on how specific rates are determined see WAC 296-23A.

APR DRG base rates

If the **hospital** is…	Then the **base rate** is:
Harborview Medical Center	**$13,411.09**
University of Washington Medical Center	**$11,875.76**
All other Washington hospitals	**$11,098.52**

APR DRG per diem rates

If the **payment category** is…	Then the **rate** is…	And the **definition** is:
Psychiatric APR DRG per diem	**$1,203.00** multiplied by the number of days allowed by L&I.	APR DRGs identified as Psych
Chemical dependency APR DRG per diem	**$994.74** multiplied by the number of days allowed by L&I.	APR DRGs identified as Chem Dep
Rehabilitation APR DRG per diem	**$1,766.16** multiplied by the number of days allowed by L&I.	APR DRGs identified as Rehab
Medical APR DRG per diem	**$2,532.96** multiplied by the number of days allowed by L&I.	APR DRGs identified as Medical
Surgical APR DRG per diem	**$5,314.62** multiplied by the number of days allowed by L&I.	APR DRGs identified as Surgical

Additional inpatient acute care hospital rates

If the **payment category** is…	Then the **rate** is…	And the **definition** is:
Transfer-out cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the APR DRGs average length of stay. If the worker's stay is less than the average length of stay, a per-day rate is established by dividing the APR DRG payment amount by the average length of stay for the APR DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the worker's stay is equal to or greater than the average length of stay, the APR DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low outlier cases (costs are less than the threshold)	Hospital-Specific POAC rate multiplied by allowed billed charges.	Cases where the cost (see note below table) of the stay is less than 10% of the statewide APR DRG rate or a statutory amount inflated to current dollars, whichever is greater.
High outlier cases (costs are greater than the threshold)	APR DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (see note below table) of the stay exceeds a statutory amount inflated to current dollars or 2 standard deviations above the statewide average cost for each DRG and SOI combination, whichever is greater.

How costs are determined

Costs are determined by multiplying allowed billed charges by the hospital-specific POAC rate. Hospitals outside of the United States will be paid at a POAC rate of 100% of allowed charges. High and low outlier amounts are listed on the APR-DRG Assignment sheet on L&I's fee schedule page.

Payment policy: Outpatient hospitals

Self-insured employer payment methods

Services for hospital outpatient care provided to workers covered by self-insurers are paid using hospital-specific POAC rates or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program payment methods

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using POAC rates or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund payment methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

- Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system.
- An amount established through L&I's Professional Services Fee Schedule for covered services not processed using the APC system.
- A POAC rate for covered hospital outpatient services not processed using either the APC system or with an amount from the Professional Services Fee Schedule.

Note: Under the APC payment model, some line items may be packaged into the payment of other services on the bill and do not receive individual payment. The outpatient code editor (OCE) that Centers for Medicare & Medicaid Services created and maintains is utilized to determine which lines get packaged and which do not.

Links: For a description of L&I's OPPS system, see WAC 296-23A (Part 4), WAC 296-23A-0220, and WAC 296-23A-0700 through WAC 296-23A-0780.

How the above payment methods are applied

Hospital types or locations…	Then the **payment method** for hospital outpatient services is:
Hospitals not in Washington State, including psychiatric facilities and HMOs	Paid by out of state POAC rates. The rates are 65.49% for hospitals within the United States and 100% for hospitals outside the United States.
Hospitals in Washington State that are excluded: • Children's hospitals, • Military hospitals, • Veterans Administration facilities, • State psychiatric facilities, • Tribal-owned facilities located on tribal land.	Paid 100% of allowed charges
Hospitals not in Washington State that are excluded: • Children's hospitals, • Military hospitals, • Veterans Administration facilities	Paid 100% of allowed charges
Rehabilitation hospitals, Cancer hospitals, Critical access hospitals, Private psychiatric facilities	Paid a facility-specific POAC rate or a fee schedule amount depending on procedure

Hospital types or locations…	Then the **payment method** for hospital outpatient services is:
All other hospitals in Washington State	Paid on an APC basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC rate.

Additional payment details

When ER visits develop into inpatient stays, hospitals should bill all charges on an inpatient bill. Use the inpatient admission date as the first covered date.

Military hospitals may bill HCPCS code **T1015** for all outpatient clinic services.

Hospitals will be sent their individual POAC and APC rates each year.

Hospitals outside the United States will be paid at a POAC rate of 100%.

Pass-through devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device hasn't already been incorporated into an APC.

Hospitals will be paid by fee schedule or if no fee schedule exists, a hospital-specific POAC rate for new or current pass-through devices.

New or current drug or biological pass-through items will be paid by fee schedule or a POAC rate (if no fee schedule exists).

Hospital OPPS payment process

Question:	If the **answer** is…	Then the **payment method** is:
1. Does L&I cover the service?	No	Don't pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Don't pay
	Yes	Go to question 3
3. Are the service codes listed on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC rate
4. Is the service packaged?	No	Go to question 5
	Yes	Don't pay. Go to question 7
5. Is there a valid APC for the service?	No	Go to question 6
	Yes	Pay the APC amount and total the APC payment(s) for outlier consideration. Go to question 7
6. Are the service codes listed in a fee schedule?	No	Pay POAC rate
	Yes	Pay the facility amount for the service
7. Does the service qualify for outlier?	No	No outlier payment
	Yes	Pay outlier amount

Additional payment details

If only 1 line item on the bill is an inpatient (IP) code, the entire bill will be paid at POAC rate.

Outlier amounts are in addition to regular APC payments.

OPPS relative weights and payment rates

The relative weights published by CMS are used for the OPPS program.

Each hospital's blended APC rate was determined using a combination of the average hospital-specific APC rate and the statewide average APC rate.

Links: Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720.

Hospitals will receive notification of their blended APC rates via separate letter from L&I or by accessing the Hospital Rates link in the fee schedule.

OPPS outlier payments

L&I uses a modified version of the CMS outlier payment policy.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for hospital payment policies	Washington Administrative Code (WAC) 296-20 WAC 296-21 WAC 296-23 WAC 296-23A WAC 296-30-090
Administrative rules for the State Fund provider network and Who may treat	WAC 296-20-01010 WAC 296-20-015
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms **Adjustments, Refunds, Protests & Appeals**	Chapter 2: Information for All Providers
Evaluation and management services	Chapter 10: Evaluation and Management Services
Fee schedules for all healthcare facility services (including hospitals)	Fee schedule on L&I's website
Residential treatment facilities for mental health	Chapter 17: Mental Health Services

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.

Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 36: Nursing Home and Other Residential Care Services

Effective July 1, 2024

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

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Payment policy: All residential care services

General requirements

The insurer covers:

- Proper and necessary residential care services that require **24 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 provider, *and*
- Authorized by an L&I ONC (occupational nurse consultant) or self-insured employer before care begins.

Prior authorization and reauthorization requirements

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.

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 perform 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.

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 daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this chapter. All residential care services should be billed on form F245-072-000 (Statement for Miscellaneous Services).

Link: The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125.

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.

Links: For more information, see RCW 51.36.100 and RCW 51.36.110.

Payment policy: Assisted living facilities, adult family homes, and boarding 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 insurer will determine the appropriate L&I payment grouping based on the 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. Facilities shouldn't submit bills for the assessment; the nurse who completes the form will bill the Department for their services.

Link: If you are a Nurse Case Manager performing an annual care assessment requested by the department, see Chapter 20: Nurse Case Management.

For assessments performed by a Home Health Agency RN, see Chapter 11: Home Health Services.

Services that can be billed

The insurer will advise the facility of which billing code to use. The 3 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 determines the level of care is**…	Then the appropriate **billing code** is…	And the **daily payment rate** is…
Basic level care	**8893H**	**$190.59**
Intermediate level care	**8894H**	**$231.46**
Advanced/Special level care	**8895H**	**$272.30**

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

Services that can't be billed

L&I won't pay adult family 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, admission fees, or any services not defined by the fee schedule.

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 requirements

You must contact an ONC for approval. 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).

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 **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.

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 (PDPM) 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.

Payment limits

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

Prior authorization requirements

A HIPPS code must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code. For a listing of HIPPS and local code combinations as well as maximum fees, see L&I's fee schedule.

Services that can't be billed

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, admission fees, or any services not defined by the fee schedule.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
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 facility services	Fee schedules on L&I's website
Minimum Data Set (MDS) Basic Assessment Tracking Form	Medicare's (CMS's) website
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Statement for Miscellaneous Services form	Statement for Miscellaneous Services form on L&I's website
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100 RCW 51.36.110

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.