Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 22: Other Services

Effective July 1, 2024

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

Table of Contents

Definitions

Authorized companion: A person authorized by L&I to accompany the claimant and share their accommodations for the authorized stay.

Behavioral health interventions (BHI): Brief courses of care with a focus on improving the worker's ability to return to work by addressing psychosocial barriers that impede their recovery. These psychosocial barriers are not components of a diagnosed mental health condition; instead, they are typically the direct result of an injury, although they can also arise due to other factors.

By Report: A code listed in the fee schedule as "By Report" which doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

Client: A worker, an individual, or a group of people that uses the professional services of an interpreter. May also be known as a patient or worker.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Lodging provider: Company, person, or group offering temporary housing, such as hotels, motels, and other temporary short-term rental locations.

Meals: Restricted to breakfast, lunch and dinner. Meals may include non-alcoholic beverages only.

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

Sight translation: Oral rendition of text written from one language into another language, usually done in the moment by the interpreter.

State Rate: The reimbursement rate for travel reimbursement set by the Office of Financial Management (OFM) within the State of Washington.

Link: For the current State Rate, see the per diem tables on the OFM website.

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

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

Modifiers

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

Use	Payment Information
–8S (Health/Surgical health services coordination by a Health Services Coordinator)	
Use this modifier to indicate when a second billable HSC case note on the same day, for the same claimant, under the same claim. Bill each case note on separate lines and apply this modifier to the second line.	Payment for the second case note is made at **50%** of the fee schedule level or billed charge, whichever is less.
–GT (Via interactive audio and video telecommunication systems)	
Use this modifier to indicate when a service was performed via telehealth. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.

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

Payment policy: Activity coaching (PGAP®)

General information

The Progressive Goal Attainment Program (PGAP®) is the standardized form of activity coaching supported by L&I. It consists of an assessment followed by up to 10 weekly individual sessions. Only L&I-approved activity coaches will be paid. A list of activity coaches can be found using the Vendor Services Lookup Tool.

Services that can be billed

Billing code	Description	Unit limit	Unit Price
1400W	Activity Coaching Initial Assessment	6 units (1 unit = 15 min)	**$46.40**
1401W	Activity Coaching Reassessment	5 units per day 10 units maximum (1 unit = 15 min)	**$44.95**
1402W	Activity Coaching Intervention	4 units per day 40 units maximum (1 unit = 15 min)	**$42.78**
1160M	PGAP® Workbook/EBook/Video	1 maximum	**$113.11**

Payment policy: Activity coaching (PGAP®) telehealth

General information

The insurer reimburses **telehealth** at parity with in-person appointments. Activity coaching (PGAP®) can be performed in person, telephonically (audio only) or via **telehealth**.

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

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

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

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**.

System requirements

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

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Services that can be billed

The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The services listed under "Services that must be performed in person",
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Activity Coaching (PGAP®) payment policy in this chapter and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in this chapter apply regardless of how the service is rendered to the worker.

Payment policy: Activity coaching telephone calls to worker legal representatives

Who must perform these services to qualify for payment

Telephone calls are payable to approved PGAP® Activity Coaches only when they personally participate in the call.

Services that can be billed

These services are payable when providing outreach, education, and facilitating services with the worker's legal representative identified in the claim file.

The insurer will pay for telephone calls if the coach leaves a detailed message for the recipient and meets all of the documentation requirements. Telephone calls are payable regardless of when the previous or next office visit occurs.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Administrative communications,
- Authorization,
- Resolution of billing issues, *or*
- Routine requests for appointments.

Requirements for billing

Use the correct local billing codes and provide documentation as described below.

If the duration of the telephone call is…	And you are a PGAP® activity coach, then bill local code…
1-10 minutes	**1725M**
11-20 minutes	**1726M**
21-30 minutes	**1727M**

Documentation requirements

Each provider must submit documentation (either in their report or in a session note) for the telephone call that includes:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The details of the call, *and*
- All medical, vocational or return to work decisions made.

Note: See Chapter 10: Evaluation and Management Services for telephonic communication with persons other than legal representatives.

Payment policy: After-hours services

Services that can be billed

CPT® codes **99050**-**99060** will be considered for separate payment in the following circumstances:

- When the provider's office isn't regularly open during the time the service is provided, *or*
- When emergency services are provided out of the office, and these services interrupt both normal office operations and other scheduled office visits.

Documentation requirements

Medical necessity and urgency of the service must be documented in the medical records and be made available to the insurer upon request.

Payment limits

Only one code for after-hours services will be paid per worker per day. A second day can't be billed for a single episode of care that carries over from one calendar day to the next.

CPT® codes **99050**-**99060** aren't payable when billed by:

- Emergency room physicians,
- Anesthesiologists/anesthetics,
- Radiologists, *or*
- Laboratory clinical staff.

Payment policy: Behavioral health interventions (BHI)

General information

The insurer covers **behavioral health interventions (BHI)** if the attending provider has reason to believe that psychosocial factors may be affecting the worker's medical treatment or medical management of an injury. Identification of psychosocial factors and recommendation of **BHI** services can be from any claim party, but the referral must come from the attending provider. This doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or treatment.

Behavioral health intervention can take many forms. Cognitive behavioral therapy and motivational interviewing are two popular evidence-based methods.

How mental health and BHI may intersect

During **behavioral health interventions**, a provider may identify apparent symptoms of a DSM-5 diagnosable mental health condition. This may be related to the industrial injury, and in such situations, it may be appropriate to ask the attending provider to refer the worker for a mental health evaluation. See Chapter 17: Mental Health Services and the authorization and reporting requirements for mental health specialists for details.

Links: For additional details about **behavioral health interventions**, see L&I's Behavioral Health resources and Psychosocial Determinants Influencing Recovery (pages 24-27).

Who must perform these services to qualify for payment

Attending providers, consultants, psychologists, and Masters Level Therapists (MLTs) may provide **BHI** services. (see Services that can be billed for details).

An MLT must have one of the following licenses:

- Licensed Marriage and Family Therapist (LMFT), *or*
- Licensed Independent Clinical Social Worker (LICSW), *or*
- Licensed Mental Health Counselor (LMHC)

Note: When MLTs are credentialed or certified in either vocational or activity coaching, they may not provide dual services for a worker. MLTs may assist the worker with finding the appropriate provider for the other service. MLTs, vocational providers, and activity coaches all require separate L&I provider account numbers. For details, see Chapter 2: Information for All Providers.

Students and student supervision

See Chapter 2: Information for All Providers for details about students and student supervision.

Services that can be billed

CPT® Code(s)	Description and notes
96156, 96158, 96159	**Individual Behavioral Health Interventions (BHI)** No prior authorization required. 16 visits per worker. Up to 8 additional visits maximum may be allowed with prior authorization if the provider has demonstrated improvement through prior treatment and established sufficient medical necessity to the insurer in advance of the additional visits. For State Fund claims, the request is submitted to the claim manager. For Self-Insured claims, the request is submitted to the self-insured employer or their third party administrator. **Note: 96159** is an add-on code and is not included in the 16-visit maximum. **96159** must be billed with **96158**.
96127	**Brief emotional/behavioral screening and risk assessment** Not billable in addition to **behavioral health intervention (BHI)** services. Completion of these types of assessments (such as 2-item GCPS, PHQ-2, and PHQ-4) are considered to be already included within **BHI** services. 3 assessments per day, per provider, with a maximum of 6 assessments per provider, per worker. This maximum is separate to the individual therapy limit noted above.
96164, 96165, 96167, 96168	**Group or Family Behavioral Health Interventions (BHI) Therapy** No prior authorization required. 16 visits max per worker. This maximum is separate from the individual therapy limit noted above.

CPT® Code(s)	Description and notes
Bundled	**Pain Management and Brain Injury Rehabilitation** **BHI** is a bundled service when performed as part of a Brain Injury Rehabilitation Program (BIRP) or a Structured, Intensive, Multidisciplinary Program (SIMP). In these cases, **BHI** isn't separately payable. See Chapter 33: Brain Injury Rehabilitation Services and Chapter 34: Chronic Pain Management for details. L&I is in the process of reviewing SIMP and Brain Injury Rehabilitation Services. Changes may be published with 30 days' notice on the Updates and Corrections webpage.

For online communications using **9918M**, see Chapter 10: Evaluation and Management Services.

Services that aren't covered

Services beyond 16 visits per worker aren't covered. Prior authorization is required for up to 8 additional visits, as described in Services that can be billed.

Treating diagnosable mental health conditions using **BHI** therapy isn't appropriate and can't be billed. Refer to Chapter 17: Mental Health Services for details on treating mental health conditions. If a mental health condition has been accepted or denied on a claim, BHIs aren't appropriate and can't be billed. Don't perform or bill for BHIs on claims with accepted or denied mental health conditions.

The following services aren't covered as part of **BHI**:

- **90885**
- **96130-96131**
- **96136-96137**
- **96170-96171**
- **98961-98962**

96160 isn't covered for any provider.

Requirements for billing

BHI is billed using the approved physical diagnosis or diagnoses on the claim as the condition causing the need for treatment.

If you are…	Then bill…
A psychologist or a Masters Level Therapist (MLT) such as an LMFT, LICSW, or LMHC	CPT® **96156** for assessment or re-assessment. CPT® **96158** and **96159**, as appropriate, for individual **BHI** therapy. CPT® **96164**, **96165**, **96167**, and **96168**, as appropriate, for group and family **BHI** therapy. CPT® **96127** for brief emotional/behavioral screening and risk assessments.
An attending provider or a consultant	The appropriate evaluation and management service procedure code(s). Stand-alone **BHI** follows the same limits as MLTs and psychologists above.

Link: See Chapter 10: Evaluation and Management Services for additional information.

Documentation requirements

All providers must document progress and improvement in function throughout the visits.

Attending providers and consultants

Attending providers and consultants performing **BHI** as part of an Evaluation and Management (E/M) service must use the documentation guidelines noted in Chapter 10: Evaluation and Management Services to document these services.

Stand-alone **BHI** follows the same documentation requirements below.

MLTs and psychologists

MLTs and psychologists must use the following form to document **BHI** services:

- Behavioral Health Initial Assessment form.

MLTs and psychologists must document outcomes from the following when performing an initial or re-assessment for individual **BHI** therapy:

- Patient Health Questionnaire 4 (PHQ-4)
- Two-item Graded Chronic Pain Scale (2-item GCPS)

Payment policy: Behavioral health interventions (BHI) audio only

General information

The insurer covers some **behavioral health interventions (BHI)** via audio only.

Telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

Services that must be performed in person

The same in-person requirements listed in the **BHI** telehealth policy in this chapter apply to audio-only **BHI** services.

Services that can be billed

When **BHI** are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has created a local codes specific to **BHI** audio-only services.

Local Code	Description and notes
9959M	**Audio-only Individual Behavioral Health Interventions (BHI)** Interventions performed by psychologists and MLTs. Must have an established relationship with the worker, regardless of how it has been established (such as in person or via telehealth).

Audio-only should only be used if **telehealth** isn't available for the worker.

Note: Telephone calls related to but not used to render individual **BHI** treatment, see Chapter 10: Evaluation and Management Services for more information on telephone calls and other case management services.

Services that aren't covered

BHI doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or treatment. See the Behavioral Health Interventions (BHI) payment policy in this chapter for more information on how mental health and BHI may intersect.

The following aren't covered via audio only:

- Establishing **BHI** care via an initial assessment (**96156**),
- Re-assessments (**96156**),
- Individual **BHI** services billed using **96158** or **96159** with modifier **–93**. These are only billable under the local code **9959M**,
- Individual **BHI** therapy performed by attending providers within the scope of an Evaluation and Management (E/M) service. E/M services can't be performed via audio only,
- Group or family **BHI** (**96164**, **96165**, **96167**, **96168**),
- Brief emotional/behavioral assessments (**96127**), *or*
- For the convenience of the provider or worker.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems aren't covered.

Documentation requirements

The same documentation requirements listed in the Behavioral Health Interventions (BHI) payment policy in this chapter apply for audio-only **BHI** services. In addition, the documentation must include the following when the service is provided via audio only:

- The date of the call, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- A notation of the worker's originating site, *and*
- Documentation of the worker's consent to participate in audio-only services.

Chart notes (including the assessment forms for **BHI** therapy in the policy above) must contain documentation that justifies the level, type and extent of services billed.

Payment limits

The same payment limits for individual therapy listed in the Behavioral Health Interventions (BHI) payment policy in this chapter apply for audio-only **BHI** services (**9959M**).

Only 1 unit of **9959M** may be billed per day, per worker.

Payment policy: Behavioral health interventions, telehealth

General information

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

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

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

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

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

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

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

Services that must be performed in person

In-person services are required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**.

System requirements

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

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

Prior authorization

The prior authorization requirements listed in this chapter apply regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that can be billed

Telehealth procedures and services that are covered include most services that don't require a hands-on component. The worker must be present at the time of the **telehealth** service and the evaluation and/or treatment of the worker must be under the control of the **telehealth** provider.

Originating site fees are covered, when applicable.

Establishing care via **telehealth** is covered.

BHI services may be payable via audio only but not using regular **BHI** CPT® codes and modifier **–93**. See the Behavioral Health, Audio Only services for additional details. Telephone calls related to but not used to render treatment, see Chapter 10: Evaluation and Management Services, case management services.

Originating Site Fee (Q3014)

The insurer will pay an **originating site** fee to a provider when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. To bill for the **originating site** fee, use HCPCS code **Q3014**. **Q3014** is payable to the **originating site** provider when no other billable service is rendered concurrently to the same worker.

Note: If the **distant site** and the **originating site** are owned or rented by the same entity, **Q3014** is payable as long as billing and documentation requirements are met.

Q3014 isn't covered when:

- The **originating site** provider performs any service during the **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, except when the same payee owns both sites and the worker is using their equipment for the telehealth service, *or*
- The provider uses an audio-only connection.

The worker won't be reimbursed for using their home as an **originating site** or for any other **telehealth** related services.

When **Q3014** is the only code billed, documentation is still required to support the service. When a provider bills **Q3014** on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Because **Q3014** is payable to the **originating site**, any provider employed by the **originating site** may bill for this service, so long as they sign the documentation supporting the **Q3014** service.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- The same services that aren't covered in this chapter,
- The services listed under "Services that must be performed in person",
- Services that require physical hands-on and/or attended treatment of a patient,
- Completion and filing of any form that requires a hands-on physical examination (such as Report of Accident or Provider's Initial Report),
- Home health monitoring,
- **G2010** and **G2250** Store and forward.

The purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems isn't covered.

Note: Completion of APFs can't occur via **telehealth** when the update will take the worker off work or the provider increases the worker's restrictions. In these situations the visit must be in-person.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person.

Bill using the **–GT** modifier to indicate **telehealth**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home and will be reimbursed at the facility rate. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

For the purposes of this policy, the following must be included in the documentation submitted by the **distant site** provider in addition to the documentation and coding requirements for services billed:

- A notation of the worker's **originating site**, *and*
- Documentation of the worker's consent to participate in **telehealth** services. This must be noted for each **telehealth** visit.

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Behavioral Health Interventions and other applicable MARFS chapter(s) for the type of service rendered and the documentation requirements.

Payment limits

The same limits noted in the Behavioral Health Interventions policy apply regardless of how the service is rendered to the worker.

Payment policy: Best practice provider incentives

General information

The Surgical Quality Care Program (SQCP) is a quality improvement initiative. Participating musculoskeletal surgeons are incentivized for consistently implementing occupational health best practices, which are designed to improve the outcomes for workers injured on the job.

This incentive is a result of scheduled performance reporting by L&I, which calculates surgeons' adoption of best practices.

Link: For additional information, see the Surgical Quality Care Program website.

Who must perform these services to qualify for payment

Only surgeons who are part of the SQCP may bill the Best Practices Incentive – Surgical (**1086M**).

Services that can be billed

1086M is payable during the global surgical period.

The adoption level is based on last scheduled reporting.

If the provider's adoption level is…	…then the maximum surgeon incentive is:
No adoption	$0.00
Low adoption	$157.33
Medium adoption	$233.45
High adoption	$492.28
Sustaining adoption	$532.88

Documentation requirements

SQCP providers are required to provide documentation to support their adoption of occupational health best practices. For details, see the Surgical Quality Care Program website.

Payment limits

1086M is limited to once per surgeon for the first 2 surgeons participating in SQC Program for the life of the claim. **1086M** is only payable at the first visit based on who bills first, irrespective of visit date or clinic.

Services that aren't covered

ARNPs and physician assistants aren't part of SQC Program and can't bill **1086M**.

Note: The incentive of **1086M** isn't tied to the Activity Prescription Form (APF). The APF may still be appropriate for the worker and can be billed separately using **1073M**, but it isn't a required component of **1086M**.

Payment policy: Health services coordination & surgical health services coordination

General information

Health Services Coordinators (HSCs) and Surgical Health Services Coordinators (SHSCs) assist providers, workers, and employers by:

- Assisting the worker in setting and accomplishing reactivation goals,
- Coordinating and tracking clinical referrals,
- Identifying barriers by conducting the Functional Recovery Questionnaire (FRQ),
- Tracking outcomes by capturing Pain and Function Scales,
- Referring workers to community services,
- Communicating medication issues to providers,
- Supporting return-to-work when medically possible,
- Facilitating the transition between providers, *and*
- Providing ongoing monitoring of the claim and worker's progress.

HSCs and SHSC can't make adjudicative decisions. L&I claim managers and self-insured employer representatives maintain adjudicative authority.

Who must perform these services to qualify for payment

Approved HSCs and SHSCs collaborate with providers, employers, workers, and vocational counselors within L&I's provider occupational health best practice program to improve communication and reduce disability.

HSCs and SHSCs must be approved by L&I and meet minimum qualifications. HSCs and SHSCs must have an L&I provider account number for each program they participate in.

L&I will have the sole responsibility for approving HSC/SHSC provider number applications, establishing minimum qualifications, and setting and reporting performance measures.

Links: For additional details, including minimum qualifications, HSCs and SHSCs should visit our Health Services Coordination homepage.

Information about occupational health and surgical best practices incentive programs is available online.

Services that can be billed

The attending provider must be enrolled in an L&I provider best practice program so that the HSC or SHSC can bill for services.

The following activities are billable per 6-minute unit:

- Care coordination planning (identification of barriers to recovery and planning how to resolve or overcome these barriers),
- Communicating with any parties to the claim or treatment plan, including, but not limited to, workers, providers, and employers,
- Community and clinical resource identification,
- Pain/function scales completion,
- Transfer of care documentation,
- Case conferences planning, participation, and documentation, *and*
- FRQ completion.

The following activities are bundled into the payment for health services coordination or surgical health services coordination:

- Claim file review, *and*
- Preparing documentation (such as case notes).

HSC and SHSC fee schedule

Code	Description	Program	Fee
1083M	**Surgical coordination intake (SCI)** Can be billed as a stand-alone service. Max 1 per claim every 3 years.	Surgical Quality Care Program (SQCP)	**$162.83**
1087M	**COHE health services coordination** Can be billed as a stand-alone service. Can be billed with the -8S modifier. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	COHE	**$10.02**

Code	Description	Program	Fee
1088M	**Surgical Quality Care Program health services coordination** Can be billed as a stand-alone service. Can be billed with the -8S modifier. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	Surgical Quality Care Program (SQCP)	**$10.02**

Services that aren't covered

Time spent documenting the case note and reviewing of the claim file isn't covered.

In addition, the following activities aren't payable:

- Traveling to/from a work site,
- Conducting provider orientation/education,
- General administrative meeting time,
- Responding to provider questions about best practice reporting, *and*
- Discussing best practice reporting with the Medical or Program Directors.

Requirements for billing

Providers must perform L&I HSC or SHSC standard work as defined on the care coordination webpage.

When completing a second billable case note on the same day for the same claimant, bill using the -8S modifier.

Documentation requirements

Document sharing agreement must be on file with L&I.

Approved application and attestations are required by each incentive program.

HSCs and SHSCs must utilize MAVEN's standard case note and submit required fields, including care coordination plan.

Note: Failure to comply with these requirements will result in denial or recoupment of payment by the insurer.

Payment limits

Each incentive program is limited to 16 hours of HSC or SHSC billing per claim.

Payment policy: Locum tenens

Who must perform these services to qualify for payment

A locum tenens physician must provide these services.

Link: For information about requirements for who may treat, see WAC 296-20-015.

Services that aren't covered

Modifier **–Q6** isn't covered, and the insurer won't pay for services billed under another provider's account number.

Requirements for billing

The department requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered.

Payment policy: Lodging providers

General information

Lodging providers must have an active L&I provider account number to be paid for lodging and **meals**.

Note: This policy applies to **lodging providers** only. If you are a claimant who needs reimbursement, see L&I's Expense Reimbursement webpage or contact your claim manager.

How to apply for an L&I provider account number

All **lodging providers** new to L&I and ProviderOne must apply for an L&I account through ProviderOne. Follow the step-by-step guide for Facility, Agency, Organization or Institution (FAOI) to complete your ProviderOne application.

Allow 60-90 days for application review. L&I will notify you of our decision when the review is complete.

Tips for success

- In step 1, mark 'No' on the dropdown for "All Medical Providers are federally mandated to have an NPI." **Lodging providers** aren't required to have an NPI.
- Upload a copy of your IRS W9 (wet signature required) and the Provider Agreement. Incomplete applications can't be processed and will delay payments.
- If you don't add your EFT/Direct Deposit information in ProviderOne (Step 17), L&I payments will be mailed to the 'Pay to' address.

To update an existing L&I provider account (such as changing your mailing address or billing information), log into your ProviderOne account and follow the Provider Modification Guide (F248-486-000) to make your updates.

If ownership of the business changes, you need to follow the steps above to obtain a new L&I provider account.

Link: For additional assistance, contact LNIProviderOne@Lni.wa.gov.

Expected claimant conduct

Claimants are expected to follow all **lodging provider** rules and policies. It is the expectation of the insurer that no additional visitors are to be staying in the authorized room without prior approval by the insurer.

Prior authorization

Reimbursement for lodging and **meals** requires prior authorization from the insurer. The claimant is responsible for obtaining authorization for their stay and **meals**. The **lodging provider** will be provided with a hotel voucher detailing what has been authorized upon booking.

Requirements for billing

Claim Type	Claims begin with…	To bill, you can:	To submit documentation, you can:
State Fund	A, B, C, F, G, H, J, K, L, M, N, P, X, Y or Z followed by six digits, *or* Double alpha letters (example AA) followed by five digits.	Submit a Statement for Miscellaneous Bill Form (F245-072-000) via mail to the address on the form (**Don't fax bills!**), *or* Use our free Provider Express Billing system. For more information and help with direct entry billing visit L&I's Provider Express Billing webpage.	Fax it to **360-902-4567**, *or* Mail it to: Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291
Self-Insured	S, T, or W followed by six digits, *or* Double alpha letters (example SA) followed by five digits.	Use the Self Insured Employer Look Up Tool or call **360-902-6901** for more information on where to submit your bills and documentation.	

Claim Type	Claims begin with…	To bill, you can:	To submit documentation, you can:
Crime Victims	V followed by six digits, or Double alpha letters (example VA) followed by five digits.	Submit a Statement for Miscellaneous Bill Form (F800-076-000) via mail to the address on the form or fax to **360-902-5333**, *or* Use our free Provider Express Billing system. For more information and help with direct entry billing for crime victims use the Crime Victims Direct Entry Billing Guide.	Fax it to **360-902-5333**, *or* Mail it to: Crime Victims Compensation Program PO Box 44520 Olympia, WA 98504-4520

Documentation must be submitted separately from bills. Please be sure to include the claimants' name and claim number in the upper right hand corner of each page.

Once your bill is processed, you will receive a remittance advice (RA) with your payment detailing each claimant's name, claim number, dates of service and payment amount for the bills submitted.

Lodging providers have 1 year from the date the expenses are incurred to bill.

Link: For more information, see WAC 296-20-1103, WAC 296-20-125, L&I's State Fund claims Expected payment dates webpage, and the Crime Victims Current payment schedule.

For further assistance with billing state fund claims, contact Provider Hotline at PHL@Lni.wa.gov or Provider Support and Outreach at ProviderFeedback@Lni.wa.gov. For Crime Victims claims, email CrimeVictimsProgramM@Lni.wa.gov or call **1-800-762-3716**.

Services that can be billed

Lodging

Code	Description	1 unit of service equals…	Maximum fee per unit
5936M	**Lodging provider reimbursement.** Requires authorization from the insurer prior to stay.	1 night	**State Rate** + taxes and state fees

Meals

Lodging providers may bill the insurer for up to 3 **meals** per day (breakfast, lunch, and dinner) per authorized person, only when onsite **meals** are offered and provided to the claimant and any **authorized companion** as part of approved lodging. Don't bill the insurer for **meals** not provided. See the table below for billing codes.

Code	Description	1 unit of service equals…	Maximum fee per unit
5937M	Lodging provider reimbursement (Breakfast)	1 meal per authorized person	**State Rate** (includes taxes & gratuity)
5938M	Lodging provider reimbursement (Lunch)	1 meal per authorized person	**State Rate** (includes taxes & gratuity)
5939M	Lodging provider reimbursement (Dinner)	1 meal per authorized person	**State Rate** (includes taxes & gratuity)

Current **State Rates** can be found on the Office of Financial Management's (OFM) website.

The lodging provider should bill the insurer their usual and customary charges for the meal(s) provided. Reimbursement will be at the usual and customary charge or the **State Rate**, whichever is less.

Note: For information regarding medical provider reimbursement of outpatient day program meals provided to claimants in an approved brain injury rehab program (BIRP) or structured, intensive, multidisciplinary program (SIMP), see Chapter 33: Brain Injury Rehabilitation Services or Chapter 34: Chronic Pain Management.

Parking

The insurer will reimburse the **lodging provider** for parking while in approved lodging, provided there are parking accommodations that are not free to the general public. Don't bill the insurer for parking not provided to the claimant.

Code	Description	1 unit of service equals…	Maximum fee per unit
0402A	Parking (Claimant/Lodging Provider).	1 stay	**By Report**

Fees

Taxes and state fees are payable in addition to the per diem rate for lodging. Taxes and gratuity is payable within per diem for meals.

Code	Description	1 unit of service equals…	Maximum fee per unit
5933M	Lodging provider – Late cancellation fee.	1 stay	**$102.00**

Lodging providers may bill the insurer **5933M** as a cancellation fee if the insurer or the claimant fails to provide 24-hour notice of cancellation for either an entire stay or the claimant checks out before the final day of the reservation. Per WAC 296-20-010(5), the cancellation fee is only payable if the stay was arranged as part of an independent medical examination (IME) or other department-arranged appointment. The **lodging provider** must contact the claim manager for prior approval and determination of responsibility before billing the cancellation fee. When billing, the **lodging provider** must include proof of late cancellation (such as date, time and method of cancellation). **5933M** is only payable once per scheduled stay.

The **lodging provider** may bill a claimant for a non-covered late cancellation if their established policy equally applies to all guests per WAC 296-20-010(6). L&I can't provide the worker's billing address.

Extending the claimant's stay

If the stay is extended by the insurer due to a change in the claimant's medical appointments, the insurer will reimburse for the additional lodging and **meals**, provided prior authorization has been obtained. It is the claimant's responsibility to contact the claim manager (CM) to request authorization to extend the stay.

Out-of-state lodging providers

Out-of-state **lodging providers** may be reimbursed for lodging and/or **meals** provided to Washington State claimants. The rate will be based on the location of the **lodging provider** and the U.S. General Services Administration's rates for lodging and/or **meals** for that location.

Documentation requirements

Each **lodging provider** must submit documentation along with their billing to include a folio or list of charges with:

- The date span, *and*
- The claimant's name, *and*
- L&I claim number(s), *and*
- Total charge for the date span, *and*
- Number of units (nights) stayed.

If **meals** were provided to the claimant, include an itemized list of **meals** broken out into breakfast, lunch, and dinner by date and charge.

The **lodging provider** must retain itemized receipts for no less than 1 year, and provide them to the insurer along with their bill and upon request.

Link: For more information, see RCW 19.48.020.

Services that can't be billed

The insurer won't reimburse **lodging providers** for the following:

- Complimentary **meals** (such as breakfast) supplied to the general public, *or*
- Lodging and/or **meals** paid for by the claimant or their authorized companion, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Cancellations made by the **lodging provider**, *or*
- Any expenses incurred by a worker's **authorized companion** except for **meals**, *or*
- Lodging, **meals** and/or fees outside the authorized period.

The **lodging provider** may bill the claimant directly for:

- Lodging and/or **meals**, if the claimant prefers to pay themselves, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Lodging, **meals** and/or fees outside the authorized period.

Don't bill the insurer for these services. For the purposes of this policy only, **lodging providers** are reimbursed the maximum per diem rate for **meals**. It is the responsibility of the claimant to cover costs beyond this rate.

It is up to the **lodging provider**'s discretion to accept reservations for claimants without a debit card, credit card, or cash for additional charges not covered by the insurer. Please contact the claim manager (CM) as soon as possible if this situation arises.

Link: For more information, see RCW 51.04.030(2) and WAC 296-20-020.

Payment limits

L&I reserves the right to revoke a **lodging provider**'s account number should lodging conditions not meet standards (clean, safe, etc.) in accordance with state and federal laws.

Payment policy: Provider mileage

Prior authorization

Prior authorization is required for a provider to bill for mileage.

The round trip mileage must exceed 14 miles.

Note: Reimbursement for provider mileage is limited to extremely rare circumstances.

Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **$5.90** per mile.

Payment policy: Sign language interpretation

General information

Sign language interpretation includes American Sign Language (ASL), tactile interpretation, other forms of sign language utilized in the United States, and sign languages from countries other than the United States.

The rules in this policy only apply to sign language interpreters. For spoken languages, see Chapter 14: Language Access Services for Spoken Languages.

Sign language interpreters may use **teleinterpretation** in place of in-person services when deemed appropriate by the medical provider.

Who must perform these services to quality for payment

All sign language interpreters must have an L&I provider account number. To obtain an L&I provider account number, interpreters must submit credentials using the Submission of Provider Credentials for Interpreter Services form (F245-055-000).

The following certifications from the Registry of Interpreters for the Deaf (RID) are accepted:

- Certified Deaf Interpreter (CDI),
- National Interpreter Certification (NIC), *or*
- Provisional Deaf Interpreter Certification (PDIC) up to 12 months. You must submit certification from the RID following the 12 months in order to continue providing services.

Certifications from other groups or agencies will be evaluated on a case-by-case basis.

Sign language interpreters are responsible for maintaining their credentials as required by the credentialing agency or organization. If a sign language interpreter's credentials expire or are revoked for any reason, the interpreter must immediately notify L&I of the expiration or revocation. Bills for services rendered after an interpreter's credentials expire or are revoked will be denied.

Prior authorization

Sign language interpretation doesn't require prior authorization on open claims.

Prior authorization is not required for **teleinterpretation**. However, the worker, interpreter, and provider must all agree that **teleinterpretation** is appropriate and desired for the visit. The provider will note their use of telehealth and rationale in their chart, as described in the telehealth requirements found throughout the Medical Aid Rules.

Requirements for billing

Sign language interpreters must have an active L&I provider account number. Each submitted bill must be supported by an Interpretive Services Appointment Record (ISAR), regardless of modality (in person or via **teleinterpretation**). Bills submitted without an ISAR may be denied. Sign language interpreters must submit a completed ISAR (F245-056-000) with each bill. In addition to the ISAR, attach an invoice with the following details:

- The interpreter's usual and customary fee amount, *and*
- Calculations used to determine the interpreter's usual and customary fee, including whether the fee includes an appearance fee and/or blocks of time (such as a 2-hour minimum).

If **teleinterpretation** is used, do the following:

- Include a note with the invoice indicating **teleinterpretation** was used, *and*
- On the ISAR in the signature line for the "person verifying services", write "**teleinterpretation**", then include the date of the visit and the medical or vocational provider's phone number.

Services that can be billed

Sign language interpreters may bill for the following:

- Interpretation during the **initial visit**,
- Interpretation during insurer-requested independent medical examinations (IMEs),
- No-show fees for IMEs,
- Interpretation related to the completion of a reopening application (if a claim is reopened, the insurer will determine which services are reimbursable),
- Interpretation which facilitates communication between the worker or crime victim and a healthcare or vocational provider, *and*
- Interpretation for family members or guardians of minor workers.

Sign language interpretation fee schedule

Code	Description	Payment limit and authorization information	1 unit of service equals…	Maximum fee
9976M	**Sign language interpretation** provided in person or via **teleinterpretation** to facilitate communication between a worker or crime victim and a healthcare or vocational provider. Interpretation time, wait time, and form completion time should be documented and shown as part of the calculation of the interpreter's usual and customary fee.	Doesn't require prior authorization.	1 visit. Each separate appointment for an individual worker/crime victim is considered 1 visit.	**By Report**
9996M	**Interpreter IME no-show fee.** Time spent when worker doesn't attend an insurer-requested IME.	Only 1 no-show per worker per day.	1 worker no-show at an IME.	**$60.15**

Services that aren't covered

Spoken language interpretation is covered under separate policies and isn't billable using code **9976M**.

Sign language interpreters can't bill for mileage or travel time. However, if a sign language interpreter's usual and customary fee includes a block of time (such as a 2-hour minimum), that block can include time spent traveling to or from an appointment.

Sign language interpreters can't bill other **telehealth** codes such as **Q3014**, **G2010**,or **G2250**.

No payment shall be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment.

In addition, the following aren't covered:

- Interpretation services for treatment visits that aren't covered by the insurer (see WAC 296-20-03002),
- Interpretation services provided for a denied or closed claim, except services associated with the **initial visit**, the visit for the worker's application to reopen a claim, or for a worker receiving a pension with a treatment order,
- Interpretation services provided on rejected claims for dates of service after the date of the rejection order, except for visits authorized and requested by the insurer,
- No-show fees for any service other than an insurer-requested IME,
- Personal assistance on behalf of the worker such as scheduling appointments, translating correspondence, or making phone calls,
- Interpretation services not related to the worker's communications with healthcare or vocational providers,
- Overhead costs such as phone calls, photocopying, and preparation of bills,
- Interpretation provided by family members or friends of the worker or crime victim,
- Interpretation provided by anyone under the age of 18,
- Interpretation services rendered by interpreters who are not registered in the scheduling system or registered directly with L&I to provide out-of-state services,
- Interpretation services provide by LAPs who have had their certification revoked by a certifying authority, *and*
- Any time prior to the start of an **appointment** if the worker is not present.

Interpretation for legal counsel

Payment for interpreter services for legal purposes including but not limited to attorney appointments, legal conferences, testimony at the Board of Industrial Insurance Appeals or any court, or depositions at any level is the responsibility of the attorney or other requesting party and isn't covered by the insurer.

Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers may provide services to workers and crime victims if the provider determines it is most appropriate for their facility to employ their own interpreter. The insurer doesn't reimburse interpreters who are employed by a healthcare or vocational provider or their office. The provider is responsible for ensuring the interpreter is credentialed and provides meaningful access.

Additional information

System requirements for teleinterpretation

Teleinterpretation services require a secure interactive telecommunication system, consisting of special two-way audio and video equipment that permits real time consultation between the worker, provider, and sign language interpreter.

Security and confidentiality requirements for teleinterpretation

Providers and interpreters are responsible for ensuring complete confidentiality and privacy of the worker is protected at all times.

Sign language interpreters must ensure their work environment is HIPAA compliant. This means sign language interpreters must:

- Work in a private and secure location free of distractions, *and*
- Avoid disruptive public or semi-public settings, such as outside the home, at playgrounds or outdoor areas including public spaces, and at home if distractions are (or might be) present.

Sign language interpreters must ensure that visits are not recorded by any party.

Team interpretation for sessions of 2 hours or more

If a visit is scheduled for more than 2 hours, L&I recommends that 2 or more **sign language** interpreters be present in order to reduce fatigue and facilitate clear communication. All interpreters will be paid **By Report** for the visit when billing **9976M**. Group billing isn't allowed; all interpreters must have valid L&I provider account numbers and must submit their own bills.

Payment policy: Translation services

Prior authorization

Document translation services are only paid when performed at the insurer's request. Services will be authorized before the request packet is sent to the translators.

Who must perform these services to qualify for payment

Only Department of Enterprise Services (DES) contracted translators may complete document translation requests.

Sight translation is provided by LAPs during an appointment with a **client** and a healthcare or vocational provider. Document translation services are for written materials and are only payable when requested by the insurer.

Services that can be billed

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9997M	**Document translation**, at insurer request	Over $500.00 per claim will be reviewed. Authorization will be documented on translation request packet. Only payable to agencies with a Department of Enterprise Services contract.	1 page	**By Report**

Links to related topics

If you're looking for more information about…	Then see…
Activity Coaching	Activity coaching guidelines on L&I's website
Administrative rules for "Who may treat"	Washington Administrative Code (WAC) 296-20-015
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Health Services Coordination	General information Minimum requirements Best practice incentive programs Standard work
Fee schedules for all healthcare facility services	Fee schedules on L&I's website
Vendor services lookup tool	Vendor services lookup tool on L&I's website

Need more help?

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

