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

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.