Washington State Department of
Labor & Industries

Medical Aid Rules and Fee Schedules (MARFS)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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Washington State Department of
Labor & Industries

Chapter 1: Introduction

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

General information: About MARFS and this manual

What is MARFS?

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

MARFS encompasses three things:

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

What is in this manual?

This manual contains 27 chapters of payment policies for healthcare and vocational services provided by individual professional providers or facilities and 4 appendices containing information that's broadly applicable to the entire manual.

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

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

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

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

- One chapter on **general policies and information** for all providers,
- Twenty-three chapters for **professional services**, which contain payment policies for individual professional healthcare and vocational providers, and interpreters, and
- Three chapters for **facility services**, which contain payment policies for healthcare facilities,
- Four appendices, which contain commonly used **definitions**, **modifiers**, **place of service codes**, and **reports and forms**.

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

What part of MARFS isn't in this manual?

This manual doesn't include:

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

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

How do I know if a policy is current?

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

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

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

General information: About the layout and design

How is each chapter organized?

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

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

Some policies also include definitions of key terms used in that policy. Definitions which apply to the entire manual appear in Appendix A.

Section headers throughout MARFS chapters include:

- **General information** sections, which are collections of information broadly applicable to the topic of the chapter and should be reviewed by all readers,
- **Payment policies**, which are the sets of rules governing when and how providers are paid, *and*
- **Supplemental payment policies**, which are subsections of larger policies that apply to a specific topic or group of providers.

Visual cues

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

Special terms

Certain terms used throughout this manual have a unique definition. These words are called out with **a special blue color and bold format**. You can find the definitions of these terms in Appendix A: Definitions.

Bulleting

Bullet lists are used to:

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

Link 

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

Note 

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

Table of Contents 

This icon appears next to the Table of Contents.

General information 

This icon appears next to general information sections.

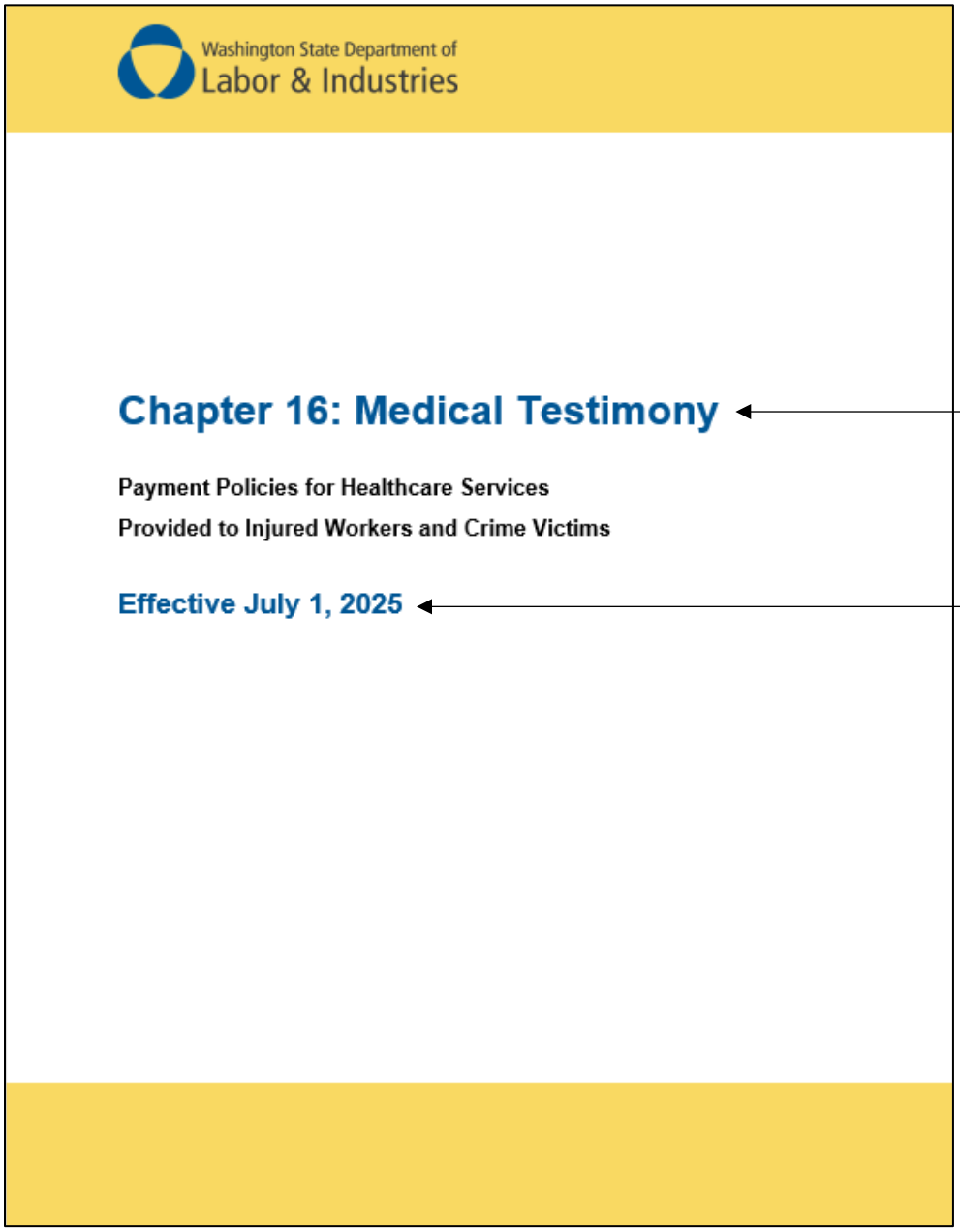
Payment policy 

This icon appears next to each payment policy.

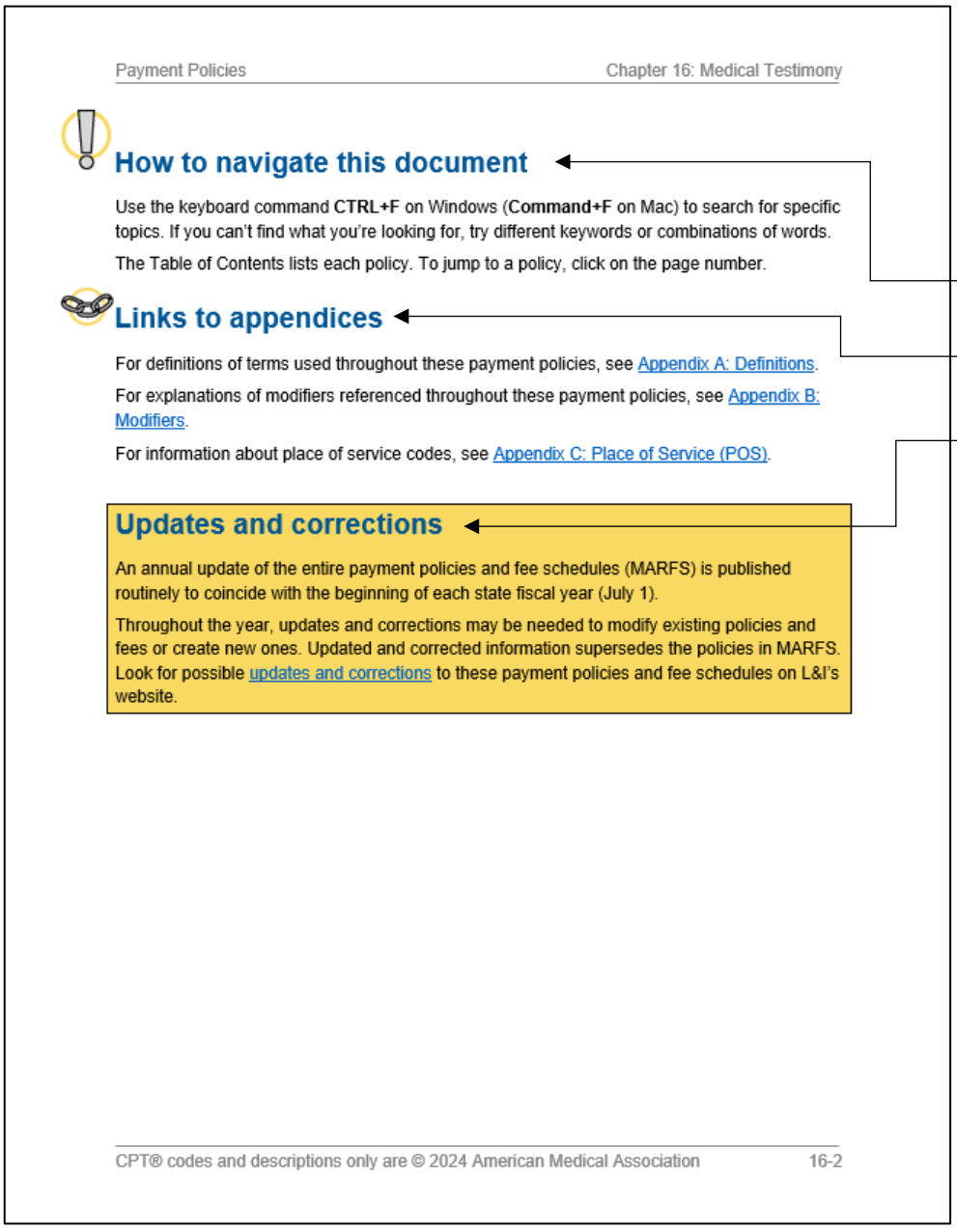
Sample pages

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

Sample title page

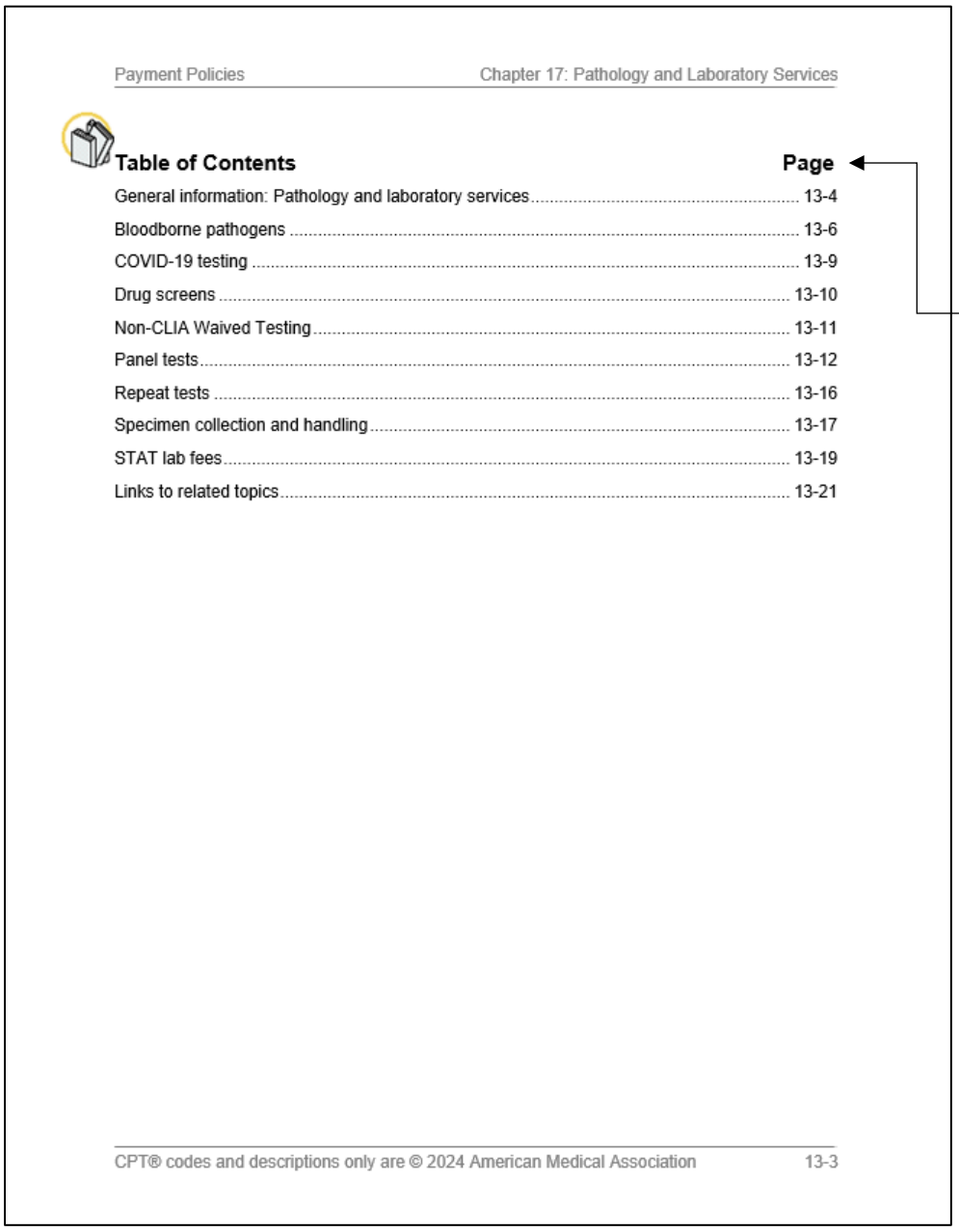


Sample navigation page



Every chapter contains navigation advice, links to the appendices, and a link to updates and corrections.

Sample table of contents



Payment Policies Chapter 17: Pathology and Laboratory Services

Table of Contents **Page**

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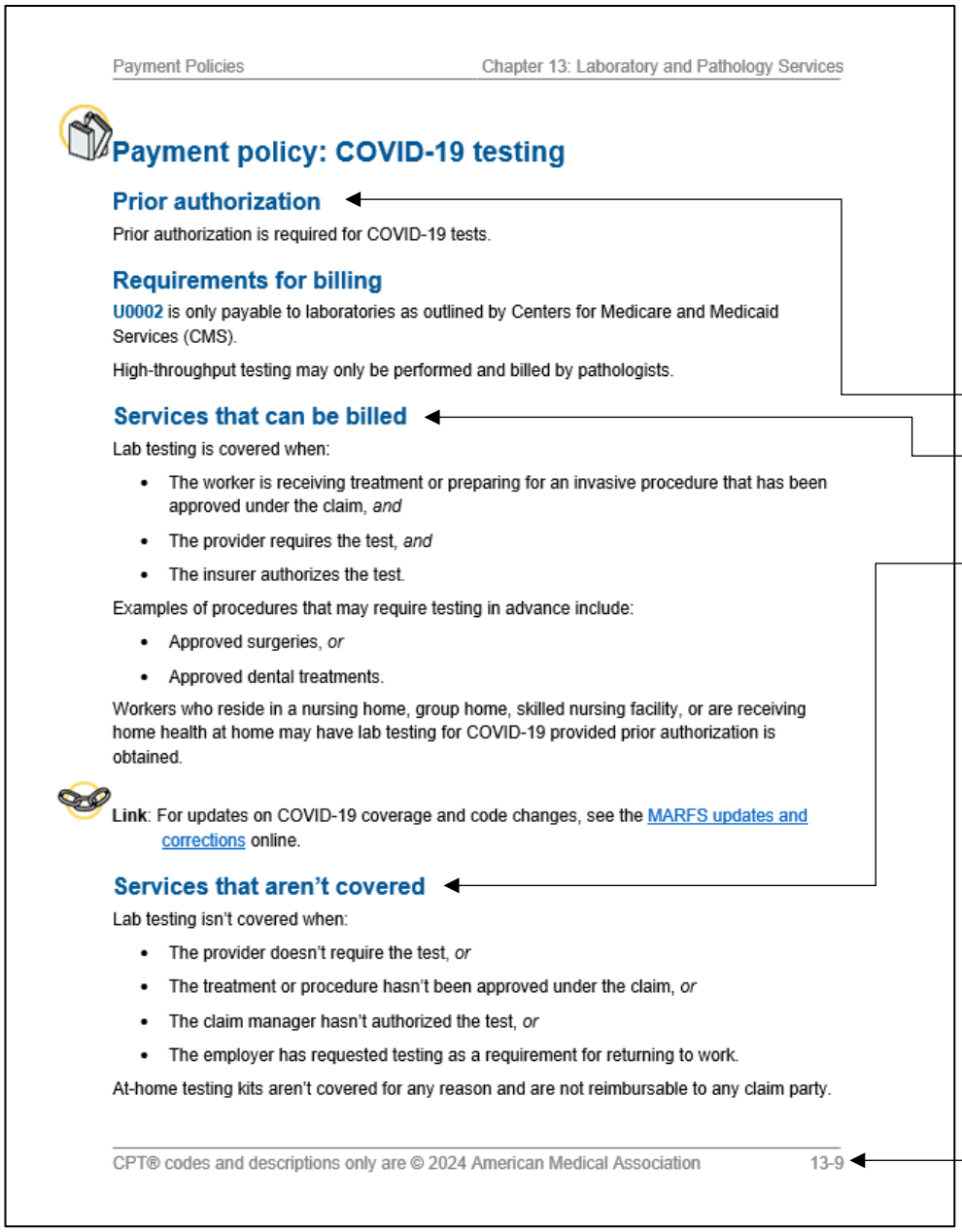
Policies are arranged alphabetically (in most cases). Click on a page number to jump to that section.

Sample payment policy page



Payment Policies Chapter 13: Laboratory and Pathology Services

Payment policy: COVID-19 testing

Prior authorization

Prior authorization is required for COVID-19 tests.

Requirements for billing

U0002 is only payable to laboratories as outlined by Centers for Medicare and Medicaid Services (CMS).

High-throughput testing may only be performed and billed by pathologists.

Services that can be billed

Lab testing is covered when:

- The worker is receiving treatment or preparing for an invasive procedure that has been approved under the claim, *and*
- The provider requires the test, *and*
- The insurer authorizes the test.

Examples of procedures that may require testing in advance include:

- Approved surgeries, *or*
- Approved dental treatments.

Workers who reside in a nursing home, group home, skilled nursing facility, or are receiving home health at home may have lab testing for COVID-19 provided prior authorization is obtained.

Link: For updates on COVID-19 coverage and code changes, see the MARFS updates and corrections online.

Services that aren't covered

Lab testing isn't covered when:

- The provider doesn't require the test, *or*
- The treatment or procedure hasn't been approved under the claim, *or*
- The claim manager hasn't authorized the test, *or*
- The employer has requested testing as a requirement for returning to work.

At-home testing kits aren't covered for any reason and are not reimbursable to any claim party.

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Each policy contains information relevant to the policy topic. Carefully review all sections of a policy before performing services or billing.

Pages are numbered with the chapter number first, then the page number.

General information: Highlights of policy changes since July 1, 2024

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

For complete code descriptions and lists of new, deleted, or revised codes, refer to the 2024 CPT© and HCPCS coding books.

Washington Administrative Code (WAC) and payment changes

The following changes to WACs and payment rates occurred:

- Cost of living adjustments were applied to **RBRVS** and anesthesia services and/or local codes,
- The **RBRVS** conversion factor is **$58.33**, which includes a cost of living adjustment of 1%,
- WAC 296-20-135 increases the anesthesia conversion factor to **$3.91** per minute (**$58.65** per 15 minutes), and,
- WAC 296-23-220 and WAC 296-23-230 increases the maximum daily cap for physical and occupational therapy services to **$149.45**, and
- WAC 296-23-250 set a daily cap for massage therapy of 75% of the daily cap for PT/OT services. The rate for July 1, 2025 is **$112.09.**

Policy & fee schedule additions, changes, and clarifications

Most chapters throughout MARFS have been renamed, renumbered, or both.

Professional services chapters

Chapter 3: Attending Providers clarifies the role and expectations for **attending providers**. This chapter encompasses several provider types and various restrictions that may apply. It also includes a new policy for **consultation** services. A separate policy specific to physical medicine services for **attending providers** (**1044M**) was added.

Chapter 5: Care Coordination includes significant updates to telephone call codes and updates to align online communications. Nurse case management services also received an update that includes new billing codes, revised reporting requirements, and changes to authorization limits.

Chapter 7: Durable Medical Equipment (DME) and Supplies clarifies the invoice requirements for prosthetic and orthotic services.

Chapter 17: Mental Health and Behavioral Health Interventions (BHI) now includes Activity Coaching (PGAP). Policies in this chapter clarify who may treat mental health conditions. Neuropsychological and psychological testing and evaluation policies further clarify who may perform these services, and includes a new section on how to bill.

Chapter 18: Other Services includes a new policy on claimant (worker) reimbursement. Changes were made to the obesity policy to allow nutritionists to create a weight loss plan.

Chapter 20: Physical Medicine includes updates to the chiropractic care services policy, clarifying the use of visit codes.

Chapter 24: Telehealth, Remote, and Mobile Services now includes a policy on mobile clinics and virtual reality devices. Clarifications have been made to **telehealth**, audio-only, and other related service policies throughout the chapter.

Facility services chapters

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

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

Fee schedules

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

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

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

Links to related topics

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

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 2: Information for All Providers

Payment Policies for Healthcare Services

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Effective July 1, 2025

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Table of Contents Page

General information: All payment policies and fee schedules

For information on how to use MARFS, refer to Chapter 1: Introduction.

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, 2025.

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

All providers

All providers (medical and non-medical) 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, and the appropriate MARFS chapters for the services being provided.

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 the Laws and Agency Rules page.

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.

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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**.

Workers may see a company doctor but have the right to refuse and choose their own provider.

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.

Links: For more information on provider and worker responsibilities, see WAC 296-20-065 and WAC 296-20-025, and our website.

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, including who is exempt from ProviderOne.

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

Health care provider network

As part of Workers' Compensation Reform laws passed by the 2011 Washington Legislature, L&I created a statewide workers' compensation health care provider network. 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 health care provider network 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 network:

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

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.

Effective July 1, 2025, Psychologists are required to join the network in order to become an **AP** on a claim or continue treating past the **initial visit**.

Links: For more information on the health care provider network, 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.

These provider types are considered **Attending Providers**, see Chapter 3: Attending Providers for more information.

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. Enrollment in a specific L&I program may be required to perform some services (such as IMEs). Refer to the appropriate chapter for more information on specific service requirements.

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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.

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

Electronic billing can't be established through ProviderOne.

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.

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.

Send an Application for Benefits - Injury Claims form (F800-042-000). Fax or mail to the address on the form.

General information: 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. Providers must bill using the code that most accurately reflects service provided.

Any procedure represented by its own CDT®, CPT®, HCPCS, or local code must be billed separately. The time spent on these services can't be included in the time used to determine the level of other services. See Chapter 9: Evaluation and Management (E/M) for details.

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**).

Link: The insurer doesn't cover controversial, obsolete, investigational, or experimental treatment, typically categorized under CPT® Category III codes, unless otherwise noted in the professional services fee schedule. For more information, see WAC 296-20-02850 and WAC 296-20-03002.

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**).

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

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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 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

Appendix B: Modifiers includes only modifiers mentioned in the text throughout each chapter. 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.

General information: Billing instructions

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.

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 Form (F245-127-000)
- Crime Victims Direct Entry Billing Manual (F800-118-000)
- Direct Entry Billing Manual (F245-437-000)
- Mental Health Fee Schedule and Billing Guidelines (F800-105-000) (For the Crime Victims Program)

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:

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- 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. More information on common reports and forms can be found in Chapter 21: Reports and Forms.

General information: Charting format

General information

Providers are required to submit **medical records** that contain the information necessary for the insurer to make decisions regarding coverage and payment. Medical documentation for an injury in workers' compensation or crime victims must contain the pertinent history and the pertinent findings found during an exam.

Required format: SOAP-ER

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, and Plan and progress) format detailed further below, or the insurer's required form. 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?

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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 and 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. Providers are personally responsible for ensuring the accuracy of the medical record, regardless of whether assistive technology is used to prepare the record.

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 signatures

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

When covered supervision occurs, the titles and signatures of both the rendering provider and the supervising provider are required.

Providers can submit **medical records** 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. How the insurer uses modifiers or place of service (POS) is listed in the appendices.

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 coding 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 21: 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: Language Access Services

How providers arrange for language access 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 18: 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: Overview of payment methods

Procedures performed in a facility pay differently than a procedure performed in a non-facility. On the fee schedule, payments are made at either a facility or non-facility rate. These different rates have separate payment structures.

L&I defines facility as having 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.

Procedures performed in a provider's office are paid at non-facility rates. This rate 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.

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 26: Hospitals and 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 26: Hospitals and Ambulatory Surgery Centers (ASCs) or refer to WAC 296-23A.

Self-insurers

Self-insurers use hospital-specific 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 26: Hospitals and Ambulatory Surgery Centers (ASCs) or refer to WAC 296-23A.

Self-insurers

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

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

Self-insurers use hospital-specific 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.

Rehabilitation services payment methods

Brain Injury Rehabilitation Program (BIRP) fee schedule

The insurer pays for Brain Injury Rehabilitation Programs (BIRP) using an all-inclusive, daily rate fee schedule. While considered facility services, there isn't a difference in payment between the facility and non-facility rate. Individual provider services aren't separately payable. See Chapter 27: Rehabilitation Programs and Facilities for additional details.

Chronic Pain Management Program (SIMP) fee schedule

The insurer pays for chronic pain management program services (**SIMP**) using an all-inclusive, phase based, per diem fee schedule. While considered facility services, there isn't a difference in payment between the facility and non-facility rate. Individual provider services aren't separately payable. See Chapter 27: Rehabilitation Programs and Facilities for additional details.

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Mental Health Residential Treatment Facilities

The insurer pays Mental Health Residential Treatment Facilities for services using hospital payment methods.

For more information, see Chapter 27: Rehabilitation Facilities and Programs.

Professional provider payment methods

The following is an overview of the non-facility 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 21: Resource-based Relative Value Scale (**RBRVS**).

Anesthesia fee schedule

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

Link: For more information, see Chapter 12: Injections and Medication Administration and Chapter 22: Resource-based Relative Value Scale (RBRVS).

Pharmacy fee schedule

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

Link: For more information, see Chapter 12: Injections and Medication Administration and Chapter 19: Pharmacy.

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 19: Pharmacy.

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

The insurer pays for some covered services on a **by report** (BR) basis. Fees for BR services is 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.

Note: For all **by report** (BR) procedure codes, providers must bill their usual and customary charges and describe in detail any service rendered. The insurer may adjust reimbursement for BR procedures when such action is indicated. The provider may be required by the insurer to furnish additional documentation to validate any specific charge is part of their usual and customary fees. For the legal definition of **by report** (BR), see WAC 296-20-01002.

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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

The insurer uses 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

The insurer uses 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

The insurer uses hospital specific POAC rates to pay for sub-acute care (swing bed) services.

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General information: Penalties

Penalty 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 Self-Insurance Compliance Penalties, 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.

Self-referrals and other conflicts of interest

RCW 51.48.280 prohibits any individual or other entity from knowingly paying, soliciting or receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to reward for business or services that are reimbursable, in whole or in part, under Washington State Industrial Insurance.

Such activities include but aren't limited to:

- Self-referrals (see CMS Physician Self-Referral)
- Employers directing or referring workers to receive care at a facility they own, contract with or have a financial stake

In such situations the Department reserves the right to take action which could include fines pursuant to RCW 51.48.080.

Per WAC 296-20-051 whenever possible, **consultation** should be made with a doctor outside the referring doctor's office or partnership.

When circumstances necessitate referring for a second opinion or additional services within the same office or partnership, efforts should be made to ensure the worker understands their choice(s). This would include informing the worker of treatment options and documenting this discussion.

Links: For more information, see also RCWs 51.48.250, 51.48.260, and 51.48.270.

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.

Health care 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.

Links: For more information on SIF-2/PIR requirements, see Chapter 21: Reports and Forms.

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) 902-6708 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**, 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 or non-payment of bills**, the SI section Medical Treatment Adjudicator will handle the dispute. Complete and submit Self-Insurance Medical Provider Billing Dispute form (F207-207-000). Call 360-902-6708 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.

CPT® codes and descriptions only are © 2024 American Medical Association

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) (see Chapter 3: Attending Provider and Chapter 21: Reports and Forms for more information)	**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 .

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.

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.

Telehealth & audio-only services

The insurer covers most services provided via **telehealth** that don't require a hands-on component. Audio-only treatment is only covered for limited mental health services. For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

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.

Prior authorization

Certain services require prior authorization and/or utilization review by the state fund's contract manager.

Conservative care requirements

Prior authorization for conservative care by an AP or concurrent care provider is always 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.

Conservative care authorization requirements are applicable per provider and include both office visits and treatment cumulatively.

Physical and occupational therapists are not subject to the conservative care authorization requirements and must instead follow the authorization requirements for physical and occupational therapy described in Chapter 20: Physical Medicine.

Link: For more information, see the applicable MARFS chapters, the provider fee schedule, our website, WAC 296-20-030(1), WAC 296-20-03001 and WAC 296-23-195.

Requirements for billing

All providers

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. Providers must bill the code that most accurately reflects services provided.

Any procedure represented by its own CDT®, CPT®, HCPCS, or local code must be billed separately. The time spent on these services can't be included in the time used to determine the level of other services. See Chapter 9: Evaluation and Management (E/M) for details.

Attending Providers (APs)

Some services are restricted to only **attending provider** types; MD, DO, DC, ND, DPM, DDS, DMD, OD, ARNP, PA/PA-C, PhD, and PsyD. For more information on these restrictions and requirements for these providers, see Chapter 3: Attending Providers.

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 an established procedure code(s). **The provider must list the most similar procedure code(s) to the services performed, including units of service and applicable modifier(s).**

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.

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.

All services rendered must be billed by providers, not workers or Crime Victims. Workers and Crime Victims won't be reimbursed for services sought outside the L&I network from a provider who doesn't have an L&I provider account.

Links: For more information, refer to RCW 51.04.030, RCW 51.36.010, WAC 296-20-010, WAC 296-20-020, and WAC 296-20-022.

Wellness plans or programs designed to improve overall health and fitness aren't covered.

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: 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. Rebills are not a proper form of protest and are subject to the 60-day appeal/protest timeline.
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.

Type of submission	Scenario	How to Submit	Notes
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.

Payment policy: Billing limitations, appeals, and protests

Billing limitations

Timely filing

Bills must be received within 1 year from the date of service to be considered for payment per WAC 296-20-125. It is recommended bills are submitted monthly to avoid possible denials due to untimely filing.

Denied bills

If the bill was denied due to claim closure or rejection, which has been subsequently reopened or 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 retrospective authorization is obtained, the denied bill should be rebilled and received within 1 year of the date of the authorization.

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. The provider bears the burden of proof of timely filing. Electronic **medical records**, EDI date stamps, and similar records showing when the provider's bill was submitted aren't considered proof of timely filing.

Health care network providers are also limited by the effective date of their L&I provider account. Any dates of service prior to their effective date will be denied, regardless of timely filing or other billing limitations.

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: Copies of medical records

Who must perform these services to qualify for payment

Only providers who have provided healthcare services to the worker may bill HCPCS codes **S9981** and **S9982**.

Services that can be billed

All records to support billed services must be provided to the department, at no cost.

If the insurer requests records from a healthcare provider that are for services not provided under the claim, the insurer will pay for the requested records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury.

HCPCS Code	Description	Additional information
S9981	Administrative fee - gathering and handling electronic and/or paper records, per request	**Records must be requested by the insurer.** Limit of 1 unit per request.
S9982	**Medical records** copy fee, per page – paper	**Records must be requested by the insurer.** May be billed in addition to **S9981** for paper or faxed records. Can't be billed for electronic records. 1 page = 1 unit.

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.

Note: Requested records must be received by the insurer within 30 days. Failure to submit records in a timely manner may result in denial or recoupment of bill payment(s).

Services that aren't covered

S9981 and **S9982** aren't payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Payment limits

Payment for **S9981** and **S9982** includes all costs, including postage.

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

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: 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: Split billing and treating multiple separate conditions

Requirements for billing

If the worker is evaluated and/or treated for 2 or more separate accepted conditions that aren't related to the same claim 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 2 or more injuries increases the complexity of the visit:

- A higher level E/M or other applicable service code, determined by the totality of the service to all injuries, 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.

If the services are related to multiple claims, 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 self-insured employer (SIE) and the other payer based on the level of service provided during the visit.

Physical Medicine Services

Physical medicine services are subject to a different split billing procedure. Therapists must appropriately document and bill the insurer only for the portion of the visit related to the accepted claim.

If part of the visit is for a condition unrelated to an accepted claim, treatment rendered for the unrelated condition may be billed to a secondary insurer, if appropriate. Only the portion of visit related to the accepted claim can be billed to the insurer.

Vocational Services

Vocational services are subject to a different split billing procedure. For more information, see Chapter 25: Vocational Services.

Links: For more information, see WAC 296-20-010 and WAC 296-20-06101(10).

Examples of split billing

Example 1: Two work-related injuries (non-physical medicine)

A worker goes to a provider to be treated for a work-related shoulder injury and a separate work-related knee injury. The provider treats both work-related injuries.

How to bill for this scenario

For State Fund claims the provider bills for 1 visit listing both workers' compensation claims in Box 11 of the **CMS-1500** form (F245-127-000). L&I will divide charges equally to the claims.

For self-insured claims, contact the SIE or their TPA for billing instructions.

Example 2: Work injury and automobile injury (non-physical medicine)

A worker goes to a provider's office to be treated for a work related ankle injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats both the work related ankle injury and the neck pain associated with the motor vehicle accident.

How to bill for this scenario

The provider would bill:

- 50% of their usual and customary fee to L&I or the SIE, and
- 50% of their usual and customary fee to the insurance company paying for the motor vehicle accident.

L&I or the self-insurer would only be responsible for the portion related to the accepted work related injury.

Example 3: Physical medicine split billing

A worker goes to a physical medicine provider to be treated for a work-related back injury and a separate work-related wrist injury. The physical medicine provider treats both work-related injuries. The visit was 45 minutes of therapeutic exercises in total, however, only 15 minutes of that was related to the wrist. The remainder was related to the back injury.

How to bill for this scenario

For State Fund claims the provider bills:

- Each workers' compensation claim separately, listing the applicable claim number in Box 11 of each of the **CMS-1500** forms (F245-127-000).
- 30 minutes (2 units) of therapeutic exercise to the claim related to the back injury and 15 minutes (1 unit) of therapeutic exercise to the claim related to the wrist injury.

For self-insured claims, contact the SIE or their TPA for billing instructions.

The same billing procedure applies if the wrist wasn't a covered condition on any L&I claim. In this case, L&I or the self-insurer would only be responsible for the portion related to the accepted work-related injury. This means that the 15 minutes (1 unit) of therapeutic exercise for the unrelated wrist injury may be apportioned to another payer, as appropriate. The provider can't bill the workers' compensation insurer for this portion of the service.

Payment limits

A provider would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day.

Scheduling back-to-back appointments doesn't meet the criteria for using modifier **–25**.

Payment policy: Students and student supervision (non-physical medicine)

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 20: Physical Medicine 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 doesn't qualify as a student

Providers with temporary or interim professional licenses aren't considered **students** and this policy doesn't apply to them.

Agency-affiliated counselors aren't considered **students** and this policy doesn't apply to them. They can't 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 (DOH) 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.

Direct supervision

Students must be supervised by their supervising provider in accordance with DOH rules while performing services for injured workers or crime victims.

Direct supervision may occur via **telehealth** (modifier **–FR**) when the service to the worker is allowed via **telehealth**. Certain services require in-person care. These services require in person direct supervision, in alignment with DOH requirements for **student** licensures.

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.

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
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

If you're looking for more information about…	Then see…
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
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) Mental Health Fee Schedule and Billing Guidelines (F800-105-000) for Crime Victims Compensation program
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

If you're looking for more information about…	Then see…
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
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
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

If you're looking for more information about…	Then see…
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 26: Hospitals and Ambulatory Surgical Centers (ASCs)
Payment policies for **anesthesia services**	Chapter 12: Injections and Medication Administration
Payment policies for **hospitals**	Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs)
Payment policies for **interpreters**	Chapter 14: Language Access Services for Spoken Languages
Payment policies for **other services**	Chapter 18: Other Services
Payment policies for **pharmacy services**	Chapter 19: Pharmacy
Payment policies for **physical medicine services**	Chapter 20: Physical Medicine
Payment policies for **radiology services**	Chapter 8: Radiology and Electrodiagnostics
Payment policies for the Resource-Based Relative Value Scale (**RBRVS**)	Chapter 22: Resource-Based Relative Value Scale (RBRVS)
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

If you're looking for more information about…	Then see…
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?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 3: Attending Providers

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

Payment policy: All Attending Provider (AP) types

General information

In addition to the information within Chapter 2: Information for All Providers, the following in this chapter is applicable to all **Attending Provider (AP)** types.

Provider type vs primary provider on a claim

The term **Attending Provider (AP)** referenced throughout MARFS, unless otherwise noted, refers to the type of provider who is eligible to be an **AP** on a claim.

Providers who can be an **AP** aren't necessarily always the **AP** on a worker's claim. Only one provider on a claim may hold this role at a time. When an eligible **attending provider** type accepts the role of **AP** on the worker's claim, they are the provider who directs the worker's treatment, much like a primary care provider.

All other providers treating the worker are considered concurrent care providers, even if they are an **attending provider** type.

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

Link: For the legal definition of **AP**, see WAC 296-20-01002.

Additional resources for **APs** are available in the Attending Provider Resource Center on L&I's website.

Provider eligibility

The following types of providers are eligible to be **attending providers**. This list includes links to provider-specific supplemental policies in this chapter detailing additional or differing requirements. Unless otherwise noted, the All Attending Provider (AP) types payment policy applies.

- Advanced Registered Nurse Practitioner (ARNP),
- Chiropractors (DC),
- Dentists (DDS/DMD),
- Naturopathic physicians (ND),
- Optometrists (OD),
- Osteopathic physicians (DO),
- Physicians (MD),

- Physician assistants (PA/PA-C),
- Podiatric physicians (DPM), *or*
- Psychologists (PhD/PsyD).

Attending providers are required to join the Medical Provider Network (MPN) and have a provider account number prior to treating a worker, except for initial office or emergency visits per WAC 296-20-015. Effective July 1, 2025, Psychologists are required to join the MPN in order to become an **AP** on a claim or continue treating past the **initial visit**.

Links: For more information regarding provider accounts, see Chapter 2: Information for All Providers, Become a Provider, and Psychologists as Attending Providers, on our website.

Attending providers are eligible to be the **AP** on a claim and may be eligible to provide the following services. Refer to the table below for a summary of coverage and to the applicable policies in MARFS for additional details.

	DO	MD	DC	ARNP	DDS/ DMD	ND	OD	PA	DPM	PhD/ PsyD
Consultations	Yes	Yes	Approved consultants only	Yes	Yes	**No**	Yes	**No**	Yes	Yes
Radiology Consultations (secondary interpretive opinions)	Radiologists only	Radiologists only	Approved radiology consultants only	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Impairment Ratings	Yes	Yes	Approved examiners only	**No**	Yes	**No**	**No**	**No**	Yes	**No**
IME Examiner eligibility	Yes	Yes	Yes	**No**	Yes	**No**	**No**	**No**	Yes	**No**

AP on the claim restrictions

The following providers have additional restrictions on when they are eligible to be the **AP** on the claim directing care for the worker. In all other instances, they are concurrent care providers.

- **Dentists (DDS/DMD)** – Dental treatment is required for accepted conditions and no other injuries require additional care. For more information, see the Supplemental Policy for Dentists in this chapter and Chapter 6: Dental.

- **Optometrists (OD)** – Eye treatment or glasses repair/replacement is required for accepted conditions and no other injuries require additional care. For more information, see the Supplemental Policy for Optometrists in this chapter and WAC 296-20-100.
- **Psychologists** – The insurer has accepted a psychiatric condition and it is the only condition being treated (mental health only claims). Mental health only claims don't include those that have previously had a physical condition, which has since been resolved. For more information, see the Supplemental Policy for Psychologists in this chapter and Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Link: For more information and resources on the services listed above, see Services that can be billed in this policy.

AP responsibilities

Attending providers are a key resource for workers.

AP on the claim is responsible for...	Such as...	MARFS reference
Initiating workers' compensation benefits	Completing and signing the report of accident (ROA/PIR) or reopening application.	Chapter 21: Reports and Forms
Managing the worker's conditions and progress	Reporting worker progress, treatment, and plan of care, Reporting and addressing restrictions to recovery, including unrelated condition(s), *and* Referring to other providers for **consultation** and/or to initiate treatment.	Applicable chapter for service provided.
Coordinating care for the worker	Reporting and coordinating any rehabilitation that the worker may need to undergo.	Chapter 5: Care Coordination
Completing and signing other reports and forms	Setting any temporary or permanent physical limitations via the activity prescription form (APF), Reviewing job analyses (JA) and **job offers** to determine whether the worker can perform a specific job, IME concurrence letters, *and* Other requests by the claim manager.	Chapter 21: Reports and Forms

AP on the claim is responsible for...	Such as...	MARFS reference
Facilitating return to work	Reporting and addressing employment issues, Reporting the worker's physical and mental ability to work, Certifying time off work or at a job with lighter physical duties, *and* Communicating with vocational rehabilitation counselors (VRCs). **APs** must abide by WAC 296-19A-030 in the following areas: • 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.	Chapter 25: Vocational Services
Initiating claim closure	Reporting when a worker reaches maximum medical improvement (MMI), *and* When applicable, referring out or performing (if eligible) rating impairments for conditions have reached maximum medical improvement.	Chapter 11: Impairment Ratings and Independent Medical Exams (IME)

As with all providers treating injured workers, **APs** must accept and abide by the Medical Aid Rules and Fee Schedules, report suspected fraud, claim suppression, and unsafe working conditions.

Services that can be billed

Attending Providers may perform and bill for services within their scope of practice and that adhere to the department's rules and policies.

Some services provided by **APs** may require additional enrollment in a specific L&I program. The table below provides a list of resources for some of the services **APs** may provide. **This is not an exhaustive list.** Providers must always refer to the appropriate MARFS chapter for the

service provided. All services must be billed using the appropriate CPT®, HCPCS Level II codes, or local code, when applicable.

Service	Additional information	MARFS reference
Case management services (team conferences, telephone calls, online communications)	**APs** have the ability to send secure messages through the Claim and Account Center. Contact the claim manager to gain access.	Chapter 5: Care Coordination
Consultations	All **APs** can request **consultations**. For more information on when **consultations** are appropriate and their requirements, see the Consultations policy in this chapter. Must be performed by a(n) MD, DO, DPM, DDS, DMD, OD, ARNP, PhD, PsyD, or DC enrolled in the Chiropractic Consultant Program. A separate provider account is required for enrolled chiropractors.	Consultations policy Chapter 17: Mental Health and Behavioral Health Interventions (BHI) Supplemental policy for chiropractors
Durable Medical Equipment (DME)	Some **DME** may be dispensed by **APs**.	Chapter 7: Durable Medical Equipment (DME) and Supplies
Evaluation and Management (E/M) services	Psychologists don't have E/M in their scope of practice and therefore must bill evaluations and **consultations** using mental health CPT® codes.	Chapter 9: Evaluation and Management (E/M) services Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Impairment ratings	Must be performed by MD, DO, DPM, DDS, DMD, or DC enrolled as approved IME examiner. Don't need a separate provider account. DCs must use their **IME** examiner provider account to bill.	Chapter 11: Independent Medical Exams (IMEs) and Impairment Ratings

Service	Additional information	MARFS reference
Independent Medical Exams (IMEs)	Must be performed by an approved IME examiner. Eligible providers include: MD, DO, DPM, DDS, DMD, and DC. Separate provider account required.	Chapter 11: Independent Medical Exams (IMEs) and Impairment Ratings
Physical medicine services	Providers who are board certified in physical medicine and rehabilitation (PM&R) may bill physical medicine CPT® codes. **AP** provider types who aren't board certified in PM&R must bill using local code **1044M**, which is limited to 6 visits.	Physical medicine services for attending providers (APs) – 1044M
Radiology consultations (secondary interpretive opinions)	Must be performed by a radiologist (MD/DO) or DC with appropriate certification. A separate provider account is required for certified chiropractors.	Supplemental policy for chiropractors Chapter 8: Electrodiagnostics and Radiology
Reports and forms for APs	Certain reports and forms are only applicable to, and billable by **AP** provider types. Other forms are applicable to all providers.	Chapter 21: Reports and Forms
Telehealth	Covered for most services that don't require a hands-on component. The provider is expected to make arrangements for in-person evaluation and/or intervention in certain circumstances. Audio-only is only covered for limited mental health services and only after first attempting **telehealth**.	Chapter 24: Telehealth, Remote, and Mobile Services

Links: For more information for these and other services, including service and documentation requirements, and payment limits, see the applicable chapter for the service provided.

For more information on coverage of services in general, see the professional fee schedule, WAC 296-20, medical coverage decisions, our website, and the applicable chapters in MARFS.

Refer to Chapter 2: Information for all providers for more information on:

- Additional billing and provider account set up requirements for all providers who hold additional certifications and/or multiple licensures.
- Prior authorization requirements for conservative care. Also see the applicable MARFS chapter for the service provided.

Fees appear in the Professional Services Fee Schedule.

Services that aren't covered

Treatment of chronic migraine or chronic tension-type headache with manipulation/manual therapy, massage, Transcranial magnetic stimulation (TMS), or trigger point injections isn't a covered benefit. For more information, see L&I's coverage decision.

Herbal supplements, minerals, botanical medicines, homeopathic remedies and other similar treatments aren't covered.

Links: For more information on treatment not authorized, see WAC 296-20-03002. Medical coverage decisions include or exclude a specific healthcare service as a covered benefit.

Supplemental payment policy: Advanced Registered Nurse Practitioners (ARNP)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to Advanced Registered Nurse Practitioners (ARNP).

Additional credentialing requirements

ARNPs must meet the education and training requirements and be credentialed as a:

- Psychiatric ARNP (PMHNP) in order to perform mental health services.

When ARNPs are working with physicians in the same group practice, they are considered as working in the exact same specialty and sub-specialty as the physician.

Services that can be billed

The table below provides additional resources for some of the other services ARNPs might provide.

Code(s)	Service	Additional information
Appropriate CPT®	Mental health services	Psychiatric ARNPs can bill for mental health services under mental health evaluation or E/M CPT® codes, as appropriate. Can't perform neuropsychological or psychological testing and evaluations. Chapter 17: Mental Health and Behavioral Health Interventions (BHI)

Links: For more information, see WAC 296-23-240, WAC 296-23-241, and WAC 296-23-245.
For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Chiropractors (DC)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to chiropractors.

Services that can be billed

The table below provides additional resources for some of the other services chiropractors might provide.

Code(s)	Service	Additional information
2050A-2052A	Chiropractic care visits	Chapter 20: Physical Medicine
Appropriate CPT®	Consultations	DCs enrolled in L&I's Chiropractic Consultant Program may perform **consultations**. Consultations policy
Appropriate CPT®	Radiology services	Limited to X-rays. DCs may order but not perform other radiological studies. DCs with the appropriate certification may perform radiology **consultations** (secondary interpretive opinions). A separate provider account is required to bill for these services. Chapter 8: Electrodiagnostics and Radiology
Appropriate CPT®	Impairment ratings & Independent Medical Exams (IMEs)	DCs must be enrolled in L&I's Approved Examiner Program to perform impairment ratings and IMEs.

Link: For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Dentists (DDS/DMD)

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to dentists.

Services that can be billed

Dentists may be **APs** a claim when dental treatment is required for accepted conditions and no other injuries require additional care.

The table below provides additional resources for some of the other services Dentists might provide.

Code(s)	Service	Additional information
Appropriate CPT®	Dental services	Chapter 6: Dental
Appropriate CPT®	**Independent Medical Exams** (IMEs)	DDS/DMDs must be enrolled in L&I's IME Examiner Program to perform IMEs.

Links: For more information, see WAC 296-23-160, and WAC 296-20-110. For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Naturopaths (ND)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to naturopaths.

Link: For more information on dual licensure requirements, see Chapter 2: Information for All Providers.

Services that can be billed

The table below provides additional resources for some of the other services naturopaths might provide.

Code(s)	Service	Additional information
98925-98927	Osteopathic Manipulative Treatment (OMT), including craniosacral therapy	Chapter 20: Physical Medicine
Appropriate CPT®	Radiology services	Limited to X-rays and ultrasound. NDs may order but not perform other radiological studies. Chapter 8: Electrodiagnostics and Radiology

Links: For more information, see WAC 296-23-205. For additional coverage information, see All Attending Provider (AP) types.

Services that aren't covered

Previous naturopathic local codes (**2130A-2134A**) for office visits and treatment were deleted on July 1, 2024. Naturopaths must bill for their services using the appropriate CPT®, HCPCS Level II, or local code. Colon hydrotherapy and enemas aren't covered, even with appropriate training.

Supplemental payment policy: Optometrists (OD)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to optometrists.

Optometrists may be **APs** a claim when eye treatment or glasses repair/replacement is required for accepted conditions and no other injuries require additional care.

Services that can be billed

The table below provides additional resources for some of the other services optometrists might provide.

Code(s)	Service	Additional information
Appropriate CPT®	Eye glasses and refractions	WAC 296-20-100

Link: For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Osteopaths (DO)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to osteopathic physicians.

Additional credentialing requirements

Osteopaths must meet the education and training requirements and be credentialed as a:

- Radiologist in order to perform radiology **consultations**.
- Psychiatrist in order to perform mental health services.

Services that can be billed

The table below provides additional resources for some of the other services osteopaths might provide.

Code(s)	Service	Additional information
98925-98927	Osteopathic Manipulative Treatment (OMT), including craniosacral therapy	Chapter 20: Physical Medicine
Appropriate CPT®	Radiology services	Radiologists may perform radiology **consultation** services (secondary interpretive opinions). Chapter 8: Electrodiagnostics and Radiology
Appropriate CPT®	Mental health services	Psychiatrists can bill for mental health services under mental health evaluation or E/M CPT® codes, as appropriate. Can't perform neuropsychological evaluation and testing (**96132-96133**). Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Appropriate CPT®	**Independent Medical Exams** (IMEs)	DOs must be enrolled in L&I's IME Examiner Program to perform IMEs.

Link: For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Physician (MD)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to medical physicians.

Additional credentialing requirements

Physicians must meet the education and training requirements and be credentialed as a:

- Radiologist in order to perform radiology **consultations**.
- Psychiatrist in order to perform mental health services.

Services that can be billed

The table below provides additional resources for some of the other services physicians might provide.

Code(s)	Service	Additional information
Appropriate CPT®	Radiology services	Radiologists may perform radiology **consultation** services (secondary interpretive opinions). Chapter 8: Electrodiagnostics and Radiology
Appropriate CPT®	Mental health services	Psychiatrists can bill for mental health services under mental health evaluation or E/M CPT® codes, as appropriate. Can't perform neuropsychological evaluation and testing (**96132**-**96133**). Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Appropriate CPT®	**Independent Medical Exams** (IMEs)	MDs must be enrolled in L&I's IME Examiner Program to perform IMEs.

Link: For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Physician Assistants (PA/PA-C)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to physician's assistants (PA) and certified physician assistants (PA-C).

All PAs must obtain an individual L&I provider account number, referencing their supervising or collaborating physician. PAs must bill under their own provider account number, even if the services are co-signed by their supervising or collaborating physician.

PAs are considered as working in the exact same specialty and sub-specialty as their supervising or collaborating physician, and can perform services within the physician's own scope of expertise and clinical practice in accordance with the practice agreement.

Links: For more information, see RCW 18.71A.030 and WAC 296-21-270.

Requirements for billing

PAs must sign all documentation required by the department for services they provide. The supervising or collaborating physician doesn't need to co-sign.

When applicable, PAs must use the appropriate modifier to describe their role in the service.

Links: For more information, see WAC 296-20-01501, WAC 296-20-12501, RCW 51.28.100, and Appendix B: Modifiers.

Services that aren't covered

PAs can't perform **consultations**, including radiology.

Links: For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Podiatrist (DPM)

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to podiatrists.

Services that can be billed

The table below provides additional resources for some of the other services podiatrists might provide.

Code(s)	Service	Additional information
Appropriate CPT®	**Independent Medical Exams** (IMEs)	DPMs must be enrolled in L&I's IME Examiner Program to perform IMEs.

Link: For additional coverage information, see All Attending Provider (AP) types.

Supplemental payment policy: Psychologists (PhD/PsyD)

General information

In addition to the information within the All Attending Provider (AP) types payment policy, the following is applicable to licensed clinical psychologists (PhD/PsyD).

On July 1, 2025, psychologists were added to the approved **attending provider** types, but only may be the **AP** on mental health only claims. Claims involving a physical condition which has resolved, are not considered mental health only claims.

Effective July 1, 2025, Psychologists are required to join the MPN in order to become an AP or continue treating past the **initial visit**.

Links: For more information regarding provider accounts, see Chapter 2: Information for All Providers, Become a Provider, and Psychologists as Attending Providers, on our website.

Services that can be billed

The table below provides additional resources for some of the other services psychologists might provide.

Code(s)	Service	Additional information
Appropriate CPT®	Mental health services, including **consultations** and testing	Must use mental health evaluation CPT® code **90791** when reporting evaluations and **consultations**. Psychologists can't bill E/M. Only neuropsychologists can perform neuropsychological evaluation and testing services. Chapter 17: Mental Health and Behavioral Health Interventions (BHI)

Link: For additional coverage information, see All Attending Provider (AP) types.

Payment policy: Consultations

General Information

The **consultation** services described in this policy refer to a type of evaluation service performed **at the request of an attending provider (AP), the department, self-insurer, or authorized department representative** to recommend care for a specific condition or problem. The insurer covers **consultations** in order to assist in making appropriate determinations to ensure proper and necessary care for the worker. **Consultations** may be requested for one of the following reasons:

- To determine if surgery is required,
- To determine if continuation of conservative care is appropriate (including but not limited to 60 and 120 day **consultations** and to satisfy the 6-month in-person mental health visit requirement),
- In lieu of an **Independent Medical Exam** (**IME**),
- To obtain a second opinion for clinical guidance on return to work, injury rehabilitation, stalled progress, controversy or dispute over treatment or diagnosis, prognosis, etc., *or*
- Other reasons identified by the insurer or **attending provider** where additional **consultation** may be necessary.

Note: **This policy is not applicable to:**

- Evaluations where the **consultant** has agreed to management of the worker's entire care (transfer of **AP** on the claim) or for the care of a specific condition or problem (concurrent care) *prior* to the visit. For example, a referral to "evaluate and treat". In these instances, the evaluation is considered a regular visit and is not coded as a **consultation** service. For more information, see the appropriate MARFS chapter for the type of evaluation provided.
- Radiology **consultation** services (secondary interpretative opinions). For more information, see Chapter 8: Electrodiagnostics and Radiology.

Who must perform these services to qualify for payment

The following **APs** may provide **consultation** services within their scope of practice and in alignment with department rules and policies.

- Advanced Registered Nurse Practitioner (ARNP),
- Chiropractors (DC) who are enrolled in the L&I Chiropractic Consultant Program,

- Dentists (DDS/DMD),
- Optometrists (OD),
- Osteopathic physicians (DO),
- Physicians (MD),
- Podiatric physicians (DPM), *and*
- Psychologists (PhD/PsyD).

A chiropractic (DC) **consultant** may render a second opinion for any conservative management of musculoskeletal conditions, even if the **attending provider** isn't a chiropractor. Chiropractors can't opine on surgical **consultations**.

Mental health **consultations** must be performed by a psychiatrist (MD or DO), Psychiatric ARNP, or licensed clinical psychologist (PhD/PsyD). Psychologists can't opine on physical injuries.

Note: Physician assistants (PA) and naturopaths can't perform **consultation** services, but can refer out to an **attending provider** type listed above.

Prior authorization

Mental health **consultations** require authorization. Other **consultations** do not require prior authorization. However, chiropractic **consultations** require prior notification (by electronic communication, letter, or phone call) to the department or self-insurer.

Links: An AP referral form (F252-098-000) may be used for **consultation** requests. For more information, see WAC 296-20-051, WAC 296-23-195, and Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Services that can be billed

The insurer only covers **consultations** requested by an **attending provider (AP)**, the department, self-insurer, or authorized department representative.

Consultants can initiate reasonable diagnostic studies during the **consultation**, as permitted within their scope of practice.

Requirements for billing

Whenever possible, **consultations** should be made with a provider outside the **APs** office or partnership.

Teleconsultations

Consultations may be performed in-person or via **telehealth**. Additional requirements for services provided via **telehealth** can be found in Chapter 23: Telehealth, Remote and Mobile Services.

How to bill for consultations

The appropriate CPT® code to bill for a **consultation** is dependent on the type of **consultant** performing the evaluation, whether the **consultant** has a previously established relationship with the worker, the location where the **consultation** was performed, and CPT® coding requirements for each level of service. The following describes the appropriate code to bill based off the applicable criteria.

L&I doesn't use the CPT® definitions for **consultation** services with respect to who can request a **consultation** service, when a **consultation** can be requested, and requirements for **established patients** receiving **consultation** services.

If the provider is a(n):

- Physician (MD or DO), ARNP, Chiropractor (DC), Dentist (DDS/DMD), Optometrist (OD), or Podiatrist (DPM), then bill using the appropriate E/M CPT® code.
- Psychiatrist (MD or DO) or psychiatric ARNP, then bill using the mental health evaluation CPT® codes **90791**, **90792** or the appropriate E/M CPT® code based on what is most reflective of the service provided.
- Psychologist (PhD/PsyD), then bill using the mental health evaluation CPT® code **90791**. **Psychologists can't bill E/M CPT® codes or 90792.**

CPT® Code(s)	Description	Worker seen provider in last 3 years?	**Consultation** performed in...
99242-99245	Outpatient E/M **consultation**	**No**	Outpatient office, home or residence
99252-99255	Inpatient E/M **consultation**	**No**	Hospital as inpatient or observation care, or nursing facility
90791, **90792**	Mental health evaluation (psychiatric diagnostic evaluation)	NA	Outpatient or inpatient setting
99212-99215	**Established patient** E/M office visit	Yes	Outpatient office

CPT® Code(s)	Description	Worker seen provider in last 3 years?	**Consultation** performed in...
99347-99350	**Established patient** E/M home or residence visit	Yes	Home or residence
99231-99233	Subsequent hospital E/M inpatient or observation	Yes	Hospital as inpatient or observation care
99307-99310	Nursing facility E/M visit	Yes	Nursing facility

For visits not requested by an **attending provider (AP)**, the department, self-insurer, or authorized department representative, initial, **new**, or **established patient** E/M codes must be used. The only exception is psychologists, who are still required to use the psychiatric diagnostic evaluation CPT® code **90791**.

Links: For more information about coverage for **consultation** services, see WAC 296-20-045, WAC 296-20-051 and WAC 296-20-01002.

For more information about chiropractic **consultation** services, see WAC 296-23-195.

For more information on mental health services, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

For additional requirements related to diagnostic studies performed during a **consultation**, see the appropriate chapter in MARFS.

Documentation Requirements

The **consultant** is required to submit a written report that meets all documentation requirements to the referring **AP** and the insurer **within 15 days** from the date of the **consultation**. The timeframe for submitting **consultation** reports is shorter than the requirement noted in Chapter 2: Information for All Providers, which states that documentation to support the service billed must be received prior to bill submission or within 30 days of the date of service, whichever comes first.

In addition to the SOAP-ER note requirements outlined in Chapter 2: Information for all providers, the **consultation** report must also include:

- Who referred the worker for the **consultation** (insurer or provider's name),
- A detailed history, including a comparison between the history provided by the AP and worker,

- A detailed physical examination,
- Complete diagnosis of all pathological conditions as a result of the injury, and any other preexisting conditions that may have been aggravated by the injury or may retard recovery,
- Recommendations for treatment of each condition and the probable duration of treatment,
- Expected degree of recovery from the industrial injury,
- Probability, if any, of permanent or partial disability resulting from the injury,
- Probability of returning to work, *and*
- If indicated, reports of diagnostic studies performed to establish or confirm the diagnosis.

Links: For additional guidelines and requirements for **consultations**, see WAC 296-20-01002, and the 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes.

Services that aren't covered

The **AP** can't request a **consultation** if an **IME** or impairment rating has already been arranged by the insurer.

Per WAC 296-20-051, providers can't bill **consultation** E/M CPT® codes for **established patients**.

Consultation E/M CPT® codes aren't covered when the **consultant** has agreed to management of the worker's entire care (transfer of AP) or for the care of a specific condition or problem (concurrent care) *prior* to the visit. For example, a referral to "evaluate and treat". In these instances, regular evaluation CPT® codes must be used.

Payment limits

Consultations billed using E/M CPT® codes are limited to 1 per provider, per worker, per day.

Mental health **consultations** (CPT® **90791**, **90792**) are limited to 1 occurrence per 6 months, per worker, per provider, and are only payable to providers listed as covered under the mental health evaluations and **consultations** payment policy in Chapter 17: Mental Health and Behavioral Health Interventions (BHI). MLTs can't provide evaluation or **consultation** mental health services.

Pre-operative E/M visits are included in the global surgical package for major surgery and aren't separately payable when they occur after the decision to operate is made. For more details on pre- and post-operative E/M visits, including when billed as **consultations**, see Chapter 9: Evaluation & Management (E/M).

Split billing

When evaluating and/or treating 2 or more separate conditions that aren't related to the same claim at the same visit, the split billing policy applies.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Payment policy: Physical medicine services for attending providers (APs) – 1044M

Services that can be billed

APs are required to bill local code 1044M for physical medicine modalities or procedures (including the use of traction devices) if they aren't board certified/qualified in Physical Medicine and Rehabilitation (PM&R). This code may only be billed for physical medicine modalities and procedures described in CPT® codes **97010**-**97750** and may only be performed if the provider's scope of practice and training permit it.

Link: For additional information on covered physical therapy services and requirements, see Chapter 20: Physical Medicine Services.

Services that aren't covered

CPT® physical medicine codes (**97010-97799**) aren't payable to **attending providers** who aren't board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

Manual therapy billed under CPT® code **97140** or local code **1044M** isn't covered for osteopathic physicians.

Documentation requirements

Chart notes must contain documentation that supports billing of local code **1044M**. Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting only the procedure code is insufficient and may result in denial of the bill or recoupment of payment. See Chapter 20: Physical Medicine Services for complete documentation requirements.

All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

Payment limits

Local code **1044M** is limited to 6 units per claim, except when the **attending provider** practices in a **remote** location where no licensed physical or occupational therapist, or physiatrist is available. After 6 units, the worker must be referred to a licensed physical (PT) or occupational (OT) therapist, or physiatrist (PM&R) for such treatment.

Only 1 unit is payable per day, per claim, per provider, regardless of the length of time the treatment is provided.

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Split billing

When treating 2 or more separate conditions that aren't related to the same claim at the same visit, the split billing policy applies.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

For more information on **attending provider** physical medicine limtations, see WAC 296-21-290

Payment policy: Radiology consultation services

General Information

Radiology **consultation** services include requests for secondary interpretive opinions by a different radiologist. These are performed at the request of the **attending provider** or insurer.

Who must perform these services to qualify for payment

Second opinion radiology **consultations** must be performed by:

- Radiologists, *or*
- Approved chiropractic radiology **consultants** who are Diplomates of the American Chiropractic Board of Radiology. If a chiropractor qualifies, they must obtain a separate provider account number to bill for these services.

Services that aren't covered

CPT® code **76140** isn't covered.

Requirements for billing

Providers who perform radiology **consultation** services must bill the specific radiology CPT® code with modifier **—26**.

Documentation requirements

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

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

The consulting provider must follow all reporting and documentation requirements for the professional service, including justification of the level, type, and extent of the services billed. See the reporting requirements policy in Chapter 8: Electrodiagnostics and Radiology for more details.

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Documentation such as "X-rays are negative" or "X-rays are normal" don’t fulfill the reporting requirements and the insurer **won’t pay** for the professional component in these circumstances.

Payment limits

Payment for radiology **consultation** services will be made at the professional component (modifier **–26**) rate for each specific radiology service performed.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and resources provider accounts and credentialing	WAC 296-20-01010 through WAC 20-01090 available in WAC 296-20 WAC 296-20-12401 Chapter 2: Information for All Providers Become a Provider
Administrative rules for Advanced Registered Nurse Practitioners (ARNP)	WAC 296-23-245 WAC 296-23-240 WAC 296-23-245
Administrative rules for claim reopenings	WAC 296-20-097
Administrative rules for dentists	WAC 296-23-160 WAC 296-20-110
Administrative rules for eye glasses and refraction coverage	WAC 296-20-100
Administrative rules for initial visit and transfer of attending providers	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 definitions	WAC 296-20-01002
Administrative rules for non-covered services	WAC 296-20-03002 WAC 296-20-03012
Administrative rules for Physician Assistants (PAs)	WAC 296-20-01501 WAC 296-20-12501

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If you're looking for more information about…	Then see…
Administrative rules for prior authorization	WAC 296-20-03001 WAC 296-20-030(1) WAC 296-23-195
Administrative rules for reports and forms	WAC 296-20-06101
Administrative rules for responsibilities when working with VRCs	WAC 296-19A-030
Attending Provider Resources	Attending Provider Resource Center
Chiropractic Services including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources	IICAC website L&I's Chiropractic Consultant Program
CMS 1500 form	F245-127-000
Fee schedules for all healthcare services	Fee schedules on L&I's website
Information for All Providers	Chapter 2: Information for All Providers
L&I's Claim and Account Center	Claim and Account Center on L&I's website
Medical coverage decisions	Coverage of Conditions and Treatment
Occupational Disease & Employment History form	F242-071-000
Payment policies for **case management services**	Chapter 5: Care Coordination
Payment policies for **dental services**	Chapter 6: Dental
Payment policies for **Durable Medical Equipment (DME) and supplies**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Payment policies for **Evaluation and Management (E/M)**	Chapter 9: Evaluation and Management (E/M) services

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If you're looking for more information about…	Then see…
Payment policies and information on **Independent Medical Exams (IME) and Impairment Ratings**	Chapter 11: Independent Medical Exams (IMEs) and Impairment Ratings L&I's IME Examiner Program
Payment policies for **mental health and Behavioral Health Interventions (BHI)**	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Payment policies for **infusions, injections and anesthesia**	Chapter 12: Injections and Medication Administration
Payment policies for **physical medicine services**, including OMT and CMT	Chapter 20: Physical Medicine
Payment policies for **radiology and Biofeedback**	Chapter 8: Electrodiagnostics and Radiology
Payment policies for **surgery**	Chapter 23: Surgery
Payment policies for **telehealth, remote, and mobile services**	Chapter 24: Telehealth, Remote, and Mobile Services
Provider's Initial Report (PIR) form	F207-028-000 for self-insurance claims.
Reopening application form	F242-079-000
Report of Accident (ROA) Workplace Injury or Occupational Disease form	F242-130-000
Utilization Review information	What requires UR

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 4: Audiology and Hearing

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

Table of Contents Page

General information: Advertising limits

False, misleading, or deceptive advertising or representations

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

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

False advertising includes mailers and advertisements that:

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

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

Payment policy: Audiology services

Worker responsibilities

Worker responsible for devices that aren't medically necessary

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

- The hearing aid, *and*
- Any future repairs.

Worker responsible for some repairs, losses, damages

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

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

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

Services that can be billed

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

A physician or advanced registered nurse practitioner (ARNP) may be paid for a narrative assessment of work-relatedness to the hearing loss condition. An Occupational Disease History Report (**1055M**) requires a separate report (See Instructions on Form F242-432-000). Simply starring a worker's work history isn't payable. (See Chapter 21: Reports and Forms)

When filing a Report of Accident, Otolaryngologists or Occupational Medicine physicians should also bill **1190M** if they perform a Comprehensive Hearing Loss Exam (see Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) for more information). If auditory testing is performed, the person performing the test will bill the appropriate procedure codes.

Services that aren’t covered

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

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

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

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

The insurer won’t cover disposable shells (“ear molds” in HCPCS codes).

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

The insurer won’t pay for loaning or renting hearing aids to workers during a new issue, repair or replacement.

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

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

Requirements for billing

Hearing aid parts and supplies paid at acquisition cost

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

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

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

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

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Payment limits

All hearing services and supplies

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

Documentation must include the:

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

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

Batteries

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

Only a maximum of 60 batteries are authorized within each 90 day period. Providers must document the request for batteries by the worker and maintain proof that the worker actually received the batteries. Please reference the above Payment Limits section for documention requirements.

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

Rechargeable hearing aids

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

Rechargeable batteries

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

Wax guards

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

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

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

Tubes and domes

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

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

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

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

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

Additional information: Audiology fee schedule

HCPCS code	Description	Maximum fee
V5008	Hearing screening	**$94.02**
V5010	Assessment for hearing aid	**Bundled**
V5011	Fitting/orientation/checking of hearing aid	**Bundled**
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V or In House repair V5267)	**$62.69**

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HCPCS code	Description	Maximum fee
V5020	Conformity evaluation	**Bundled**
V5030	Hearing aid, monaural, body worn, air conduction	**Acquisition cost**
V5040	Body-worn hearing aid, bone	**Acquisition cost**
V5050	Hearing aid, monaural, in the ear	**Acquisition cost**
V5060	Hearing aid, monaural, behind the ear	**Acquisition cost**
V5070	Glasses air conduction	**Acquisition cost**
V5080	Glasses bone conduction	**Acquisition cost**
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	**Acquisition cost**
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	**Acquisition cost**
V5130	Binaural, in the ear	**Acquisition cost**
V5140	Binaural, behind the ear	**Acquisition cost**
V5150	Binaural, glasses	**Acquisition cost**
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,780.27**
V5171	Hearing aid, contralateral routing device, monaural, in the ear (ite)	**Acquisition cost**
V5172	Hearing aid, contralateral routing device, monaural, in the canal (itc)	**Acquisition cost**
V5181	Hearing aid, contralateral routing device, monaural, behind the ear (bte)	**Acquisition cost**
V5190	Hearing aid, cros, glasses	**Acquisition cost**

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HCPCS code	Description	Maximum fee
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,067.05**
V5211	Hearing aid, contralateral routing system, binaural, ite/ite	**Acquisition cost**
V5212	Hearing aid, contralateral routing system, binaural, ite/itc	**Acquisition cost**
V5213	Hearing aid, contralateral routing system, binaural, ite/bte	**Acquisition cost**
V5214	Hearing aid, contralateral routing system, binaural, itc/itc	**Acquisition cost**
V5215	Hearing aid, contralateral routing system, binaural, itc/bte	**Acquisition cost**
V5221	Hearing aid, contralateral routing system, binaural, bte/bte	**Acquisition cost**
V5230	Hearing aid, bicros, glasses	**Acquisition cost**
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,067.05**
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$890.13**
V5242	Hearing aid, analog, monaural, CIC (completely in the ear canal)	**Acquisition cost**
V5243	Hearing aid, monaural, ITC (in the canal)	**Acquisition cost**
V5244	Hearing aid, digitally programmable analog, monaural, CIC	**Acquisition cost**
V5245	Hearing aid, digitally programmable, analog, monaural, ITC	**Acquisition cost**
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)	**Acquisition cost**

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HCPCS code	Description	Maximum fee
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)	**Acquisition cost**
V5248	Hearing aid, analog, binaural, CIC	**Acquisition cost**
V5249	Hearing aid, analog, binaural, ITC	**Acquisition cost**
V5250	Hearing aid, digitally programmable analog, binaural, CIC	**Acquisition cost**
V5251	Hearing aid, digitally programmable analog, binaural, ITC	**Acquisition cost**
V5252	Hearing aid, digitally programmable, binaural, ITE	**Acquisition cost**
V5253	Hearing aid, digitally programmable, binaural, BTE	**Acquisition cost**
V5254	Hearing aid, digital, monaural, CIC	**Acquisition cost**
V5255	Hearing aid, digital, monaural, ITC	**Acquisition cost**
V5256	Hearing aid, digital, monaural, ITE	**Acquisition cost**
V5257	Hearing aid, digital, monaural, BTE	**Acquisition cost**
V5258	Hearing aid, digital, binaural, CIC	**Acquisition cost**
V5259	Hearing aid, digital, binaural, ITC	**Acquisition cost**
V5260	Hearing aid, digital, binaural, ITE	**Acquisition cost**
V5261	Hearing aid, digital, binaural, BTE	**Acquisition cost**
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	**Acquisition cost**
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	**$1.10**

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HCPCS code	Description	Maximum fee
V5267	Hearing aid supply/accessory	**Acquisition cost**
5091V	Hearing aid **restocking fee** (the lesser of 15% of the hearing aid total purchase price or $150.00 per hearing aid)	**By report**
5092V	Hearing aid cleaning visit per ear (1 every 90 days, after the first year)	**$29.24**
5093V	Hearing aid repair fee. Invoice required	**By report**
5094V	Bilateral in office tubes/dome replacement (maximum of 18 times per calendar year)	**$25.00** per unit (limited to 1 unit per date of service)
5095V	Wax guards (maximum of 104 per calendar year)	**$1.25** each

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

Payment policy: Dispensing fees

Services that can be billed

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

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

Payment policy: Documentation and record keeping requirements

Documentation to support initial authorization

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

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

Documentation to support repair

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

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

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

Requirements for billing

Correspondence with the insurer

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

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

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

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

Providers are required to send warranty information for:

- **State Fund** claims to:

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

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

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

General requirements

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

All manufacturers and assemblers must hold a valid FDA certificate.

Self-insurers with purchasing contracts for hearing aids

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

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

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

Types of hearing aids authorized

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

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

The insurer covers the following types of hearing aids:

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

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

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

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

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

Prior authorization

Initial and subsequent hearing related services

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

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

To initiate the authorization process for:

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

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

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

Cases of special need

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

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

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

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

Masking devices for tinnitus

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

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

Required documentation

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

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

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

Who must perform these services to qualify for payment

Authorized testing

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

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

The provider must obtain prior authorization for subsequent testing.

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

Requirements for billing

All hearing aids, parts, and supplies

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

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

Link: For more details, refer to the **Acquisition Cost** Policy in Chapter 7: Durable Medical Equipment (DME) and Supplies.

Binaural hearing aids

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

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

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

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

Monaural hearing aids

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

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

Only bill 1 unit of service.

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

Tinnitus masking devices

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

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

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

Payment limits

Authorized testing

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

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

The insurer doesn't cover annual hearing tests.

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

30-day trial period

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

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

Payment policy: Repairs and replacements

Warranties

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

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

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

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

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

Prior authorization

Repairs

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

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

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

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

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

Replacements

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

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

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

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

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

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

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

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

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

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

Who must perform these services to qualify for payment

Repairs

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

Requirements for billing

Repairs

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

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

Additional information

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

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

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

Replacements

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

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

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

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

Need more help with repairs and replacements?

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

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

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Payment policy: Replacement of linear nonprogrammable analog hearing aids

When these hearing aids may be replaced

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

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

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

Prior authorization

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

Authorization documentation and record keeping requirements

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

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

For State Fund claims prior authorization:

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

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

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

Who must perform these services to qualify for payment

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

Payment policy: Restocking fees

Services that can be billed

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

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

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

Requirements for billing

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

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

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

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

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

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and **Washington state laws** for audiology and hearing services	Washington Administrative Code (WAC) 246-828-290 WAC 296-20-015 WAC 296-20-1101 WAC 296-23-165 Revised Code of Washington (RCW) 18.35.185 RCW 51.36.130
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including audiology)	Fee schedules on L&I's website
Hearing Services Worker Information form	F245-049-000
Occupational Disease Employment History Hearing Loss form	F262-013-000
Occupational Hearing Loss Questionnaire	F262-016-000
Payment policies for **acquisition cost, durable medical equipment (DME),** and **supplies**	Chapter 7: Durable Medical Equipment and Supplies
Payment policies for **reports and forms**	Chapter 21: Reports and Forms
Report of Accident form	F242-130-000
Statement for Miscellaneous Services form	F245-072-000
Termination of Agreement (Rescission) form	F245-050-000

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 5: Care Coordination

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS) Codes.

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

Payment policy: Case management telephone calls

General information

Case management telephone calls are audio-only communications conducted to assist in managing a worker's health condition, treatment plan, and/or the clinical aspects of their claim. These services don't include evaluating and/or treating the worker.

The American Medical Association (AMA) made substantial changes to telephone calls, effective **January 1, 2025**. The insurer has chosen to **not** adopt these changes, including CPT® codes (**98000**-**98016**). Providers must use the local code in this policy to report case management telephone calls.

Link: L&I has limited coverage of audio-only services used to evaluate and/or treat injured workers. For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

Who must perform these services to qualify for payment

Case management telephone calls are payable only when an **attending provider**, **consultant**, or concurrent care provider has an existing relationship with the worker's claim and personally participates in the call.

Qualified PGAP® providers can participate in and bill for case management telephone calls, except when communicating directly (one-on-one) with legal representatives; they must use PGAP® telephone call codes. For details, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Link: Case management telephone call code **9919M** isn't payable to providers who already account for participation of these services within their own procedure codes, such as Vocational Rehabilitation Counselors (VRCs), Health Service Coordinators (HSCs), and Nurse Case Managers (NCMs). For details, see Chapter 25: Vocational Services and other policies in this chapter.

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Who is a covered participant

Case management telephone calls are only payable when having in-depth clinical discussion with at least one of the following covered participants:

- The worker,
- L&I staff,
- **Attending providers**,
- **Consultants**,
- Concurrent care providers,
- Vocational rehabilitation counselors,
- Nurse case managers,
- Health services coordinators (COHE),
- Surgical Health Services Coordinators (SHSCs),
- Activity coaches (PGAP®),
- SIEs/TPAs, *or*
- Employers.

Attorneys can only participate in case management telephone calls under certain conditions:

- When an attorney is the only other participant, the worker must also be present, such as when participating in a call with only the **attending provider**.
- When there is another participant in addition to the attorney, the worker isn't required to be present, such as when participating in a call with the **attending provider** and a member of L&I staff.

Services that can be billed

Case management telephone calls are billed using local code **9919M** and are only payable when the discussion includes in-depth clinical conversation regarding the following topics:

- Discussing and interpreting diagnostic tests that require counseling and may require adjustments to treatment and/or medication,
- Discussing of return to work activities with workers, employers, or the claim manager,
- Discussing medical rationale or employability, including but not limited to those conversations surrounding:
    - Contended conditions,
    - Notification of non-compliance which includes further discussion on remaining care and treatment plan, *and/or*
    - Clinical discussions with another provider.

When the discussion involves the worker as a sole participant, discussion is limited to topics that don't require a return to the office, either in-person or via **telehealth**, and aren't related to a visit within the last 7 days. See payment limits in this policy for additional details.

Services that aren't covered

Case management telephone calls where a covered provider doesn't personally participate aren't payable. Ancillary or office staff (including but not limited to medical assistants) can't participate in case management telephone calls on behalf of the provider, even under supervision.

Administrative communications focusing on the logistical aspects of care aren't payable to any provider, including but not limited to:

- Voicemails, even if the provider leaves a detailed message,
- Discussing authorization, including requests,
- Resolution of billing issues,
- Routine communications related to appointments, such as scheduling, requests, and reminders,
- Ordering prescriptions, including requests for refills,
- General notifications, such as test results that are informational only,
- Following up on referrals,
- Relaying information contained in other billable services, such as calling to notify the CM that the worker had their MRI or to update the CM after a visit. In these scenarios, only the visit would be payable as the information is already contained within the chart note,

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- Discussing the L&I claims process with the worker/family/caregiver. All questions, discussions, and/or concerns regarding the administrative process of L&I claims must be directed to the insurer, *and*
- Communications with office staff.

Interprofessional online and telephone consultative services (**99446**-**99452**) aren't covered.

Audio-Only Services

Telephone calls used to evaluate and/or treat injured workers aren't considered case management; these are referred to as audio-only services.

Audio-only evaluation and management services (**98008**-**98016**) aren't covered. The insurer covers a limited list of audio-only services. For details, see Chapter 24: Telehealth, Remote, and Mobile Services.

Requirements for billing

Mental health services must be authorized for psychiatrists, psychiatric ARNPs, clinical psychologists, and MLTs to bill for these services, per WAC 296-21-270.

Team conferences over the phone must be billed using **9919M**.

Documentation requirements

Each provider must submit comprehensive documentation for the case management telephone call, which must include:

- The date,
- The participants and their titles,
- The details of the call (see Services that can be billed), *and*
- All medical, vocational or return to work decisions made.

Note: General statements such as "check in" or "coordination of care" aren't acceptable.

Payment limits

9919M is limited to 1 per day, per claim, per provider, regardless of the number of calls.

Case management telephone calls (**9919M**) and online communications (**9918M**) to transmit or simply reiterate the information on the APF are **bundled** into **1073M** and aren't separately payable.

The provider can't include the time spent performing or documenting case management telephone calls in selecting the appropriate E/M level, as this service is required to be billed separately.

Worker discussion limits

When the discussion involves the worker as a sole participant, the following isn't separately payable as it's considered to be included (**bundled**) in the work associated with another service:

- Discussions resulting in a decision to see the worker within 24 hours or the next available appointment.
- Discussions related to a visit within the previous 7 days, such as addressing questions and concerns about a previously established plan of care.
- Discussions within the global period of a previously completed procedure, such as pre- and post-surgical instructions, questions, addressing of concerns, and status check-ins. Refer to the professional services fee schedule for global period information.

Split billing

If a case management telephone call pertains 2 or more open claims, providers are expected to split the billing between the claims.

Link: For more information on split billing procedures and requirements, see the Split billing – Treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

For more information on E/M within a global period, see Chapter 9: Evaluation and Management (E/M).

Payment policy: Health services coordination (HSC) & surgical health services coordination (SHSC)

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

HSCs and SHSCs must meet minimum qualifications and be approved by L&I's Occupational Health Services Unit. HSCs and SHSCs must have an L&I provider account number for each best practice program they participate in. L&I has sole responsibility for approving HSC/SHSC provider account 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 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).

The following activities are billable per 6-minute unit:

- Build/determine a care coordination plan (assess needs, analysis of next steps, establish patient goals and desired outcomes, track goal progression/regression),
- Communicate with any parties to the claim or treatment plan, including, but not limited to, workers, providers, and employers,
- Identify community and clinical resources,
- Complete of the pain/function scale,
- Assist with transfers of care,
- Determine and communicate worker issues with medication,
- Plan and participate in case conferences, *and*
- Complete an FRQ.

HSC and SHSC fee schedule

Code	Description	Program	Fee
1083M	**Surgical coordination intake (SCI)** Can be billed as a stand-alone service. Refer to the SHSC Manual & Toolkit for documentation requirements. Max 1 per claim every 3 years.	Surgical Quality Care Program (SQCP)	**$164.46**
1087M	**COHE health services coordination** Can be billed as a stand-alone service. Can be billed with the modifier **-8S**. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	COHE	**$10.12**

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 modifier -8S. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	Surgical Quality Care Program (SQCP)	**$10.12**

Billing units

When billing the time-based local codes for HSC and SHSC services, use whole numbers only (don't use fractions of units) rounded to the nearest whole number.

If the combined duration of the service **is at least**…	**and less than**…	**Then**, **when billing**, **report**:
3 minutes	9 minutes	1 unit
9 minutes	15 minutes	2 units
15 minutes	21 minutes	3 units
21 minutes	27 minutes	4 units
27 minutes	33 minutes	5 units
33 minutes	39 minutes	6 units
39 minutes	45 minutes	7 units
45 minutes	51 minutes	8 units
51 minutes	57 minutes	9 units
57 minutes	63 minutes	10 units

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

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

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 worker, bill using the modifier **-8S**. Modifier **-8S** is paid at 50%.

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.

Case management services such as telephone calls, team conferences, and online communications are included within the HSC/SHSC local codes and aren't separately billable.

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Payment policy: Nurse case management

General information

Nurse case management (NCM) referrals are intended to help injured workers navigate the sometimes challenging and complex world of medical treatment and workers' compensation claim processes. The intent of this policy is to allow nurse case managers (NCMs) flexibility as they complete goals set collaboratively with occupational nurse **consultants** (ONCs) or self-insured employer's (SIE) representatives.

What's new in the 2025 version

A number of key changes were made to this policy for the 2025 publication of MARFS. These include, but aren't limited to:

- Removed the 75-hour limit per NCM per claim,
- Removed the 16-hour travel/wait limit,
- Removed the time limit on report creation,
- Removed 9918M as a billable code for NCMs,
- Added a 90-day authorization period,
- Added reporting period billing requirements,
- Added new time-based codes for Initial, Progress, and Closing Reports,
- Updated required report elements,
- Condensed case management local codes into one code (added **1297M**, removed **1220M**-**1223M**),
- Changed from 6-minute units to 15-minute units,
- Annual assessments (Care Management Tool) are now separately billable; see policy for details.

Eligibility for nurse case management referrals

Workers must meet one or more of the following criteria to be eligible for a referral:

- Work-related injuries not managed under the Catastrophic Project,
- Medically complex condition(s),
- Significant care coordination issues, *or*
- Barriers to successful claim resolution.

Prior authorization

Prior authorization by the ONC or SIE representative is required for all nurse case management referrals (**1294M-1297M**).

Nurse case management services are authorized for periods of 90 days. The initial date of acceptance of an assignment is considered the start of a referral, and the date of submission of a Closing Report is considered the end of a referral.

Referral extensions of 90 days may be authorized with ONC or SIE representative approval. The NCM must document the need for additional time in a Progress Report (see Documentation requirements). The insurer will then add a note to the claim file which includes: confirmation of approval, reason for approval and current case goals (in summary), and the new authorization period.

As long as an NCM's actions are helping progress the case in a way that is satisfactory to the NCM and insurer, a referral may be extended as many times as needed. However, a more extensive review will be performed by the ONC or SIE representative every 180 days in order to ensure goals are progressing and the assignment is still necessary.

The insurer can terminate authorization at any time at their discretion.

Pausing and resuming referrals

There may be situations in which it is appropriate to pause a referral without closing it. This means the NCM is still assigned to the claim, but doesn't take any actions, file reports, or submit bills for a specified period.

The ONC or SIE representative will note the referral pause period and reason for pause in the claim file. Once the pause period is over, the insurer will contact the NCM and instruct them to resume work on the referral. A note will also be added to the claim file.

A new Initial Report isn't required following a pause unless a substantial amount of time has passed and the insurer gives approval. Pausing a referral should be done sparingly and with agreement between the NCM and insurer.

Who must perform these services to qualify for payment

Required qualifications

Only registered nurses with case management certification can be paid for nurse case management referrals.

Examples of case management certification include but aren't limited to:

- Certification of Disability Management Specialists (CDMS).
- Commission for Case Manager Certification (CCMC or CMC).
- Certified Rehabilitation Registered Nurse (CRRN).

- Certified Occupational Health Nurse (COHN).
- Certified Occupational Health Nurse-Specialist (COHN-S).

Note: If you are unsure whether your certification is sufficient to qualify, email the provider credentialing unit at pacmail@Lni.wa.gov.

NPIs for NCMs

NCMs are required to submit a National Provider Identifier (NPI) through the ProviderOne portal. NPIs are unique 10-digit numbers used for identifying specific providers. NPIs are used by medical providers nationwide.

If you don't have an NPI number, go to the National Provider Identifier Standard section of the Centers for Medicare and Medicaid Services (CMS) website. Registering for an NPI number is free and does not require a social security number. Assistance with submitting the NPI is available on L&I's ProviderOne website.

Services that can be billed

Nurse case management referrals are ongoing services billed per reporting period. They continue until ended by either the ONC, insurer, or NCM.

Referral structure

A nurse case management referral begins with a request from the insurer. The NCM and ONC or SIE representative discuss goals for the referral and determine a plan. The NCM then submits an Initial Report. The NCM bills for casework every 30 days while the referral is ongoing, and submits a Progress Report along with their bill. When the insurer or NCM believe that the referral is no longer needed and communicates this to the NCM, the NCM submits a Closing Report along with their bill for any remaining casework. The referral is now considered "closed" and a new Initial Report must be filed to "reopen" it.

Nurse case management services

Code	Description and notes	Maximum fee
1297M	**Casework** 1 unit = 15 minutes (4 units = 1 hour) Billable for time spent working on a case for the benefit of a worker. It includes the following activities: - Telephone calls related to scheduling appointments on behalf of a worker, performing care coordination, attempting to secure a provider, or communicating with claim parties and providers (except for a worker's attorney) regarding the worker's case. - Time spent in appointments with providers, participating in face-to-face team conferences, or when visiting a worker for case-related reason, including via **telehealth**. - Time spent reviewing claim files, responding to emails or texts, performing services related to finding providers, engaging in care coordination, or researching a worker's condition or claim. - Time spent driving, waiting for appointments, or other similar circumstances. Casework performed for less than 8 minutes on a single date of service isn't billable.	**$32.88** per 15 minutes
1294M	**Initial Report** 1 unit = 15 minutes (4 units = 1 hour) Prior authorization is required. Due within 30 days of acceptance of a referral. Billable for time spent writing an Initial Report only.	**$32.88** per 15 minutes

Code	Description and notes	Maximum fee
1295M	**Progress Report** 1 unit = 15 minutes (4 units = 1 hour) Only billable once every 30 days. Due every 30 days during an active referral. A report may only be submitted if action was taken to advance one or more goals set for the referral. If no actions were taken this month, don't submit or bill for a Progress Report. Billable for time spent writing a Progress Report only.	**$32.88** per 15 minutes
1296M	**Closing Report** 1 unit = 15 minutes (4 units = 1 hour) Due within 30 days of request from ONC or insurer. NCMs may also choose to close a referral if they feel their services are no longer needed. Billable for time spent writing a Closing Report only.	**$32.88** per 15 minutes

Mileage and travel expenses

NCMs may bill **1224M** (Mileage) and/or **1225M** (Travel expenses) along with **1294M-1297M**. Documentation and prior authorization rules apply. See the payment policy in Chapter 15: Lodging, Transportation, and Travel for additional details.

Requirements for billing

Reporting periods

Instead of billing each date of service separately, NCMs must bill for reporting periods. The length of a reporting period is typically 30 days, but can be shorter at the beginning or end of a referral. One reporting period is:

- The time between when the NCM accepts a referral and when they submit their Initial Report (no more than 30 days),
- 30 days, *or*
- The time between when the NCM submits a Progress Report and a Closing Report (no more than 30 days).

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Bills for code **1297M** (casework) are typically submitted every 30 days, with all units for that period included on a single bill. The first and last date of service should be the date of submission of the corresponding report (Initial, Progress, or Closing) that documents the services. The reporting period includes the date the report is submitted and billed for.

Bills where the first and last date of service aren't the same may be denied. Please bill for a single date, not a date range.

The documentation for each reporting period includes the corresponding report (codes **1293M**-**1925M**). In most cases, this will be the Progress Report, but may also be the Initial or Closing Report.

Billing examples

Example 1: An NCM accepts a referral on March 12. They meet with the worker, complete initial history and case planning, and create an Initial Report. They spent 180 minutes writing the report. The NCM submits the Initial Report on March 31. In this case, the reporting period would be March 12-31. The NCM should submit one bill on March 31 that includes all billable units for March 12-31 under code **1297M** (casework) and 12 units of code **1294M** (Initial Report). The date of service on the entire bill should be March 31.

Example 2: An NCM has just submitted a Progress Report on October 1. They continue working the case throughout the month of October. The next Progress Report cannot be submitted until 30 days after the previous one, and a report is due every 30 days. The NCM spends 30 minutes writing the Progress Report and submits it on October 31. The reporting period is October 2-31, so the NCM bills for all time spent across those dates using **1297M** (casework) and 2 units of code **1295M** (Progress Report). The date of service on the entire bill should be October 31.

Example 3: An NCM has completed all goals set for a referral, so no further services are needed. The NCM submitted their last Progress Report and bill on July 24. The ONC has asked the NCM to end the referral by the end of the month. The NCM spends 197 minutes completing a Closing Report, and submits it on August 1, as well as a bill for all services rendered between July 24-August 1 using **1297M** (casework) and 13 units of **1296M** (Closing Report). The date of service on the entire bill should be August 1. The referral is now closed, and a new Initial Report will be needed to reopen it (only upon insurer request.)

Billing units

When billing the local codes for nurse case management services, use whole numbers only (don't use fractions of units) rounded to the nearest whole number.

If the combined duration of the services **is at least**…	**and less than**…	**Then**, **when billing**, **report**:
8 minutes	23 minutes	1 unit
23 minutes	38 minutes	2 units
38 minutes	53 minutes	3 units
53 minutes	68 minutes	4 units
68 minutes	83 minutes	5 units
83 minutes	98 minutes	6 units
98 minutes	113 minutes	7 units
113 minutes	128 minutes	8 units

Documentation requirements

Reporting deadlines

Initial Reports are due within 30 days of acceptance of the referral by the NCM or when submitting a bill for an Initial Report, whichever is first.

Progress Reports are due every 30 days after submission of an Initial Report or during an ongoing referral, whichever is greater. A report may only be submitted if action was taken to advance one or more goals set for the referral. If no actions were taken this month, don't submit or bill for a Progress Report.

Closing Reports are due within 30 days of a request to close the referral from either the ONC, insurer, or NCM.

Goals for referrals

Goals are **required** for all levels of referral and must be documented in each report. Upon acceptance of a referral, the NCM should actively work with the ONC to determine one or more goals for the referral that, if completed, would improve the worker's situation and/or advance the progress of the case. Whenever possible, goals should be specific, measurable, actionable, realistic, and time-limited. They should be objectives within the NCM's control, rather than objectives the worker may have for their recovery. Goals may be added, removed, or modified throughout a referral as needed with agreement from the NCM and ONC or SIE representative.

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Reports revolve around goals. The Initial Report outlines starting goals for the referral. Progress and Closing Reports include an explanation of the current status of each goal, what steps were taken in the last reporting period toward completing that goal, and what steps will be taken or tasks completed in order to make additional progress on that goal in the coming month.

The insurer will monitor NCM activity as outlined in the reports and provide feedback to the NCM if progress isn't being made. Failure to demonstrate progress on achieving agreed-upon goals may result in closure of a referral.

See the table of report elements below for details on required goal documentation.

Note: NCMs will be evaluated on the steps they take toward achieving goals set collaboratively with ONCs or SIE representatives. NCMs won't be evaluated based on case progress, worker recovery, or claim outcome.

Required report elements

The required elements for Initial, Progress, and Closing reports are largely the same. Each report must contain all elements listed in the table below unless otherwise noted. NCMs are permitted to use their preferred report format as long as it contains all required elements.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your report is properly entered into L&I's systems.

Report element	Required in…
Report tracking information Type of report: Indicates the type (Initial, Progress, Closing). Date of initial referral: Date NCM accepted the referral. Care episode: Date span this report covers, which is from the date of the last report to the date this report was completed.	Initial Report Progress Report Closing Report

Report element	Required in…
Worker information Name: Worker's full name. Date of birth: Worker's date of birth. Contact info: Worker's contact information including mailing address and phone number. Attorney info (if applicable): Worker's attorney contact information (if applicable). Current work status: Worker's work status (such as not working, light duty, working full time, and so on).	Initial Report Progress Report Closing Report
Claim information Claim number: Claim number(s) for the claim(s) related to the referral. Assigned ONC and CM: Names of ONC and claim manager (CM) assigned to the claim(s) at time of report. Date of injury: Worker's date(s) of injury.	Initial Report Progress Report Closing Report
Healthcare provider information Name: **Attending provider's** full name. Contact info: **Attending provider's** contact information including current mailing address and phone number. Date of last visit with provider: Date of worker's most recent visit with **attending provider**.	Initial Report Progress Report Closing Report
Medical information Allowed condition(s): List of currently allowed conditions on the claim(s). Medical history: A narrative summary of the relevant history of the worker's medical condition since last report or start of referral, whichever is most recent. Current status: A narrative description of the worker's current medical status (such as recovering from surgery, in physical therapy, pending **independent medical exam**, and so on).	Initial Report Progress Report Closing Report

Report element	Required in…
Goal information Each goal should be listed separately and include all of the following details: Goal title: Brief descriptive name of the goal. Goal start date: Date the goal was added to the referral. Narrative of current status: Narrative description that includes the current status of the goal and the progress made on the goal since the last report or start of referral, whichever was later. Barriers: Description or list of current barriers preventing completion of this goal. Plan: A time-limited plan for how the NCM intends to overcome barriers and achieve the goal or make progress toward achieving the goal. Goal change requests: List of new goals to be added, completed goals to be closed, or requested changes to existing goals (if applicable). Additional notes: Any other relevant details pertaining to goals or case progress (as necessary).	Initial Report Progress Report Closing Report
Historical goal information Each goal that has been completed or is closed (per NCM and insurer agreement) should be listed separately and include the following: Goal title: One-sentence description of the goal. Goal dates: Date the goal was added to the referral and date the goal was completed or closed. Goal description: Narrative description of key milestones in progress toward completion of this goal.	Progress Report Closing Report
Next steps Appointments: List of upcoming appointments set to occur during the next 90 days. Testing: List of upcoming tests and evaluations set to occur during the next 90 days. Communication: Description of communication tasks to be carried out in the next 90 days.	Initial Report Progress Report Closing Report

Report element	Required in…
CAC access and authorization: Current referral authorization period, including date authorization will end and request for additional 90-day authorization (if applicable).	Initial Report Progress Report

Split billing

See Chapter 2: Information for All Providers for details about billing for multiple claims for the same worker.

Payment limits

Initial Reports are billable once per referral.

Progress Reports are billable once every 30 days.

Closing Reports are billable once per referral.

Services that aren't covered

Non-billable services and expenses include:

- Nurse case manager training,
- Nurse case manager certification upkeep activities and/or fees,
- Supervisory visits,
- Postage, printing, and photocopying except of **medical records** requested by insurer and not required to support billing,
- Telephone or fax equipment,
- Clerical activity (such as faxing, mailing, or organizing documents),
- Travel time not covered under **1297M** (such as travel time to post office or fax machine),
- Services less than 8 minutes in duration,
- Fees related to legal work, such as deposition and testimony, *and*
- Any other administrative costs not specifically mentioned above.

Note: Legal fees may be charged to the requesting party, but not the claim.

Payment policy: Nurse case management annual assessments

General information

This policy allows nurse case managers (NCMs) to be paid for completion of the Care Assessment Tool (F245-377-000), which is used to review the condition of a worker receiving home health care or living in a residential care facility or similar setting. This is also known as an "annual assessment". Such assessments generally apply to workers who are pensioned, but may also be needed for open workers' compensation claims. The form is typically completed once per year, but changes in circumstances for a worker might necessitate additional assessments.

Who must perform these services to qualify for payment

Only NCMs may bill **1298M** (Annual assessment).

Note: For details on how to become an NCM, see the list of required qualifications later in this chapter.

Prior authorization

Prior authorization from the insurer is required in order to bill for completion of the Care Assessment Tool.

Services that can be billed

Code	Description and notes	Maximum fee
1298M	**Annual assessment.** 1 unit = 15 minutes (4 units = 1 hour) Requires prior authorization. Requires submission of Care Assessment Tool (F245-377-000). This service includes time spent: - Traveling to/from a location to perform the assessment. - Time spent performing the assessment. - Phone calls with provider(s) and the worker related to the assessment. - Time spent completing the Care Assessment Tool.	**$32.88** per 15 minutes

NCMs may bill **1298M** (Annual assessment) upon completion and submission of the Care Assessment Tool.

The Care Assessment Tool is due within 30 days of acceptance of an assignment. If additional time is needed, please contact the insurer to request an extension. You must send in the form prior to submitting your bill or within 30 days of bill submission.

Failure to submit the form or submission of an incomplete form may result in denial or recoupment of payment.

Annual assessments and nurse case management referrals

1298M (Annual assessment) and **1294M-1297M** (nurse case management referral codes) are separately billable. NCMs may be asked to complete an annual assessment during the course of a referral or separately from a referral. See Payment policy: Nurse case management for additional details regarding nurse case management referrals.

Mileage and travel expenses

NCMs may bill **1224M** (Mileage) and/or **1225M** (Travel expenses) along with **1298M** (Annual assessment). Documentation and prior authorization rules apply. See the payment policy in Chapter 15: Lodging, Transportation, and Travel for additional details.

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Multiple annual assessments in a one-year period

The annual assessment service is typically only needed once per year, but may be appropriate to perform more than once if:

- The worker moves from home into a care facility or changes care facilities,
- There is a significant change in the worker's medical condition that warrants a change in care delivery, *or*
- Other circumstances arise that require a reassessment of the worker's long-term care.

If needed, the insurer can request additional annual assessments based on the above factors. The insurer will add a written justification for the extra assessment to the claim file.

Payment policy: Online communications

General information

Online communications are electronic communications conducted over a secure network, including but not limited to electronic mail (email), patient portals, or Claim and Account Center (CAC).

Link: Online communications aren't payable to providers who already account for participation of these services within their own procedure codes, such as Vocational Rehabilitation Counselors (VRCs), Health Service Coordinators (HSCs), and Nurse Case Managers (NCMs). For details, see Chapter 25: Vocational Services and other policies in this chapter.

Who must perform these services to qualify for payment

Online communications are payable only when an **attending provider**, **consultant**, or concurrent care provider has an existing relationship with the worker's claim and personally provides the service.

Who is a covered participant

Payable online communications must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The online communications must be with:

- The worker,
- L&I staff,
- **Attending Provider**,
- **Consultants**,
- Concurrent care providers,
- PT, OT, speech language pathologist,
- Nurse case managers,
- Vocational rehabilitation counselors,
- SIEs/TPAs, *or*
- Employers.

Requirements for billing

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association, *or*
- The Federation of State Medical Boards, *or*
- The eRisk Working Group for Healthcare.

Services that can be billed

Online communciations are billed using local code **9918M** and are only payable when the discussion includes in-depth clinical conversation regarding the following topics:

- Discussing and interpreting diagnostic tests that require counseling and may require adjustments to treatment and/or medication,
- Discussing of return to work activities with workers, employers, or the claim manager.
- Discussing medical rationale or employability, including but not limited to those conversations surrounding:
    - Contended conditions,
    - Notification of non-compliance which includes further discussion on remaining care and treatment plan, *and/or*
- Clinical discussions with another provider.

Services that aren’t covered

Online communications where a covered provider doesn’t personally provide the service aren’t payable. Ancillary or office staff (including but not limited to medical assistants) can’t provide the service on behalf of the provider, even under supervision.

CPT® codes **99421**-**99423** aren’t covered. The provider must bill local code **9918M**.

Administrative communications focusing on the logistical aspects of care aren’t payable to any provider, including but not limited to:

- Discussing authorization, including requests,
- Resolution of billing issues,
- Routine communications related to appointments, such as scheduling, requests, and reminders,
- Ordering prescriptions, including requests for refills,
- General notifications, such as test results that are informational only,
- Following up on referrals,

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- Relaying information contained in other billable services, such as calling to notify the CM that the worker had their MRI or to update the CM after a visit. In these scenarios, only the visit would be payable as the information is already contained within the chart note,
- Discussing the L&I claims process with the worker/family/caregiver. All questions, discussions, and/or concerns regarding the administrative process of L&I claims must be directed to the insurer,
- Communications with the worker's attorney or their staff, *and*
- Communications with office staff.

App-based and texting evaluation and/or treatment isn't covered.

Interprofessional online and telephone consultative services (**99446**-**99452**) aren't covered.

Requirements for billing

Mental health services must be authorized for psychiatrists, psychiatric ARNPs, clinical psychologists, and MLTs to bill for these services, per WAC 296-21-270.

Documentation requirements

Online communication documentation must include:

- The date, *and*
- The participants and their titles, *and*
- The details of the online communication (see Services that can be billed, above), *and*
- All medical, vocational or return to work decisions made.

A copy of the online communication must be sent to L&I.

Providers aren't required to submit a separate document for online communications with an L&I claim manager made through the Claims and Account Center (CAC). CAC meets the documentation requirements for secure messaging.

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Payment limits

9918M is limited to once per day, per claim, per provider, regardless of the number of communications.

Case management telephone calls (**9919M**) and online communications (**9918M**) to transmit or simply reiterate the information on the APF are **bundled** into **1073M** and aren't separately payable.

The provider can't include the time spent performing or documenting online communications in selecting the appropriate E/M level, as this service is required to be billed separately.

Split billing

If a communication pertains 2 or more open claims, providers are expected to split the billing between the claims.

Link: For more information on split billing procedures and requirements, see the Split billing – Treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Payment policy: Team conferences

Who must perform team conferences to qualify for payment

Payable team conferences must be related to the worker and for the purposes of discussing or coordinating care, treatment, or return to work activities. The team conference must include 2 or more of the following:

- Current or former medical providers,
- Concurrent care providers, *or*
- Consulting providers, *or*
- Vocational rehabilitation counselors, *or*
- Nurse case managers, *or*
- PTs, OTs, and speech language pathologists, *or*
- Psychologists, *or*
- L&I staff, *or*
- L&I medical **consultants**, *or*
- Employers, *or*
- SIEs/TPAs.

The insurer doesn't follow CPT® by requiring all providers to have seen or treated the worker in the previous 60 days. However, all participating providers, with the exception of **consultants**, must have an established relationship with the worker.

Requirements for billing

All participants of the team conferences must participate in-person or via telehealth. Team conferences via **telehealth** must follow the **telehealth** guidelines. For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

The following criteria must be met for team conferences:

- The need for a conference exceeds the day-to-day correspondence/communication among providers, and
- The worker isn't participating in a program in which payment for a conference is already included in the program payment (such as brain injury rehab program, or pain clinic), and
- Two or more disciplines/specialties need to participate.

ARNPs, PAs, psychologists, MLTs, speech-language pathologists, PTs, and OTs must bill using non-physician codes.

If the **worker status** is…	And you are **physician**, then bill **CPT®** code:	And you are a **non-physician**, then bill **CPT®** code:
Worker present	Appropriate level E/M	**99366**
Worker not present	**99367**	**99368**

For conferences **exceeding 30 minutes**, multiple units of **CPT®** codes **99366**, **99367**, or **99368** may be billed. For example, if the duration of the conference is:

- 1-30 minutes, then bill 1 unit, *or*
- 31-60 minutes, then bill 2 units.

Link: Team conferences provided over the phone (conference calls) are considered case management telephone calls and must be billed using **9919M**. For details, see Case management telephone calls.

Services that aren't covered

The insurer won't reimburse PT/OT and/or speech language pathologists for team conferences with members of the same clinic or care organization's physical medicine team unless part of an approved work rehabilitation program care conference.

Documentation requirements

Each provider must submit their own team conference documentation; joint documentation isn't allowed for any provider. Each team conference participant's documentation must include:

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

In addition to the documentation requirements noted above, team conference documentation must also include a goal oriented, time limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, *or*

- Objective measures of function.

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function. For PTs and OTs, the team conference documentation must include an evaluation of the effectiveness of the previous therapy plan.

Additionally, if the worker is present, and you are a physician, you must comply with all Evaluation and Management (E/M) service and documentation requirements. For more information, see Chapter 9: Evaluation and Management (E/M) services.

Payment limits

Providers in a hospital setting may only be paid if the services are billed on a **CMS-1500** with their L&I provider account number.

Team Conferences are limited to once per day, per claim, per provider.

Split billing

If a team conference pertains 2 or more open claims, providers are expected to split the billing between the claims.

Link: For more information on split billing procedures and requirements, see the Split billing – Treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for E/M services	Washington Administrative Code (WAC) 296-20-045 WAC 296-20-051 WAC 296-20-01002 WAC 296-23-195 WAC 296-20-030
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Care Assessment Tool	F245-377-000
Fee schedules for all healthcare services	Fee schedules on L&I's website
General Provider Billing Manual	F245-432-000
Health Services Coordination	General information Minimum requirements Best practice incentive programs Standard work
Nurse Case Management Initial Care Management Plan	F245-442-000
Nurse Case Management Progress Report	F245-439-000
Reporting rules for ancillary providers	WAC 296-20-06101
The **2021 American Medical Association (AMA) E/M Code and Guideline Changes** for new and established outpatient office visits	2021 AMA E/M guidelines

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If you're looking for more information about…	Then see…
The **2023 American Medical Association (AMA) E/M Code and Guideline Changes** for all other E/M services	2023 AMA E/M guidelines

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 6: Dental

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All dental services

Prior authorization

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and Crime Victims Compensation (CVC) claims, *or*
- Self-insured employer or their third party administrator.

Only claim managers can authorize dental services for State Fund workers' compensation claims and CVC claims.

For self-insured workers' compensation claims, contact the insurer directly for prior authorization procedure details.

Link: A list of self-insured employers' contact information is available online.

Prior authorization review of treatment plan

Dental services requiring prior authorization require a treatment plan. Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to:

- Restorative,
- Endodontic,
- Prosthodontic,
- Prosthetic,
- Implant,
- Orthodontics,
- Surgery, *and*
- Anesthesia procedures.

In cases presenting complication, controversy or diagnostic/therapeutic problems, the claim manager may request **consultation** by another dentist to support authorization for procedures.

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Who must perform these services to qualify for payment

Dental providers licensed in the state in which they practice may be paid for performing dental services, including:

- Dentists,
- Oral and Maxillofacial surgeons,
- Orthodontists,
- Endodontists,
- Periodontists,
- Pediatric Dentists,
- Prosthodontists,
- Denturists,
- Hospitals, *and*
- Dental clinics.

Dental providers **must be enrolled in the provider network** to treat injured workers beyond the **initial visit**. The **initial visit** is the first visit to a healthcare provider during which the Report of Accident is completed and the worker files a claim for workers compensation. For more information about the Health Care Provider Network, see the Becoming a provider policy in Chapter 2: Information for All Providers. Network requirements do not apply to Crime Victim services.

Links: You can find more information about dental services in WAC 296-20-110, WAC 296-23-160, and WAC 296-20-015, and about becoming an L&I provider at Becoming an L&I Provider.

Services that aren't covered

Pre-existing conditions

Pre-existing conditions aren't payable unless medically justified as related to the injury. Prior authorization is required for treatment.

Underlying conditions

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker. It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that won't be covered.

Periodontal disease

Periodontal disease is an underlying condition that isn't covered because it isn't related to industrial injuries.

Link: For more information, see WAC 296-20-110.

Requirements for billing

Bills must be submitted within 1 year from the date the service is rendered. See the HCPCS fee schedule for dental billing codes.

Link: For more information, see WAC 296-20-125.

All workers' compensation dental claims should be billed using the ADA American Dental Association Dental Claim form (© 2024 American Dental Association J43024), or L&I's Statement for Miscellaneous Services form (F245-072-000).

For Crime Victims Compensation (CVC) claims, dentists should use the ADA American Dental Association Dental Claim form (© 2024 American Dental Association J43024), or CVC's Statement for Crime Victims Miscellaneous Services form (F800-076-000).

Failure to use the most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the:

- Full billing code, including the letter D if using a Current Dental Terminology (CDT®) code,
- Materials used, *and*
- Injured tooth number(s).

Note: When using Current Dental Terminology (CDT®) codes, please include the D in front of the code billed to avoid delays in claim/bill processing.

Treatment plan requirements

Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The dentist should outline the extent of the dental injury and the treatment plan. To **obtain authorization** for a treatment plan, all of the following are **required**:

- Causal relationship of injury to condition of the mouth and teeth,

- Extent of injury,
- Alternate treatment plan,
- Time frame for completion, *and*
- Medical history and risk level for success.

Please include:

- Procedure code,
- Tooth number,
- Tooth surface, *and*
- Charge amount.

To avoid delays in treatment, please **exclude** information regarding treatment that isn't directly related to the injury. The ADA American Dental Association Dental Claim form (© 2024 American Dental Association J43024) may be attached to treatment plan. Select Request for Predetermination/Preauthorization in section 1 of the ADA form.

In addition, to **avoid delays in authorization** of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number, *and*
- State the condition of the mouth and involved teeth including:
    - Missing teeth, existing caries and restorations, *and*
    - Condition of involved teeth prior to the injury (caries, periodontal status).

Link: For more information, see WAC 296-20-110.

Where to submit a treatment plan

State Fund treatment plans (not billing info) may be:

- Faxed to **360-902-4567**, or
- Mailed to:

    Department of Labor & Industries
    PO Box 44291
    Olympia, Washington 98504-4291

Crime Victims Compensation (CVC) treatment plans (not billing info) may be:

- Faxed to **360-902-5333**, or

- Mailed to:

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

Mail **self-insured** treatment plans to the Self-insured employer (SIE) or third party administrator (TPA).

Documentation and recordkeeping requirements

Acceptance of a claim

If you are the first provider seen by the injured worker and you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. To initiate a claim for your worker, send the following form to the correct insurer:

- **L&I claim**: send a **Report of Accident** form (F242-130-000) (also known as Accident Report or Report Of Accident (ROA) Workplace Injury, Or Occupational Disease). For more information on ROA requirements, see Chapter 3: Attending Providers.
- **Crime Victim claim:** send an Application for Benefits - Injury Claims form (F800-042-000). Fax or mail to the address on the form.
- **Self-insured Employer:** send a **Provider's Initial Report** form (F207-028-000) to the self-insured employer.

Links: You can order copies of the **Report of Accident** (ROA) Workplace Injury, Accident or Occupational Disease (F242-130-000) or by calling **1-800-LISTENS** or **1-360-902-4300**. To request a supply of the **Provider's Initial Report** (PIR) form used for workers of self-insured employers (F207-028-000), or call **1-360-902-6898**.

Chart notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service. Legible copies of office notes are required for all initial and follow up visits.

For ongoing treatment, use the **SOAP-ER** (Subjective, Objective, Assessment, Plan and progress, Employment issues, Restrictions to recovery) format.

Links: Information on the charting format can be found in Chapter 2: Information for All Providers.

Links: For more information, see WAC 296-20-010 and WAC 296-20-06101.

Attending provider

If dental treatment is the only treatment the injured worker requires and you are directing the care, you will be the **attending provider (AP)**. Regardless of if dental treatment is the only treatment required, dentists are subject to the **AP** payment policy. For more information on responsibilities, requirements, and AP-specific services, see Chapter 3: Attending Providers.
Additional information: L&I's periodic review of dental services

Note: L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but aren't limited to, review of the injured worker's dental records.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules Medical Aid	Washington Administrative Code (WAC) 296-20-110 WAC 296-20-015 WAC 296-20-125 WAC 296-20-06101
Administrative rules dental services, general information and instructions	WAC 296-23-160
Attending providers	Chapter 3: Attending Providers
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Charting format (SOAP-ER) instructions	Chapter 2: Information for All Providers
Crime Victim - Application for Benefits - **Injury Claims form**	F800-042-000
Fee schedules for all healthcare professional services (including dental)	Fee schedules on L&I's website
Payment policies for **diagnostic X-ray services**	Chapter 8: Electrodiagnostics and Radiology
Provider's Initial Report (PIR) form for all State Fund and crime victims claims	F207-028-000
Report Of Accident (ROA) Workplace Injury, Accident or Occupational Disease form for all State Fund claims	F242-130-000
Statement for Crime Victims Miscellaneous Services form for all crime victims claims	F800-076-000

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If you're looking for more information about…	Then see…
Statement for Miscellaneous Services form for all worker's compensation claims	F245-072-000

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of Labor & Industries

Chapter 7: Durable Medical Equipment (DME) and Supplies

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

Table of Contents Page

Payment policy: Acquisition cost and itemized invoices

General information

This policy describes what **acquisition cost** means, how it's calculated, and when charges for supplies are reimbursed at this rate. It also describes when an itemized invoice is required.

This policy doesn't apply to hospital bills. For the hospital **acquisition cost** policy, see Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs).

For the purposes of this policy, an itemized invoice is an invoice for a supply item that includes **acquisition cost**.

Components of acquisition cost

The **acquisition cost** includes:

- Wholesale cost of the item, *and*
- Shipping and handling if applicable, *and*
- Sales tax.

Services that can be billed

Providers are reimbursed at **acquisition cost** for supply codes that:

- Are listed as **by report** in the Fee Schedule, *and*
- Cost $150 or more.

The following table summarizes the various ways the insurer pays for supplies:

	If the supply has a fee listed in the Fee Schedule…	If the supply is listed as "**by report**" in the Fee Schedule…	If the supply is listed as "**Bundled**" in the Fee Schedule…
You bill less than $150 for the item…	Submit standard documentation. Itemized invoice not required. Payment is made at the amount billed or the maximum fee, whichever is less.	Submit standard documentation. Itemized invoice not required. Payment is made at 80% of the amount billed.	You won't be paid for this item separately from the associated service(s).

	If the supply has a fee listed in the Fee Schedule…	If the supply is listed as "**by report**" in the Fee Schedule…	If the supply is listed as "**Bundled**" in the Fee Schedule…
You bill $150 or more for the item…	Itemized invoice required. Submit with standard documentation. Payment is made at the amount billed or the maximum fee, whichever is less.	Itemized invoice required. Submit with standard documentation. Payment is made at **acquisition cost**.	You won't be paid for this item separately from the associated service(s).

Requirements for billing

The **acquisition cost** must be billed as one charge. Sales tax and shipping and handling charges aren't paid separately and must be included in the total cost for the supply.

Documentation requirements

All supplies require documentation to support purchase regardless of cost. See Chapter 2: Information for All Providers for details.

As described in the table above, an itemized invoice showing **acquisition cost** must also be submitted with bills for all supplies that:

- Cost more than $150, *and*
- Aren't listed as **bundled** in the Fee Schedule.

Providers must keep invoices for all supplies in their office files for a minimum of 5 years. A provider must submit a copy of the itemized invoice to the insurer when required (see table above) and/or upon request. Failure to produce an itemized invoice when required may result in bill denial, payment reduction, or recoupment.

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Payment policy: Casting materials

Services that can be billed

Casting materials may be billed with HCPCS codes **Q4001**-**Q4051** in addition to application services.

Services that aren’t covered

No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider’s practice expense.

Payment policy: Hot or cold therapy DME

Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for **DME** providers only and is **bundled** for all other provider types.

Link: See L&I's coverage decision for additional details.

Services that aren't covered

Hot or cold therapy **DME** for home use isn't covered or is **bundled**, including but not limited to:

- Hot or cold water bottles,
- Heating and/or cooling wraps,
- Heating and/or cooling pads, *and*Cryotherapy **DME** with or without compression.

Hot and/or cold modalities used in a clinical setting are considered to be **bundled** into existing physical medicine services billable under CPT® **97010** and/or **1044M**.

HCPCS code **E1399** isn't appropriate for cryotherapy **DME** in any setting.

Link: For more information, see WAC 296-20-1102.

Payment limits

Application of hot or cold packs (CPT® code **97010**) is **bundled** for all providers.

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Payment policy: Medical and surgical supplies

General information

Supplies must be medically necessary and prescribed by a treating provider for the direct treatment of an accepted condition.

Supplies include, but aren't limited to:

- Drugs administered in a provider's office,
- Medical and surgical supplies, *and*
- Prefabricated orthotics.

Providers must bill the appropriate, most specific HCPCS or local codes for supplies and materials dispensed during an office visit or with other office services.

All covered medical and surgical supplies must be billed using the provider's usual and customary fees, including those that pay **by report**. To find out which codes pay **by report**, see the Medical and Surgical Supplies section of the Professional Services Fee Schedule.

Links: For more information on billing usual and customary fees, see WAC 296-20-010(2).

Services that can be billed

Bundled supplies

Certain items listed in the Medical and Surgical Supplies fee schedule may be paid separately **for permanent conditions** if they are provided in the physician's office.

If the condition is **acute or temporary**, these items aren't separately payable.

For example:

- Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions may be paid separately when provided in the physician's office.
- The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction wouldn't be paid separately because it is treating a temporary problem.
- If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be paid separately because the incontinence is permanent.

L&I follows CMS's policy of bundling HCPCS codes for surgical trays and supplies used in a physician's office. Surgical trays and supplies won't be paid separately.

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Surgical dressings and other items dispensed for home use

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier **–1S**.

Payment limits

Some supplies are considered **bundled** into the cost of other services (associated office visits or procedures) and won't be paid separately. These include:

- Supplies used in the course of an office visit, *and*
- Fitting fees that are **bundled** into the office visit or into the cost of the supply.

For medical and surgical supplies that pay **by report** (except **E1399**), see Payment policy: Acquisition cost and itemized invoices.

For more information on **E1399**, see Payment policy: Miscellaneous supplies.

To see which billing codes are **Bundled**, see L&I's Professional Services Fee Schedule; in the dollar value column, such items show the word **Bundled** (instead of a dollar amount).

Payment policy: Miscellaneous supplies

Services that can be billed

HCPCS billing code **E1399** can only be billed for a miscellaneous supply that meets both of these criteria:

- The supply or **DME** item doesn't have a valid HCPCS code assigned, *and*
- The item is appropriate relative to the covered injury or type of treatment being received by the worker.

Services that aren't covered

The insurer won't pay CPT® code **99070** for miscellaneous supplies and materials used or dispensed by the provider.

Requirements for billing

All bills for **E1399** items must have:

- Either modifier **–NU** or **–RR**, *and*
- A description of the **DME** must be on the paper bill or in the remarks section of the electronic bill.

See Payment policy: Acquisition cost and itemized invoices for more details.

These specific miscellaneous supplies must be billed using HCPCS code **E1399**:

- Therapy putty and tubing, *and*
- Anti-vibration gloves.

Payment limits

When billing for items with multiple components where parts of the item have distinct HCPCS codes but the whole item doesn't, you can't bill **E1399** and must bill for each component using the most appropriate HCPCS code.

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Payment policy: Negative pressure wound therapy (NPWT)

General information

Negative Pressure Wound Therapy (NPWT) is a method of wound treatment involving the use of a device that creates subatmospheric pressure around a wound to enhance healing.

NPWT devices are rental only. They won't be purchased even if rented for periods of 12 months or more.

Prior authorization

Rental of NPWT **DME** is covered when the wound is related to an injury or illness allowed on the claim. See the L&I coverage decision for authorization requirements.

Prior authorization is required before starting NPWT and every 30 days thereafter during a given episode of care.

Billing requirements

Unlike most other forms of rented **DME**, NPWT devices are rented by day. Each rental day equals 1 unit.

Payment limits

If the item is a…	And the code is…	Then the payment limits are…
Wound therapy device	**E2402**	Limit 1 pump per episode. Limit 4 months of treatment per episode; see below.
Wound therapy device dressing kit	**A6550**	Limit 15 kits per month.
Wound therapy device canister	**A7000**	Limit 10 canisters per month.

NPWT devices are limited to 4 months (120 days or 120 units) of treatment per episode of care. See L&I's coverage decision for more information.

Payment policy: Oxygen and oxygen equipment

General information

Two primary forms of oxygen systems exist and are covered under this policy.

Portable oxygen systems

Portable oxygen systems, sometimes referred to as ambulatory systems, are lightweight (less than 10 pounds) and can be carried by most patients. These systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.

Small gas cylinders are available as portable systems. Some are available that weigh less than five pounds.

Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights.

Stationary oxygen systems

Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems, and oxygen concentrators.

Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders.

Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas, but takes up less space and can be transferred more easily to a portable tank.

Oxygen concentrators are electric devices that extract oxygen from ambient air and compress it to 85% or greater concentration. A backup oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

Requirements for billing

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes.

Delivery charges, shipping and handling, tax, and fitting fees aren't payable separately. Include these charges in the total charge for the supply.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Services that can be billed

To bill for oxygen, if the worker has a:

- Portable oxygen system, bill using either **E0443** (gaseous contents) or **E0444** (liquid contents), *or*
- Stationary oxygen system, bill using either **E0441** (gaseous contents) or **E0442** (liquid contents).

Payment limits

Except on rare occasions, oxygen equipment is always rented and never purchased. Oxygen equipment may only be purchased for a worker with explicit authorization from the insurer. The reason for purchase should be explained in detail in the claim file.

If the worker **rents** the oxygen system:

- A monthly fee is paid for oxygen equipment. This fee includes payment for the equipment, contents, necessary maintenance, and accessories furnished during a rental month, *and*
- Oxygen accessories are included in the payment for rented systems. The supplier must provide any accessory ordered by the provider. (See Examples of oxygen accessories, below.)

If the worker **owns** the oxygen system:

- The fee for oxygen contents must be billed once a month, not daily or weekly. 1 unit of service equals 1 month of rental, *and*
- Oxygen accessories are payable separately only when they are used with a patient-owned system.

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Payment policy: Pneumatic compression devices

General information

Pneumatic compression devices are used in the following ways:

- During surgery only, *or*
- During and after surgery, either in the facility or at home, *or*
- At home only.

Pneumatic compression devices used during surgery and subsequently sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and isn't separately payable. The insurer won't reimburse separately for **pneumatic compression devices** used in this capacity.

Services that can be billed

Pneumatic compression devices are considered **DME** and are separately billable using HCPCS codes **E0650-E0675** when **all** of the following criteria are met:

- The device isn't used during surgery in any capacity, *and*
- The worker is being treated for lymphedema or is at risk for developing venous thromboembolism (VTE). If at risk for VTE, the worker has been evaluated and the risk has been documented using a validated thrombosis risk factor assessment tool, *and*
- The provider includes a statement indicating the device is medically necessary and FDA approved for the prevention of VTE based on the results of the screening tool or treat lymphedema and the device being supplied is intended for home use only.

Services that aren't covered

Pneumatic compression devices are considered surgical supplies and aren't separately billable when *any* of the following conditions are met:

- The device is used during surgery in any capacity, *or*
- The device is used following surgery while the worker is in the facility, *or*
- The device isn't prescribed by the provider.

CPT® code **99070** isn't covered.

HCPCS code **E0676** isn't covered.

Link: For more information on the use of **pneumatic compression devices** in a clinical setting, see Chapter 20: Physical Medicine Services.

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Payment policy: Prosthetic and orthotic services

Prior authorization

Prior authorization is required for prosthetics, surgical appliances, and other special equipment described in WAC 296-20-03001 and replacement of specific items on closed claims as described in WAC 296-20-124.

For **State Fund** claims, contact the Provider Hotline at **1-800-848-0811**.

For **Self-insured** claims, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims.

If **DME**, prosthetics, or orthotics requires prior authorization and it isn't obtained, then bills may be denied.

Link: The Professional Services Fee Schedule has a column designating which codes require prior authorization.

Who must perform these services to qualify for payment

Pre-fabricated orthotics that are off-the-shelf and given to the worker as-is or are customized to fit the worker are billable by providers who may dispense orthotics.

The insurer will only pay for custom-made (sometimes called "custom-fabricated") prosthetic and orthotic devices manufactured by these providers specifically licensed to produce them:

- Prosthetists,
- Orthotists,
- Occupational therapists,
- Certified hand specialists, *and*
- Podiatrists.

Link: To determine if a prosthetic or orthotic device is in this category, see the "license required" field in the fee schedule.

For more information on responsibilities, requirements, and **AP**-specific services for Podiatrists, see Chapter 3: Attending Providers.

Requirements for billing

Providers must bill their usual and customary fees for covered prosthetics, including those that pay **by report**. Any procedure represented by its own CPT®, HCPCS, or local code must be billed separately (for example, **97760**, **97761** or **97763**).

Each **by report** CPT®, HCPCS, or local code billed should be listed individually. Sales tax and shipping and handling charges aren't paid separately and must be included in the total charge.

A detailed invoice must be submitted to the claim file along with your bill to support charges for any custom prosthetic or orthotic device listed as **by report** in the fee schedule. Invoices for **by report** codes must include:

- Total charges for all items and services combined, *and*
- The **acquisition cost** for the item(s), broken down into wholesale cost, shipping/handling, and sales tax, *and*
- Administrative charges and/or markups, *and*
- An itemized list of services provided to the worker, such as fittings, education, travel expenses, or counseling, including the dates of service and the amount of time spent performing each service.

Bills without a detailed invoice may be denied.

Links: For more information on billing usual and customary fees, see WAC 296-20-010 (2).

For information on where to send bills and invoices, see Chapter 2: Information for All Providers.

To find out which codes pay **by report**, see the Professional Services Fee Schedule.

Payment limits

For **by report** prosthetic items, the insurer will pay 80% of the appropriate charges.

Payment policy: Purchasing DME

General information

This policy contains rules regarding when and how **DME** is purchased for a worker.

Purchased **DME** belongs to the worker, not the provider or insurer. Purchased **DME** doesn't need to be returned to the provider or insurer even after treatment is complete.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Prior authorization

Prior authorization is required for some **DME**. If prior authorization is required but isn't obtained, bills may be denied or recouped. The Professional Services Fee Schedule has a column designating which codes require prior authorization. These codes include (but aren't limited to):

- HCPCS E codes,
- HCPCS K codes,
- Replacement of specific items on closed claims (see WAC 296-20-124), *and*
- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).

To obtain prior authorization for State Fund claims, contact the Provider Hotline at **1-800-848-0811**. For self-insured claims, contact the self-insured employer or their third party administrator.

Requirements for billing

Delivery charges, shipping and handling, tax, and fitting fees aren't separately payable.

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes. Errors will result in suspension and/or denial of payment.

Modifiers for purchased DME

The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which **DME** items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).

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Example: **E0117–NU** (Underarm spring-assist crutch) is only purchased (there isn't a modifier **–RR** for that code).

Always include a modifier with a **DME** HCPCS code (except repair codes **K0739** and **K0740**). Bills submitted without the correct modifier will be denied. Providers may continue to use other modifiers (for example **–LT** or **–RT**) in conjunction with the mandatory modifiers, if appropriate.

Miscellaneous DME

Bills for miscellaneous **DME** (**E1399**) are payable only for **DME** that doesn't have a valid HCPCS code. The item must be appropriate relative to the injury or type of treatment received by the worker. A description of the item must be on the paper bill or in the remarks section of the electronic bill.

All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).

Documentation requirements

All providers must submit documentation to support billing for the purchase of any **DME**. Documentation must include (for each item):

- Worker's name,
- Type of item,
- Name of the item's manufacturer,
- Item's model name and model number (if applicable),
- Item's serial number (if applicable),
- Full description of the item,
- Date the item was dispensed,
- Copy of the manufacturer's warranty (see details below), *and*
- Itemized list of all costs charged to the insurer.

Warranties

Upon purchase of any **DME**, the supplier must send a copy of the manufacturer's warranty to the claim file as part of their documentation to support their bill. Payment may be denied if no warranty is filed.

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

Different types of **DME** require different warranty specifications. Where a manufacturer provides a warranty greater than what is required below, the manufacturer's warranty will apply. The following table outlines required warranty specifications:

If the **DME item type** is…	Then the **required warranty coverage** is…
DME purchased new (excluding disposable and non-reusable supplies)	Limited to the manufacturer's warranty
Power-operated vehicles (3-wheel or 4-wheel non-highway scooter)	Minimum of 1 year or manufacturer's warranty, whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	
Wheelchair codes **K0004**, **K0005**, and **E1161**	Lifetime warranty on side frames and cross braces

Payment limits

Supplies used during or immediately after surgery and not sent home with a worker aren't **DME** and won't be reimbursed as **DME**.

If any **DME** item is rented for 6 months or more, the insurer may review rental payments and decide to purchase the equipment at that time. Rental payments won't exceed 12 months. After the 12th month of rental, the equipment is considered "purchased" and is now owned by the worker. No additional rental fees are payable (with the exception of oxygen equipment; see the Oxygen and oxygen equipment payment policy for details).

DME purchase after rental period of less than 12 months

For equipment rented for less than 12 months that is determined after rental to be permanently needed by the worker:

- For **State Fund** claims, the worker may be asked to return the rented **DME** and the provider may issue new **DME** to be purchased by the insurer. The provider must bill their usual and customary charge for the new **DME** and append modifier **–NU**. L&I will pay the fee schedule amount for the new **DME** or billed charge, whichever is less.
- For **self-insured** claims, self-insurers may purchase the equipment and receive rental credit toward the purchase.

Used DME

State Fund and Crime Victims Compensation Program won’t purchase used **DME**.

Self-insured employers may purchase used **DME**.

Payment policy: Renting DME

General information

This policy contains rules regarding when and how **DME** is rented for a worker.

During the authorized rental period, the **DME** belongs to the provider. When the **DME** is no longer authorized, the worker must return it to the provider.

If unauthorized **DME** isn't returned to the provider within 30 days, the provider can bill the worker for charges related to **DME** rental, purchase, and supplies that accrue after the insurer denies authorization for the **DME**.

Link: For more information on purchasing or renting **DME**, see WAC 296-20-1102.

Prior authorization

Prior authorization is required for some **DME**. If prior authorization is required but isn't obtained, bills may be denied. The Professional Services Fee Schedule has a column designating which codes require prior authorization. These codes include but aren't limited to:

- HCPCS E codes,
- HCPCS K codes,
- Replacement of specific items on closed claims (see WAC 296-20-124),
- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).

To obtain prior authorization for State Fund claims, contact the Provider Hotline at **1-800-848-0811**. For self-insured claims, contact the self-insured employer or their third party administrator.

Requirements for billing

Delivery charges, shipping and handling, tax, and fitting fees aren't separately payable.

If the **DME** is rented for:

- **1 day**: use the same date for the first and last dates of service.
- **More than 1 day**: use the actual first and last dates of service.

Pharmacies and **DME** providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes. Errors will result in suspension and/or denial of payment.

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Modifiers for purchased DME

Always include a modifier with a **DME** HCPCS code (except repair codes **K0739** and **K0740)**. Bills submitted without the correct modifier will be denied. Providers may continue to use other modifiers (for example **–LT** or **–RT**) in conjunction with the mandatory modifiers, if appropriate (up to 4 modifiers may be used with any 1 HCPCS code).

The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which **DME** items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).

Example: **E0117–NU** (Underarm spring-assist crutch) is only purchased (modifier **–RR** can't be used with this code).

Miscellaneous DME

Bills for miscellaneous **DME** (**E1399**) are payable only for **DME** that doesn't have a valid HCPCS code. The item must be appropriate relative to the injury or type of treatment received by the worker. A description of the item must be on the paper bill or in the remarks section of the electronic bill.

All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).

Documentation requirements

All providers must submit documentation to support billing for the rental of any **DME**. Documentation must include (for each item):

- Worker's name,
- Type of item,
- Name of item's manufacturer,
- Item's model name and model number,
- Item's serial number (if applicable),
- Full description of the item,
- Date the item was dispensed, *and*
- Itemized list of all costs charged to the insurer.

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Payment limits

For most **DME**, each month of rental should be billed as 1 unit of service. Rental periods of less than 1 month should be billed as 1 unit unless otherwise noted in the rental limit exceptions below or in other policies in this chapter.

If any **DME** item is rented for 6 months or more, the insurer may review rental payments and decide to purchase the equipment at that time. Rental payments won't exceed 12 months. After the 12th month of rental, the worker owns the equipment and no additional fees are payable (with the exception of oxygen equipment; see the Oxygen and oxygen equipment payment policy for details).

Rental limit exceptions

DME item	Code(s)	Rental requirements
Continuous passive motion exercise devices	**E0935-E0936**	Rented on a per diem basis up to 14 days. 1 unit of service = 1 day.
Extension / flexion devices	**E1800-E1818** **E1825-E1840**	Rented for 1 month. If needed beyond 1 month, insurer's authorization is required.
Oxygen equipment	See Payment policy: Oxygen and oxygen equipment for codes.	Rented in perpetuity. Can't be purchased without permission from the insurer.
Wound therapy devices	**E2402**	Rented per day. 1 unit of service = 1 day.

Payment policy: Repairs and non-routine services

Requirements for billing

DME repair codes (**K0739**, **K0740**) must be billed per each 15 minutes. One unit of service equals 15 minutes.

- **Example**: 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with 3 units of service.

Only equipment out of warranty will be considered for repair, non-routine service, and maintenance coverage. If an item is still under warranty, bills for warranty-covered repairs for that item will be denied.

Repair codes **K0739** and **K0740** don't require modifiers.

Payment limits

Purchased equipment repair

The insurer won't pay for any repairs (including parts and labor) that are covered by a manufacturer's warranty during the period of warranty coverage.

Repair or replacement of **DME** is the responsibility of the worker when the item is:

- Damaged due to worker abuse, neglect, misuse, *or*
- Lost or stolen.

Rented equipment repair

Repairs, non-routine service, and maintenance are included as part of the monthly rental fee for **DME**. No additional payment will be provided.

The insurer won't pay for rental of disposable or non-reusable supplies.

Payment policy: Surgical dressings dispensed for home use

Requirements for billing

Providers must bill the appropriate HCPCS code for each dressing item, along with the local billing code modifier **–1S** for each item.

Payment limits

Primary surgical dressings and secondary surgical dressings dispensed for home use are payable at **acquisition cost** when all of these conditions are met:

- They are dispensed to a patient for home care of a wound, *and*
- They are medically necessary, *and*
- The wound is due to an accepted work related condition.

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. Separate payment isn't allowed.

Items such as elastic stockings, support hose, and pressure garments aren't secondary surgical dressings and must be billed with the appropriate HCPCS code.

Surgical dressing **supplies** and codes billed without the local modifier **–1S** are considered **Bundled** and won't be paid.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and is not separately payable, even to **DME** suppliers. For details on coverage of **pneumatic compression devices**, see Payment policy: Pneumatic compression devices.

Payment policy: Urinary catheterization

Services that can be billed

Separate payment is allowed for placement of a temporary indwelling catheter when treatment is:

- Performed in a provider's office, *and*
- Used to treat a temporary obstruction.

Link: For more information about catheterization to obtain specimen(s) for lab tests, see the Specimen collection and handling payment policy in Chapter 13: Pathology and Laboratory Services.

Payment limits

Separate payment isn't allowed when placement of a temporary indwelling catheter is performed:

- On the same day as a major surgical procedure, *or*
- During the postoperative period of a major surgical procedure that has a follow up period.

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Payment policy: Ventilator management services

Payment limits

Ventilation management service codes (CPT® codes **94002**-**94005**, **94660**, and **94662**) are payable only when an Evaluation and Management (E/M) service (CPT® codes **99202**-**99499**, except for case management services) is not performed on the same day. When an E/M service is performed on the same day, ventilation management is **bundled** into the payment for the E/M service.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules (Washington state laws) for purchasing or renting **DME**	Washington Administrative Code (WAC) 296-20-1102
Administrative rules for miscellaneous services and appliances	WAC 296-23-165
Administrative rules for payments for rejected and closed claims	WAC 296-20-124
Administrative rules for treatments requiring authorization	WAC 296-20-03001
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
Negative Pressure Wound Therapy coverage and treatment	Negative Pressure Wound Therapy coverage decision
Payment policies for **catheterization to obtain specimens for lab tests**	Chapter 13: Pathology and Laboratory Services
Payment policies for **durable medical equipment (DME)**	Chapter 7: Durable Medical Equipment
Payment policies for **hospital acquisition cost policy**	Chapter 26: Hospitals and Ambulatory Surgery Centers (ASCs)

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 8: Electrodiagnostics and Radiology

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All radiology reporting requirements

General information

Global radiology services include both a **technical component** (producing the study) and a **professional component** (interpreting the imaging study). When billing for radiology services globally the reporting requirements for both the technical (**–TC**) and professional (**–26**) components must be met.

For billing purposes, the **technical component** (modifier **–TC**) accounts for equipment costs, supplies, and clinical staff (technicians) involved in producing the test or procedure. The **professional component** (modifier **–26**) accounts for the interpretation of the study.

Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

Requirements for billing

HCPCS modifiers **–RT** (right side) and **–LT** (left side) don't affect payment. Use these modifiers with CPT® radiology codes **70010**-**79999** to identify duplicate procedures performed on opposite sides of the body.

Modifiers

Use modifier **–TC** when only the **technical component** of a radiology service is performed.

Use modifier **–26** when only the **professional component** of a radiology service is performed.

Don't use modifier **–TC** or **–26** for **global radiology services** when both the technical and professional components are performed by the same provider.

Component eligibility

The **technical component** (modifier **–TC**) can only be billed by the facility or provider's practice where the radiology service was actually performed. For example, an X-ray was taken by an ordering provider or a technician in their practice, then the ordering provider may bill for the technical component. However, if the X-ray was taken at a facility outside the ordering provider's practice, then the ordering provider can't bill for the technical component. Only 1 technical component is allowed per study.

The **professional component** (modifier **–26**) can only be billed by the provider who personally performed an interpretation and has met all reporting requirements.

If a provider is billing for a **global radiology service**, the provider must meet each component eligibility for both modifier **–TC** and modifier **–26**.

Documentation requirements

Documentation for each component of radiology services is required, whether billed separately or as part of a **global service**.

Technical component (modifier–TC)

Any provider who is billing separately for the **technical component** (**–TC**) is required to submit documentation to the insurer to support that a radiology service was performed. The documentation must include the following:

- Patient name, age, sex, *and*
- Date of study, *and*
- Name of ordering provider, *and*
- The location of where the service was performed (e.g., the provider's office, a hospital, etc.), *and*
- The anatomic location of the procedure, including laterality as applicable, and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- A description of any contrast media or pharmaceutical used, including route of administration and dose, when applicable, *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable).

Note: Documentation for the **technical component** may be included within the ordering provider's chart note for the office visit where the radiology service was ordered and performed.

Professional component (modifier –26)

Any provider who produces and interprets their own imaging studies, and any radiologist who over reads imaging studies must produce a report of radiology findings to bill for the **professional component**. The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, *and*
- Date of study, *and*
- The anatomic location of the procedure, including laterality as applicable, and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- Brief sentence summarizing history and/or reason for the study, such as:
  - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
  - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description or listing of, imaging findings:
  - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
  - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*
  - Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*
- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the report. For example:
  - For a skeletal plain film report with imaging findings of normal osseous density and contours and no joint abnormalities, the impression could be: "No evidence of fracture, dislocation, or gross osseous pathology."
  - For a skeletal plain film report with imaging findings of reduced bone density and thinned cortices, the impression could be: "Osteoporosis, compatible with the patient's age."

- For a chest report with imaging findings of vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be: “Emphysema.”

Note: Documentation for the **professional component** may be included within the provider’s chart note or as a separate report. Copying an imaging report with interpretation from another provider into a chart note isn’t enough to support billing of the **professional component** or a global service.

Attending provider (AP) documentation

APs who order diagnostic imaging studies are responsible for:

- Determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:
  - Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain, or
  - PA and lateral chest films to determine cause for dyspnea.
- Acknowledging and integrating the imaging findings into their case management. **APs** must include brief documentation in their chart notes. Examples include:
  - “Imaging rules out fracture, so rehab can proceed.”
  - “Flexion/extension plain films indicate hypermobility at C5/C6, and spinal manipulation will avoid that region.”

Payment limits

Documentation such as "X-rays are negative" or "X-rays are normal" don’t fulfill the reporting requirements described in this policy and the insurer **won’t pay** for the professional component (**–26**) separately or as part of a global service in these circumstances.

The **technical component** (**–TC**) or global radiology service is only payable once per study.

The **professional component** (**–26**) must be billed by the provider who performed an independent interpretation the study, under their individual provider number.

Payment policy: Biofeedback

Who must perform these services to qualify for payment

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

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

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

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

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

Link: For more information and a legal definition of licensed practitioner, see WAC 296-21-280 and WAC 296-20-01002.

Prior authorization

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

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

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

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

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

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

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

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

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

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

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

Services that can be billed

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

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

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

Requirements for billing

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

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

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

Use evaluation and management codes for diagnostic evaluation services.

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Payment limits

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

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

Payment policy: Contrast material

General information

The Average Wholesale Price (AWP) is a pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark, which is developed independently by companies that specifically monitor drug pricing.

Requirements for billing

Use the following HCPCS codes to bill for contrast material:

- Low osmolar contrast material (LOCM): **Q9951**, **Q9965** - **Q9967**
- High contrast osmolar material (HOCM): **Q9958** - **Q9964**

For LOCM and HOCM, bill 1 unit per ml.

Providers may use either HOCM or LOCM. The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart.

Separate payment will be made for contrast material for imaging studies.

Payment limits

HCPCS codes for LOCM and HOCM are paid at a flat rate based on the AWP per ml.

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Payment policy: Electrocardiograms (EKG)

Service that can be billed

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

Services that aren't covered

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

Payment limits

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

Note: For more information on portable radiology services, including mobile EKG, see Chapter 23: Telehealth, Remote, and Mobile Services.

Payment policy: Electrodiagnostic services

Who must perform these services to qualify for payment

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

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

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

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

Services that can be billed

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

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

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

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

Services that aren't covered

Electrodiagnostic testing isn't covered when:

- It isn't proper and necessary (see Note and Link, below this list), *or*
- Performed in a mobile diagnostic lab in which the specialist physician isn't present to examine and test the patient, *or*
- Performed with noncovered devices, including:
    - Portable, *and*
    - Automated, *and*

- “Virtual” devices not demonstrated equivalent to traditional lab based equipment (for example, NC-stat®, Brevio), *or*

- Determined to be outside of AANEM recommended guidelines without proper documentation supporting that the testing is proper and necessary.

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

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

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

Requirements for billing

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

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

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

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

Example: Reasonable limits on units required to determine a diagnosis

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

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

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

Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	Motor NCS with and without Fwave	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Carpal tunnel (unilateral)	1	3	4	—	—
Carpal tunnel (bilateral)	2	4	6	—	—
Radiculopathy	2	3	2	2	—
Mononeuropathy	1	3	3	2	—
Poly/ mononeuropathy multiplex	3	4	4	2	—
Myopathy	2	2	2	—	2
Motor neuronopathy (for example, ALS)	4	4	2	—	2
Plexopathy	2	4	6	2	—
Neuromuscular Junction	2	2	2	—	3
Tarsal tunnel (unilateral)	1	4	4	—	—
Tarsal tunnel (bilateral)	2	5	6	—	—
Weakness, fatigue, cramps, or twitching (focal)	2	3	4	—	2

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

Payment policy: Extracorporeal shockwave therapy (ESWT)

Services that aren’t covered

The insurer doesn’t cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature. See L&I’s coverage decision for details.

Payment policy: Noninvasive cardiac imaging for coronary artery disease

Services that can be billed

Certain noninvasive cardiac imaging technologies for coronary artery disease are covered with conditions. See L&I's coverage decision for details.

Cardiac magnetic resonance angiography (CMRA)

Cardiac magnetic resonance angiography is covered with conditions. See L&I's coverage decision for details.

Payment policy: Nuclear medicine

Payment limits

The standard multiple surgery policy applies to the following radiology CPT® codes for nuclear medicine services:

- **78306**,
- **78802**, *and*
- **78803**.

The multiple procedure reduction will be applied when these codes are billed:

- With other codes subject to the standard multiple surgery policy, *and*
- For the same patient:
    - On the same day by the same provider, *or*
    - By more than 1 provider of the same specialty in the same group practice.

Link: For more information about the standard multiple surgery payment policy, refer to Chapter 22: Surgery.

Payment policy: Ultrasound

General information

For more information on reporting requirements, see the All radiology services policy in this chapter.

Who must perform these services to qualify for payment

Providers and/or technicians performing ultrasounds must have the appropriate licensure per Department of Health requirements.

Facilities billing for the technical component must have an L&I provider account number and provide documentation to support the service rendered.

Providers performing the professional component (modifier **–26**) must bill under their individual L&I provider account number.

Services that can be billed

Refer to the fee schedule for codes covered by the insurer. Refer to CPT® for additional guidelines.

The use of ultrasounds for treatment such as guided needle placement and for quick assessments in emergency departments are separately reimbursable services.

Services that aren’t covered

Office-based ultrasounds

Office-based ultrasounds used for evaluation and diagnosis are considered **bundled** into the evaluation and management (E/M) service and can’t be billed separately. No separate payment will be made for these services.

Transportation of portable equipment

HCPCS codes **Q0092**, **R0070** and **R0075** aren’t payable for mobile ultrasound services.

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Documentation requirements

Technical component (modifier –TC)

The following documentation is required for the technical component of an ultrasound study:

- Patient name, age, sex,
- Date and time of ultrasound exam,
- Name of ordering provider,
- The anatomic location of the procedure, including laterality as applicable, and type of procedure,
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable,
- Specific ultrasound examination performed, including all joint spaces and structures examined,
- Output display standard (thermal index & mechanical),
- Address where study took place (for mobile providers).

Professional component (modifier –26)

The following documentation is required for the professional component of an ultrasound study:

- Patient's name, age, sex, *and*
- Date of study, *and*
- Indication for exam, *and*
- Relevant clinical information, including indication for the exam and/or relevant ICD-10 code, *and*
- The specific method use for endocavity techniques, if performed, *and*
- A description of the studies and/or procedures performed, *and*
- A description of any contrast media or pharmaceutical used, including route of administration and dose when applicable, *and*
- Anatomic measurements, if taken, *and*
- A description of examination findings, *and*
- Impression, conclusion, or summary statement, *and*
- Specific diagnosis, if appropriate, *and*
- Recommendation for follow-up, if necessary, *and*

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- Accounting of any failure to include standard views or other necessary components, if necessary, *and*
- Statement of comparison of relevant imaging studies if reviewed, *and*
- Details on any provider-to-provider communication if there are delays which may have an adverse effect on the patient's outcome.

Payment limits

CPT® codes **76881** and **76882** are limited to **1 unit per extremity per day.**

76881 and **76882** aren't payable in conjunction with each other when performed on the same anatomical region on the same date of service. Refer to CPT® for additional restrictions and requirements.

Payment policy: X-ray services

General Information

Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

Custody

X-rays must be retained for 10 years.

Links: For more information on custody requirements, see WAC 296-20-121 and WAC 296-23-140.

For more information on reporting requirements, see the All radiology services policy in this chapter.

Services that can be billed

Full spine studies

Radiologic exams of the entire spine (also known as full spine studies) must always include the entire thoracic and lumbar regions. These studies also may include the skull, cervical and sacral regions, if performed. Depending on the size of the film and size of the patient, the study may require 6 or more views. Providers must bill the correct code, based on the number of views taken to complete the study.

- For a single view bill **72081**.
- For 2 or 3 views bill **72082**.
- For 4 or 5 views bill **72083**.
- For 6 or more views bill **72084**.

For studies that do not include radiographs of the entire thoracic and/or lumbar spine, the applicable spinal region radiograph CPT® code(s) must be billed.

Transportation of portable equipment

HCPCS codes **Q0092**, **R0070** and **R0075** may be payable for mobile X-ray services. See the Portable Radiology Services policy in Chapter 23: Telehealth, Remote, and Mobile Services.

Services that aren't covered

Dynamic Spinal Visualization

Dynamic Spinal Visualization (DSV) refers to several imaging technologies for the purpose of assessing spinal motion, including videofluoroscopy, cineradiology, digital motion X-ray, vertebral motion analysis and spinal X-ray digitization.

DSV isn't a covered benefit. Don't bill CPT® code **76496** for these services.

Link: For more information about DSV, see the L&I's coverage decision.

Requirements for billing

Most radiology services include both a technical component (**–TC**) for producing the study and a professional component (**–26**) for interpreting the imaging study. When billing for radiology services, the reporting requirements for the component(s) billed must be met. See the All radiology reporting requirements policy in this chapter for more information, including documentation requirements for the ordering and performing providers.

Repeat X-rays

Per WAC 296-20-121, the insurer won't pay for excessive or unnecessary X-rays.

Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Billing code modifiers –RT and –LT

HCPCS modifiers **–RT** (right side) and **–LT** (left side) don't affect payment. Use these modifiers with CPT® radiology codes **70010**-**79999** to identify duplicate procedures performed on opposite sides of the body.

Payment limits

Number of views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exam of the cervical spine are payable as outlined below:

If the **CPT® code** is…	Then it is **payable**:
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or 5 cervical views
72052	Once, 6 or more views, regardless of the number of cervical views it takes to complete the series

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for biofeedback	Washington Administrative Code (WAC) 296-21-280
Administrative rules for the definitions of "licensed practitioner" and "proper and necessary"	WAC 296-20-01002
Administrative rules for the policy on rental equipment	WAC 296-20-1102
Administrative rules for the requirements on who may provide electroneuromyographic tests	WAC 246-915-370
Administrative rules for X-ray custody requirements	WAC 296-20-121 WAC 296-23-140
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Coverage decision for **electrodiagnostic testing**	Electrodiagnostic testing coverage decision
Coverage decision for extracorporeal shockwave therapy	Extracorporeal shockwave therapy coverage decision
Dynamic Spinal Visualization coverage decision	Dynamic spinal visualization coverage decision
Fee schedules for all healthcare professional services (including chiropractic)	Fee schedules on L&I's website
Payment policies for **physical medicine services**	Chapter 20: Physical Medicine
Payment policies for **surgery**	Chapter 22: Surgery

If you're looking for more information about…	Then see…
Submission of proper license documentation to perform electrodiagnostic services	PACMail@Lni.wa.gov

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 9: Evaluation and Management (E/M)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All E/M services

Who must perform these services to qualify for payment

Physicians, including medical doctors (MD), osteopaths (DO), psychiatrists (MD/DO), chiropractors (DC), naturopaths (ND), physician assistants (PAs), Advanced Registered Nurse Practitioners (ARNPs), and any other provider who has evaluation and management (E/M) services in their scope of practice.

Link: For more information on mental health **consultations** and evaluations, including those performed by psychologists, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Prior authorization

Prior authorization is required when billing for:

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

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

Requirements for billing

All **medical records** must contain documentation that justifies the level, type and extent of service billed. See the Documentation requirements section of this policy for more details.

Determining type of visit: New patient, established patient or consultation evaluation and management service

If a patient presents with a work-related condition and meets the definition in a provider's practice as:

- A **new patient**, then a **new patient** E/M service must be billed, *or*
- An **established patient**, then an **established patient** E/M service must be billed, even if the provider is treating a new work related condition for the first time, *or*
- An inpatient or outpatient **consultation** that has been requested by the **attending provider**, the department, self-insurer or authorized department representative and all requirements for a **consultation** service has been met, then a **consultation** E/M service must be billed.

Per WAC 296-20-051 providers may **not** bill **consultation** codes for **established patients**.

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Some E/M services apply to both **new** and **established patients**, such as hospital inpatient, observation care, and nursing facilities. These services are differentiated by initial and subsequent service. In these cases, the insurer uses the CPT® definition to determine the appropriate **type of service** that must be billed.

Links: For the definitions of **new** and **established patients**, **consultations**, and initial and subsequent services, see Appendix A: Definitions and the CPT® book.

Consultations

Consultations are only payable in certain circumstances and to only certain **attending provider** types. For more information, see the **Consultations** policy in Chapter 3: Attending Providers.

Case management services

Case management services, such a telephone calls, team conferences, and online communications, have separate restrictions and requirements from those outlined in this policy. For more information, see Chapter 5: Care Coordination.

E/M services via telehealth and audio-only

Telehealth is covered for most services that don't require a hands-on component. E/M provided via **telehealth** must be billed using in-person CPT® codes and modifier **–GT**. **New** and **established** outpatient **telehealth** CPT® codes **98000**-**98007** aren't payable.

The insurer doesn't cover any E/M services via audio-only, including the use of audio-only **new** and **established** outpatient CPT® codes **98008**-**98015**, brief virtual check-in CPT® code **98016**, or the use of modifier **–95** with in-person E/M CPT® codes.

For more information on **telehealth**, **remote**, and mobile service delivery, see Chapter 23: Telehealth, remote, and mobile clinic services.

Documentation requirements

The American Medical Association (AMA) made substantial changes to the **New** and **established patient** E/M services effective January 1, 2021, and expanded those guidelines to all other E/M services (including **consultations**) effective January 1, 2023. The insurer has chosen to adopt these updated changes with slight modification as of July 1, 2023. Modifications include policies on separately billable services and admissions within the course of an encounter at another site. Additionally, the insurer doesn't allow shared billing for visits in which multiple providers contribute to an E/M service.

SOAP-ER note requirements

As outlined in Chapter 2: Information for All Providers, the insurer requires the addition of ER (Employment and Restrictions) to the SOAP format. Chart notes must document the worker's status at the time of each visit.

Links: For additional coding guidelines and requirements, see 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes or a CPT® book.

Selecting the level of service

Select the appropriate level of E/M service based on coding guidelines in the CPT® book. This information can also be found in the 2021 AMA E/M new and established outpatient visit guideline updates or the 2023 AMA E/M guideline updates for all other E/M services.

Only time spent in covered activities by the provider on the calendar day of the visit (midnight to 11:59pm) can be counted toward the E/M visit time. Check-in and check-out time can't be used when determining the length of a visit as this may include ancillary staff time, **wait time**, etc.

When billing based on time, documentation must describe the covered activities performed. Generalized statements, such as "provided care coordination" aren't acceptable.

Examples of services that can't be included in the time used to determine the level of E/M service, include but are not limited to:

- The performance of other services that can be reported separately. See Separately Billable Services in this policy,
- Travel,
- Teaching that is general and not limited to a discussion that is required for the management of a specific worker,
- Discussions of the L&I claims process with the worker/family/caregiver.

Note: All questions, discussions, and/or concerns regarding the administrative process of L&I claims should be directed to the insurer.

Separately billable services

Any procedure represented by its own CPT®, HCPCS, or local code must be billed separately, and the time spent on these services can't be included in the time used to determine the level of E/M service. This includes but is not limited to services, such as:

- Care coordination (such as telephone calls or online communications), *or*
- Completing forms (such as a Report of Accident (ROA) or Activity Prescription Form (APF)), *or*
- Independently interpreting results (when represented by its own CPT® code), *or*
- Procedures (such as injections or Osteopathic Manipulative Treatment), *or*
- Any treatment-based service.

When these services are performed in conjunction with an E/M service, you must append modifier **–25.**

Note: Evaluation and reporting is **bundled** into the payment of many services.

Pre- and post-operative visits

Pre-operative visits are included in the global surgical package for major surgery when they occur after the decision to operate is made. E/M services that include the initial decision to perform surgery beginning on the day before major surgery aren't included in the global payment. In these instances, the E/M is payable separately when appending modifier **–57** (decision for surgery).

The decision to perform minor procedures is considered routine pre-service work and is included in the payment for the minor procedure. An office visit is only appropriate if it is significantly separately identifiable from the pre, intra, and post service work associated with the minor procedure and is billed with modifier **–25** (significantly, separately identifiable service).

Post-operative visits aren't separately payable within the established global period for the service billed.

Link: For more information on what is included in the global surgery package, see Chapter 23: Surgery.

Using CPT® billing code modifier –25

Modifier **–25** must be appended to an E/M code when reported with another procedure or service on the same day. This applies to all E/M services.

The E/M visit and the procedure must be documented separately.

For the E/M to be payable, modifier **–25** must be reported in the following circumstances:

- Same worker, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Worker's condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

Scheduling back-to-back appointments, including to address injuries covered under separate claims, isn't appropriate and doesn't meet the criteria for using modifier **–25**. In these cases, one visit addressing all injuries must be performed and the bill split equally between the claims. For more information on split billing procedures and requirements, see Chapter 2: Information for All Providers.

Examples of billing with modifier –25

Example 1: Minor procedure and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related elbow and shoulder injury. The provider evaluates and documents findings of the shoulder injury and suggests a steroid injection based on their findings. The provider also evaluates and documents findings related to the elbow injury and determines that physical therapy may provide benefit and provides a referral.

The provider performs the pre-service work (such as cursory history, palpatory examination, discusses side effects). The provider then performs the steroid injection, discusses self-care and follow up with the worker, and completes the other necessary post-service work.

The provider documents the steroid injection (including pre-, intra- and post service work), totaling 25 minutes and an additional separately identifiable E/M service including record review, history, exam, counseling provided and charting time, totaling 30 minutes.

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How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the steroid injection, and
- CPT® code **99214**, with modifier **–25**.

The provider can't include the time or activities spent performing the steroid injection (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service, including time spent on each service.

Link: For more information on billing minor office procedures, see Chapter 23: Surgery.

Example 2: Case management service and time-based E/M service

A worker goes to the provider's office for a follow-up of their work related head injury. After reviewing the notes from the worker's neurologist the provider finds that they have questions regarding the current treatment plan. The provider documents a 10-minute telephone conversation with the neurologist on the day of the visit including all required documentation elements of that CPT® code. The provider evaluates the worker and documents findings of the head injury as well as the treatment plan.

The provider documents 10 minutes for the telephone call as noted above, and the separately identifiable E/M service including record review, history and exam, and charting, totaling 40 minutes.

How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- Local code **9919M** for the telephone call, and
- CPT® code **99215**, with modifier **–25**.

The provider can't include the time or activities spent performing or documenting the telephone call in selecting the appropriate E/M level, as this service is required to be billed separately. The provider must clearly document each service, including time spent on each service.

Link: For more information on billing telephone calls, see Chapter 5: Case Management Services.

Example 3: OMT and E/M service

A worker goes to an osteopathic provider's office to be treated for back pain. The provider performs an E/M visit, including a multi-system examination, reviewing the worker's prior records, and counseling the worker on the importance of appropriate lifting techniques for when they return to work. Based on their findings the provider then advises the worker that osteopathic manipulative treatment (OMT) is a therapeutic option for treatment of the condition.

The provider obtains verbal consent, determines the appropriate technique for the worker and performs other pre-service work (such as cursory history, palpatory examination, discusses side effects). The provider then performs the manipulation, discusses self-care, provides follow up instructions for the worker, and completes the other necessary post-service work.

The provider documents the OMT, including the pre, intra and post service work, in their chart note along with the separately identifiable E/M service (such as the multi- system examination above and beyond the palpatory exam completed for the OMT service, reviewing recordsm and counseling the worker on return to work).

How to bill for this scenario

For this office visit, the provider would bill the appropriate:

- CPT® code for the OMT service, and
- **New** or **established patient** E/M code, with modifier –**25**.

The provider can't include the activities or time spent performing OMT services (including the associated pre, intra and post service work) in selecting the appropriate E/M level. The provider must clearly document each service.

Link: The same scenario and method would apply for chiropractors performing chiropractic care (**2050A-2052A**) with an E/M service. For more information on billing OMT and chiropractic care services, see Chapter 20: Physical Medicine.

Example 4: Multiple E/M visits performed on the same day

A worker arrives at a provider's office in the morning for a scheduled follow up visit for a work related injury.

That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The triage nurse agrees that the worker needs to be seen again. The provider sees the worker for a second office visit.

How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed, with the appropriate level of **established patient** E/M code for that visit alone, with no modifier appended, *and*
- The unscheduled visit would be billed, with the appropriate level of **established patient** E/M code for that visit alone, with modifier **–25**.

The activities or time spent performing each separate E/M service can't overlap between the 2 visits, including charting or any other time spent in covered activities conducted on the same calendar day of the encounters (such as review of records, referrals). You can only count these activities under the applicable visit.

Payment limits

A provider would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day. See Using CPT® billing code modifier –25 and Example 4 in the Separately Billable Services section of this policy for a scenario in which this may be appropriate.

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

Split billing

When evaluating and/or treating 2 or more separate conditions that aren't related to the same claim at the same visit, the split billing policy applies.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Additional information

Hospital admissions in the course of an encounter at another site

If a provider sees a worker at a location (initial site) and then sends them to the hospital to be admitted and performs the admission on the same date of service, only the initial hospital inpatient or observation care CPT® code can be billed (**99221**-**99223**). Any E/M performed at the initial site is considered **bundled** into the initial hospital inpatient visit and isn't payable separately. L&I follows CMS (Centers for Medicare and Medicaid Services) in regards to hospital admissions in the course of encounter at another site for E/M services.

Behavioral Health Interventions (BHI)

When an E/M is performed on the same say as behavioral health interventions (BHI), BHI is included within the E/M service. BHI performed by an **attending provider** without an E/M service, may be billed using BHI local codes. For more information on requirements related to BHI, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Office-based ultrasounds

Office-based ultrasounds used for evaluation and diagnosis are considered **bundled** into the evaluation and management (E/M) service and can't be billed separately. No separate payment will be made for these services.

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Payment policy: Care plan oversight

Who must perform these services to qualify for payment

The **attending provider** must personally perform these services.

Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

Requirements for billing

Payment for care plan oversight to a provider providing post-surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, and
- Modifier **–24** is used.

The medical record must document the medical necessity as well as the level of service performed.

Payment limits

Payment is limited to once per **attending provider**, per worker, in a 30-day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren't separately payable.

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Payment policy: End stage renal disease (ESRD)

General information

L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital inpatient or observation visit (CPT® codes **99221**-**99223**),
- An inpatient or observation **consultation** (CPT® codes **99252**-**99255**), *or*
- A hospital inpatient or observation discharge service (CPT® code **99238** or **99239**).

Payment limits

E/M services (CPT® codes **99231**-**99233** and **99307**-**99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are **bundled** in the dialysis service.

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Payment policy: Home and nursing facility E/M

General information

L&I allows **attending providers** to charge for E/M services in:

- Nursing facilities, *and*
- Home or residence.

Who must perform these services to qualify for payment

The **attending provider** must personally perform these services.

Documentation requirements

In addition to the documentation requirements for E/M services, the medical record must document the location where the service was performed.

Payment policy: Prolonged E/M

Requirements for billing

Refer to the table below for prolonged E/M services billing requirements. Refer to CPT® for further details, including documentation requirements.

If you are billing for this **CPT® code**…	Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service**:
99417	**99205**, **99215, 99245, 99345, 99350** or **99483**
99418	**99223, 99233, 99236, 99255, 99306** or **99310**

Prolonged Services Example – Established patient visit

For an 84-minute **established patient** E/M service bill **99215** and **99417** x 2.

To calculate this, the first 40 minutes are applied to the **99215**, which leaves a remaining 44 minutes of prolonged service. This equates to 2 units of **99417**. Do not report **99417** for any additional time increment of less than 15 minutes.

Separately billable services and the time spent on those services can't be included in the calculation for the E/M service, including prolonged services.

Links: For more information on prolonged E/M services, see the 2021 and 2023 American Medical Association (AMA) E/M Code and Guideline Changes and the CPT® book.

Payment limits

E/M office visits are limited to a maximum of 3 hours per day. Payment of prolonged services is allowed within the maximum.

Prolonged E/M service codes are payable only when another time-based E/M is billed on the same day.

The following prolonged services are not payable:

- When the prolonged service is less than 15 minutes beyond the time for the associated E/M service, *or*
- When prolonged services are on a date of service other than the face-to-face evaluation and management service without direct patient contact, (CPT® **99358**, **99359**), *or*
- When a prolonged service is performed by clinical staff services (CPT® **99415**, **99416**).

Payment policy: Standby services

Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face worker contact, *and*
- The standby provider isn't concurrently providing care or service to other workers during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Round all fractions of a 30-minute period downward.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for E/M services	Washington Administrative Code (WAC) 296-20-045 WAC 296-20-051 WAC 296-20-01002 WAC 296-23-195 WAC 296-20-030
Administrative rules for authorization	WAC 296-20-030 WAC 296-20-03001
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information For All Providers
CMS 1500 form	F245-127-000
Fee schedules for all healthcare services	Fee schedules on L&I's website
Information for All Providers	Chapter 2: Information for All Providers
Payment policies and information on **Independent Medical Exams (IME) and Impairment Ratings**	Chapter 11: Independent Medical Exams (IMEs) and Impairment Ratings L&I's IME Examiner Program
Payment policies for **case management services**, including telephone calls, team conferences, and online communications	Chapter 5: Case Management Services
Payment policies for **Durable Medical Equipment (DME) and supplies**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Payment policies for **physical medicine**, including manipulation services	Chapter 20: Physical Medicine

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If you're looking for more information about…	Then see…
The **2021 American Medical Association (AMA) E/M Code and Guideline Changes** for new and established outpatient office visits	2021 AMA E/M guidelines CPT® Book
The **2023 American Medical Association (AMA) E/M Code and Guideline Changes** for all other E/M services, including consultations	2023 AMA E/M guidelines CPT® Book

Need more help?

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Washington State Department of
Labor & Industries

Chapter 10: Home and Vehicle Modifications

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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Payment policy: Home modifications

Prior authorization

To request prior authorization for a **consultation**, contact:

- The claim manager for State Fund claims.
- The employer or their claims representative for self-insured claims.

For **construction and design work**, pre-authorization:

- Must be done by the Assistant Director (AD) for Insurance Services for State Fund claims.
- Can't be denied without the AD's approval for self-insured claims.

Who must perform these services to qualify for payment

The home modification consultant must:

- Be a licensed nurse, occupational therapist, or physical therapist, *and*
- Have training or experience in both rehabilitation of catastrophic injuries and modifying homes.

Services that can be billed

A residence or home modification is a permanent change to an existing residence or a repair of a modification previously approved and paid for by the department or self-insured employer, or a modification made when constructing a new residence.

Links: For more information, see WAC 296-14-6200. For Job Modifications and Pre-Job Modifications, see Chapter 25: Vocational Services.

Home modifications fee schedule

For this **HCPCS or local billing code**…	The **provider that can bill** is a:	And the **insurer pays for**:	With a **maximum fee** of:
8914H Home modification **construction and design**	Contractor, Architect, Construction material supplier, *and* Worker.	• Construction materials, • Labor & tax, • Permits and inspections, and • Architect plans. If the worker pays for inspections, predesign, or planning services, the worker may be reimbursed if the modification request is approved.	Each bill pays **By Report** (as billed) up to the maximum amount authorized for the home modification.
8916H Home modification **consultation**	Home modification **consultant**.	**Time spent** doing: • Onsite home evaluation, • **Consultation**, or • Required reports.	**By Report**
8917H Home modification **mileage, lodging, bridge and ferry tolls, airfare, and car rental**	Home modification **consultant**.	**Mileage** **Lodging** for 1 person when the onsite visit requires: • 2 or more consecutive days, *and* • Is greater than 125 miles one-way. **Airfare** (economy) for 1 person when travel is greater than 180 miles one-way. **Car rental** (economy) when air travel is involved.	**State Rate**

For this **HCPCS or local billing code**…	The **provider that can bill** is a:	And the **insurer pays for**:	With a **maximum fee** of:
0391R **Travel**	Home modification **consultant**.	**Travel time or wait time**	**$5.81** per unit (1 unit = 6 minutes)

Requirements for billing

To get reimbursed, you must submit a copy of receipts for:

- Materials,
- Lodging,
- Airfare, *and*
- Car rental.

Payment limits

The insurer will pay for home modification construction and design for only 1 residence for each catastrophically injured worker. The maximum amount payable is the current Washington State average annual wage.

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Payment policy: Vehicle modifications

Prior authorization

Vehicle modifications require prior authorization based on approval by the Assistant Director of L&I's Insurance Services Program.

Link: More information about vehicle modifications is available in RCW 51.36.020(8).

Who must perform these services to qualify for payment

Consultations

The vehicle modification **consultant** must:

- Be a licensed occupational or physical therapist, or licensed medical professional, *and*
- Have training or experience in both rehabilitation and vehicle modification.

Services that can be billed

If the **HCPCS and local billing code** is…	Then the **provider who can bill** is:	And **the insurer pays** for:	And the **maximum fee** is:
8915H Vehicle modification	Vehicle modification supplier	**Vehicle modification**	Maximum payable for all work is ½ **the current Washington State average wage.** The amount paid may be increased by no more than **$4,000.00** by written order of the Supervisor of Industrial Insurance (see Link below table).

If the **HCPCS and local billing code** is…	Then the **provider who can bill** is:	And **the insurer pays** for:	And the **maximum fee** is:
8917H Vehicle modification mileage, lodging, bridge and ferry tolls, airfare, and car rental	Vehicle modification **consultants**	**Mileage** **Lodging** for 1 person when the onsite visit requires: • 2 or more consecutive days, and • Is greater than 125 miles one-way. **Airfare** (economy) for 1 person when travel is greater than 180 miles one-way. **Car rental** (economy) when air travel is involved.	**State Rate**
8918H Vehicle modification **consultation** or driving evaluation	Vehicle modification **consultants**	**Time spent** doing: • Onsite – vehicle and/or driving evaluation, • **Consultation**, or • Required reports.	**By Report**
0391R Travel	Vehicle modification **consultants**	**Travel time or wait time**	**$5.81** per unit (1 unit = 6 minutes)

Requirements for billing

To get reimbursed, you must submit copies of receipts for:

- Lodging,
- Airfare, *and*
- Car rental.

Payment limits

For local billing code **8915H**, the maximum payable for all vehicle modification is 50% of the current Washington State average wage. The amount paid may be increased by no more than **$4,000.00** by written order of the Supervisor of Industrial Insurance.

Link: For more information about vehicle modification payment increases, see RCW 51.36.020(8)(b).

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for home modifications	Washington Administrative Code (WAC) 296-14-6200 through WAC 296-14-6238 available in WAC 296-14
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Contractors' questions and answers about home modifications for workers with catastrophic injuries	F252-061-000
Fact sheet on home modifications for workers with catastrophic injuries	F252-060-000
Fee schedules for all healthcare and vocational services	Fee schedules on L&I's website
Home Modification Acknowledgement of Responsibilities form	F247-003-000
Laws for definitions	Revised Code of Washington (RCW) 50.04.355
Laws for modification to residences or motor vehicles	RCW 51.36.020(7) and (8)
Laws for residence modification services	RCW 51.36.022
Laws for right to and amount	RCW 51.32.095(4) RCW 51.32.250

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Impairment ratings

Prior authorization

Prior authorization is only required when:

- A psychiatric impairment rating is needed, *or*
- An **Independent Medical Exam** (**IME**) is scheduled.

Only the claim manager may request and authorize local billing code **1198M** **(Impairment rating, addendum report)**.

When and how to perform an impairment rating

When to rate impairment

When the worker has reached maximum medical improvement (MMI) or when requested by the insurer. Impairment rating should occur during the closing exam.

Rate impairment only for medical conditions accepted under the claim.

Body areas and organ systems

For purposes of this chapter, the following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Genitalia, groin, buttock,
- Back,
- Abdomen, *and*
- Each extremity.

Each extremity is counted once per extremity examined when determining standard or complex codes.

The following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,

- Respiratory,
- Genitourinary,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, *and*
- Hematologic/lymphatic/immunologic.

These definitions of body areas and organ systems must be used to distinguish between standard and complex impairment rating.

How to rate impairment

Use the appropriate rating system.

Link: For an overview of systems for rating impairment, see the Medical Examiners' Handbook.

Include the objective findings to support the impairment rating. The objective medical information is required if a worker requests the claim be reopened. **If there isn't an impairment, document that in the report.**

Impairment rating reports must include all of the following elements:

- **MMI**: Statement that the patient has reached maximum medical improvement (MMI) and that no further curative or rehabilitative treatment is recommended, *and*
- **Examination**: Pertinent details of the physical examination performed (both positive and negative findings). The report must include pertinent measurements (such as range of motion) even if they are within normal limits. This is important to document for comparison with potential reopening applications, *and*
- **Diagnostic tests**: Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam, *and*
- **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example:
    - The AMA Guidelines to the Evaluation of Permanent Impairment Fifth Edition, *or*
    - The Washington State Category Rating System.
- **Rationale**: The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including

the specific rating system, tables, figures and page numbers on which the rating was based.

Links: Refer to WAC 296-20-19000 through WAC 296-20-19030 and WAC 296-20-200 through WAC 296-20-690, and for amputations refer to RCW 51.32.080.

Who must perform these services to qualify for payment

Qualified **Attending Providers (APs)** (see table below) may rate impairment of their own patients.

APs who are permitted to rate their own patients, with exception of chiropractors, don't need a separate provider account number and may use their existing provider account number. In order to perform impairment ratings, chiropractors must be an approved **IME** examiner, which requires a separate provider account. Chiropractors must bill using their **IME** examiner provider account number. Providers may only give ratings for areas of the body or conditions within their scope of practice.

If the **AP** is unable or unwilling to perform the rating examination, the **AP** can ask a **consultant** to perform the rating examination in accordance with table below.

Psychologists can't rate impairment for injured workers but may rate impairment for victims of crime.

Providers qualified to provide impairment ratings include the following:

Provider Type Code	Provider type	Can you rate impairment as an AP or consultant?
20	Medicine and surgery (MD)	Yes
21	Physicians' Assistant (PA/PA-C)	No
22	Osteopathic medicine and surgery (DO)	Yes
27	Dentistry (DDS/DMD)	Yes
28	Optometry (OD)	No
30	Chiropractic (DC)	Yes, if L&I-approved **IME** examiner
31	Psychology (PsyD/PhD)	No
32	Podiatric medicine and surgery (DPM)	Yes
40	Advanced Registered Nurse Practitioners (ARNP), including Psychiatric ARNPs	No
92	Naturopathy (ND)	No

Links: To see how these qualifications are set in state law, see WAC 296-20-2010.

For more details on the topic of impairment ratings, refer to the Medical Examiners' Handbook.

For more information, see L&I's Become a Chiropractic Consultant webpage.

For information on becoming an **IME** webage, see L&I's Independent Medical Exams and Impairment Rating Information.

Services that can be billed

When an impairment rating exam is requested by the insurer, it must be sufficient to achieve the purpose and reason per the request.

Choose the local billing code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related (see fee schedule, below).

The report must document the relationship of the areas examined to the accepted work related injury(s) or contended condition(s).

Local billing code	Description	Maximum fee
1190M	**Comprehensive Hearing loss exam** Use this code for comprehensive examination of the hearing system. The hearing system is comprised of 2 organ systems that need to be thoroughly examined for evaluation of the contended or accepted condition(s). Use of this code requires: • This specialty exam is directed only toward the affected body area or organ system. • Familiarity with the history of the industrial injury, exposure or condition through worker interview and medical and work records if available. • Appropriate diagnostic tests needed, including audiograms, are ordered and interpreted by the physician. • The degree of impairment is based on the audiogram and is interpreted by a physician. • The report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or conditions(s). • A statement regarding eligibility for permanent partial impairment. Note: Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within 2 years of last injurious exposure. Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1191M	**Impairment rating by attending physician, standard, 1-3 body areas or organ systems.** Use this code if there are 1-3 body areas or organ systems examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area(s) or organ system(s). • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1192M	**Impairment rating by attending physician, complex, 4 or more body areas, or organ systems.** Use this code if there are 4 or more body areas or organ systems examined for sufficient evaluation of the accepted condition(s). • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$910.07**

Local billing code	Description	Maximum fee
1194M	**Impairment rating by consultant, standard, 1-3 body areas or organ systems.** Use this code if there are 1-3 body areas or organ systems examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Records are reviewed. • Physical exam is directed only toward the affected body area(s) or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$728.06**

Local billing code	Description	Maximum fee
1195M	**Impairment rating by consultant, complex, 4 or more body areas or organ systems.** Use this code if there are 4 or more body areas or organ systems examined for sufficient evaluation of the accepted condition(s). Use of this code requires: • Records are reviewed. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating is performed. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a **bundled** service and are included in the impairment rating fee.	**$910.07**
1198M	**Impairment rating, addendum report.** Must be requested and authorized by the claim manager. Addendum report for additional information which necessitates review of new records. Payable to attending physician or **consultant**. This code isn't billable when the impairment rating report didn't contain all the required elements. (See the Medical Examiners' Handbook for the required elements.)	**$139.29**

Rating hearing loss

When performing a comprehensive exam for hearing loss, the report must include a statement regarding eligibility for permanent partial impairment. Per RCW 51.28.055, workers aren't eligible for a disability payment if they don't file a claim within 2 years of last injurious exposure.

Additional information: How to find out if an IME is scheduled

To see if an **IME** is scheduled for a claim:

- **State Fund**, use our secure online Claim & Account Center.
- **Self-insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

Payment policy: Independent medical exams (IMEs)

General information

Independent medical exams (IMEs) are medical examinations requested by the department or self-insured employers to answer medical and legal questions about the claim. Performing IMEs or impairment ratings requires considerable judgement and understanding of specialized terms and a mastery of skills that aren't always part of a doctor's original training. **IME** providers must be familiar with and follow the Medical Examiners' Handbook.

Per RCW 51.36.070(2), the department or self-insurer shall provide the physician performing the exam all relevant **medical records** from the worker's claim file.

Who must perform services to qualify for payment

Only **department-approved IME** Providers with an **IME** provider account number can bill **IME** codes. Applications are available on our website. **Attending providers** eligible to become an **IME** examiner include:

- Medical physicians and surgeons,
- Osteopathic physicians and surgeons,
- Podiatric physicians and surgeons,
- Chiropractic physicians , *and*
- Dentists.

For more information on **becoming an approved IME provider** or to perform impairment ratings, see the Medical Examiners' Handbook.

To receive email updates on IMEs, subscribe to the ListServ.

Prior authorization

Prior authorization is only required when an **IME** is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an **IME** is scheduled.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA).
- **Crime Victims**, call **1-800-762-3716**.

Services that can be billed

Interpretation services during IMEs

Interpreter services are covered during IMEs. All interpreter requests must be scheduled through the scheduling system. For additional information regarding interpreter services, see Chapter 14: Language Access Services. For Sign Language interpretation, see Chapter 18: Other Services.

IME fee schedule

Local code	Description and notes	Maximum fee
1104M	**IME, addendum report** Must be requested and authorized by claim manager. Addendum report is for additional information that isn't requested in original assignment, which necessitates review of records. Not to be used in place of a new **IME**, if requested by the insurer. Fee already includes additional reimbursement for file review of 50 pages or less of records not previously provided by the insurer during the initial exam. For addendums over 50 pages, use **1129M**. To bill for review of **job analysis**, only use when records are reviewed and a report attesting to that review is submitted with the **job analysis**. The review of diagnostic testing or study results ordered by the examiner isn't separately payable or billable under this code. When diagnostics weren't ordered by the examiner originally, an addendum may be payable to account for review of the records. Not payable with **1066M**.	**$169.88**
1105M	**IME Physical Capacities Estimate** (F242-387-000) Must be requested by the insurer. If an exam is performed by multiple examiners, bill under only one of the performing examiner's provider account number. (Bill once per exam.)	**$37.18**

Local code	Description and notes	Maximum fee
1108M	**IME, standard exam – 1-3 body areas or organ systems** Use this code if there are only 1-3 body areas or organ systems examined for sufficient evaluation of the accepted condition(s). L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only towards the affected **body area(s)** or **organ system(s)**. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The **IME** report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional examiners use **1112M**. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$728.06**

Local code	Description and notes	Maximum fee
1109M	**IME, complex exam – 4 or more body areas or organ systems** Use this code if there are 4 or more body areas or organ systems examined for sufficient evaluation of the accepted condition(s) or contended conditions. L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the worker. Use of this code requires: • Records reviewed by examiner and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests needed are ordered and interpreted. • Impairment rating performed if requested. • The **IME** report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note**: Additional complex examiners use **1126M**. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$910.07**

Local code	Description and notes	Maximum fee
1112M	**IME, additional examiner for Standard IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 examiner on IMEs with a combined report should bill a standard (**1108M**). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$728.06**
1118M	**IME by psychiatrist** Psychiatric diagnostic interview with or without direct observation of a physical exam. L&I expects these exams will typically involve at least 60 minutes of face-to-face time with the worker. Includes: • Review of records, other specialist's or provider's exam results, if any. • **Consultation** with other examiners and submission of a joint report if scheduled as part of a panel. • The **IME** report containing the required elements noted in the Medical Examiners' Handbook. • Impairment rating performed if requested. • Review of up to 2 job analyses. Also includes impairment rating, if applicable. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1123M	**IME, communication issues** Exam was unusually difficult due to a worker's expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report. If an interpreter is needed, verify and record name of interpreter in report. Bill once per examiner per exam. Isn't payable with a no show fee (1144M).	**$243.78**
1124M	**IME, other, by report** Requires prior authorization and prepay review: • For State Fund claims, contact the claims manager, or • For self-insured claims, contact the self-insured employer or third party administrator. Billable services under this code are limited to: • Research and review for chemically related illness (CRI) claims to be billed only by contracted providers authorized to perform CRI IMEs, • Security services for potentially violent workers, or • Guard services for incarcerated workers.	**By report**
1125M	**Physician travel per mile** Allowed when roundtrip exceeds 14 miles using Personally Owned Vehicles. Code usage is limited to extremely rare circumstances, such as IMEs in correctional facilities. Requires prior authorization and prepay review: • For State Fund claims, call Provider Quality and Compliance at **800-468-7870**, or • For self-insured claims, contact the self-insured employer or third party administrator.	**$5.96**

Local code	Description and notes	Maximum fee
1126M	**IME, additional examiner for Complex IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, and • Contribution to combined report. L&I expects these exams will typically involve at least 45 minutes of face-to-face time with the worker. **Note**: One examiner on an **IME** with a combined report should bill a complex **IME** (1109M). The **IME** report must meet the criteria required for a complex **IME** (**1109M**). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$910.07**
1128M	**Occupational disease report** (Doctor's Assessment of Work Relatedness for Occupational Diseases) Must be requested by insurer. Examples of conditions which L&I considers occupational diseases are: • Occupational carpal tunnel syndrome, • Noise-induced hearing loss, • Occupational dermatitis, and • Occupational asthma. The legal standard is different for occupational diseases from occupational injuries. Refer to RCW 51.080.140 on the definition for occupational disease. This is a detailed assessment of work relatedness, with the exact content presented in the Medical Examiners' Handbook. An examiner may bill this code **only once for each worker.** **Note:** An examiner can't use **1055M**. **1055M** is used by **attending providers** and **consultants**.	**$225.44**

Local code	Description and notes	Maximum fee
1129M	**IME, extensive file review by examiner** Units of service are based on the number of hardcopy pages reviewed by the **IME** examiner on microfiche, paper, Claim and Account Center, or other medium. Review of the **first 400 hardcopy pages** is included in the base exam fee (**1104M***, **1108M**, **1109M**, **1112M**, **1118M**, **1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**). * Please see **1104M** description for specific information regarding billing **1104M** with **1129M**. Review of the first 50 hardcopy pages is included in the fee for **1104M**. Bill for each additional page reviewed beyond the first 400 hardcopy pages (for **1104M**, bill for each additional page beyond the first 50 hardcopy pages). Isn't payable with **IME** late cancellations (**1143M**) or **IME** no show fee (**1144M**). Only the following document categories will be paid for **unless** the authorizing letter requests a review of **all** documents: • Medical files, • History, • Report of Accident, • Reopen Application, *and* • Other documents specified by claim manager or requestor. Bill per examiner. Not payable for review of duplicate documents. **Note**: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook.	**$1.23**

Local code	Description and notes	Maximum fee
1130M	**IME, terminated exam** Bill for exam ended prior to completion. Requires file review, partial exam by the examiner and report (including reasons for early termination of exam). Bill per examiner. Terminated exams don't include failure to obtain an interpreter. Terminated exams are payable when the worker is uncooperative, becomes obstructive (for example, the exam starts and the worker insists on recording but hadn't provided required notice), or becomes ill in the middle of the exam. **Note**: A partial exam is face-to-face time between the examiner and the worker where, at a minimum, the worker's history is obtained. **Note**: **1130M** or **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$431.85**
1139M	**No show fee for missed neuropsychological testing.** Must be scheduled or approved by department or self-insurer in conjunction with an **independent medical examination**. (For more information, see: WAC 296-20-010(5).) This code is payable only once per **independent medical examination** assignment. Must notify department or self-insurer of no-show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$1,084.03**

Local code	Description and notes	Maximum fee
1140M	**No show fee for missed Functional Capacity Evaluation (FCE).** Must be scheduled or approved by department or self-insurer in conjunction with an **independent medical examination**. (For more information, see: WAC 296-20-010(5).) This code is payable only once per **independent medical examination** assignment. The code is only payable to the rendering provider performing the FCE in conjunction with the exam. Must notify department or self-insurer of no show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$346.77**

Local code	Description and notes	Maximum fee
1141M	**IME, rare specialty exam – 1-4 or more body areas or organ systems** Use this code in lieu of **1108M** or **1109M** when exam is performed by 1 of the following rare provider specialties: • Allergy and Immunology • Cardiology • Dermatology • Endocrinology • Gastroenterology • Hematology • Obstetrics and Gynecology • Oncology • Ophthalmology • Pain Medicine/Dolorology • Pulmonology • Thoracic surgery • Urology • Vascular surgery L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: Follow the exam requirements for either **1108M** or **1109M** depending on number of body areas or organ systems involved. This specialty list may be updated depending on the number of examiners available. For additional rare specialty examiners use **1142M**. **1108M** or **1109M** may be billed with an **1141M** if 1 of the examiners is completing a standard or complex exam, and the other is completing a rare specialty exam. Only the rare specialty examiner may bill **1141M**. **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$1,319.61**

Local code	Description and notes	Maximum fee
1142M	**IME, additional examiner for Rare Specialty IME** Use where input from more than 1 rare specialty examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects these exams will typically involve at least 30 minutes of face-to-face time with the worker. **Note**: 1 rare specialty examiner on IMEs with a combined report should bill a rare specialty **IME** exam (**1141M**). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$1,319.61**
1143M	**IME late cancellation fee, per examiner** Bill only if worker cancels the appointment within 5 business days prior to exam. May be billed if worker arrives for exam but the exam can't start due to obstructive behavior (for example, worker insists on recording exam but didn't provide required notice). Billable if appointment time can't be filled. (Business days are Monday through Friday.) Isn't payable for no shows of **IME** related services (for example, neuropsychological evaluations) or when **IME** provider cancels exam (for example, provider wants to co-record and worker doesn't allow) **IME** providers must notify department or self-insurer of no show as soon as possible. **Note**: **1130M** and **1143M** can't be billed together. Only one code can be billed per the determination on whether it was a termination or cancellation.	**$399.88**

Local code	Description and notes	Maximum fee
1144M	**IME no show fee, per examiner** Bill only if worker fails to show, and appointment time can't be filled. Isn't payable for no shows of **IME** related services (for example, neuropsychological evaluations). **IME** providers must notify department or self-insurer of no show as soon as possible. For more information, see WAC 296-20-010.	**$399.88**
1145M	**IME, for multiple claims**. Requires prior authorization Bill by unit (1 unit = 1 additional claim). This code is used in addition to the primary **IME** exam code (**1108M, 1109M, 1112M, 1118M, 1126M, 1130M, 1141M, 1142M, 1146M** or **1147M**) only. This can't be reported as a stand-alone code A maximum of 5 additional claims (units) are billable with this code. Anytime 6 or more additional claims are included, special review and authorization is required by the insurer. Not payable when only 1 claim is examined. Bill per examiner. **Note:** Don't bill a unit for the first claim. The first claim must be billed using a base exam code (such as **1108M**).	**$140.54 per unit**
1146M	**Forensic IME** Requires prior authorization Bill only if the worker is unavailable for the physical portion of the **IME** exam. Isn't payable for no shows of **IME** related services (for example, neuropsychological evaluations). **Note**: Compensation for downloading, printing and sorting files is **bundled** into the reimbursement for the examination fees.	**$431.85**

Local code	Description and notes	Maximum fee
1147M	**Correctional facility IME** Bill for IMEs conducted at a correctional facility, if the examiner travels to the facility. This code requires prior authorization. Examiners may also bill for travel to conduct anr **IME** conducted at a correctional facility; bill using **1125M**, which requires prior authorization.	**$2,730.22**

Requirements for billing

State Fund (L&I) provider account number requirements for IMEs

For IMEs, examiners working through a firm need 1 **IME** provider account number for each payee.

An **IME** examiner who isn't working through an **IME** firm will need 1 **IME** provider account number, which will also serve as their payee number.

Bills for testing or other services performed in conjunction with an **IME** must be submitted by the provider who rendered the service (WAC 296-20-125(3)(o)). These services include:

- X-ray, diagnostic laboratory tests in conjunction with **IME** (append modifier **–26** and **–7N**).
- Psychological/neurological testing CPT® codes – **90791**, **96136, 96137, 96138, 96139.** Automated testing and results for psychological/neurological CPT® code **96146**. (For more detailed information on psychological/neurological services, refer to Chapter 17: Mental Health and Behavioral Health Interventions (BHI).)
- Functional Capacity Evaluations (FCE) – **1045M.**
    - **IME** examiners may only review and comment on an FCE as part of the exam. Please see Medical Examiners' Handbook.

Body areas and organ systems

For billing purposes, the following body areas are recognized:

- Head, including the face,
- Neck,
- Chest, including breasts and axilla,
- Genitalia, groin, buttock,
- Back,

- Abdomen, *and*
- Each extremity.

Each extremity is counted once per extremity examined when determining standard or complex codes.

The following organ systems are recognized:

- Eyes,
- Ears, nose, mouth, and throat,
- Cardiovascular,
- Gastrointestinal,
- Respiratory,
- Genitourinary,
- Musculoskeletal,
- Skin,
- Neurologic,
- Psychiatric, *and*
- Hematologic/lymphatic/immunologic.

Standard and complex coding

The exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the code based on the number of body area(s) or organ system(s) that are examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related.

The report must documentsthe relationship of the areas examined to the accepted work related injury(s) or contended condition(s).

The definitions of body area(s) and organ system(s) above must be used to distinguish between standard and complex IMEs.

Payment limits

Limit on total scheduled exams per day

L&I has placed a limit of 12 **independent medical examination**s scheduled per examiner per day. For psychiatrist examiners, the limit is 8 per day.

This limit includes IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- **1108M IME**, standard exam – 1-3 body areas or organ systems,
- **1109M IME**, complex exam – 4 or more body areas or organ systems,
- **1112M IME**, additional examiner for Standard **IME**,
- **1118M IME** by psychiatrist,
- **1126M IME** additional examiner for Complex **IME**,
- **1130M IME**, terminated exam,
- **1141M IME,** rare specialty exam,
- **1142M IME,** additional examiner for Rare Specialty **IME**,
- **1143M IME,** late cancellation fee,
- **1144M IME,** no show fee,
- **1146M IME,** forensic exam,
- **1147M IME,** correctional facility exam

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Payment policy: Radiology reporting requirements for IMEs

Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing.

Documentation includes:

- Charting of justification,
- Findings,
- Diagnoses, *and*
- Test result integration, including a comparison between repeat radiology studies where applicable.

When billing for the professional component of radiology services, bill using modifier **–26** and modifier **–7N**.

IME providers who read imaging studies they order in relation to an **IME**, or reinterpret imaging studies previously performed, are required to document their findings within the **IME** report. Each imaging study must be separately documented in its own section and include all of the following:

- Patient's name, age, sex, *and*
- Date the imaging study was performed, *and*
- The anatomic location of the procedure, including laterality as applicable, and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- When ordering imaging studies, a brief sentence describing the reason for the study, such as:
    - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
    - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description of, or listing of, imaging findings:
    - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*

  - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*
  - Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*

- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the **IME** report. If the same imaging study was performed on multiple dates of service, the provider must document a comparison between the studies, in sequential order, noting any significant changes that occurred. For example:
  - For a neck comparison where there is a difference between the original imaging study and the most recent findings, the impression could be: “A comparison of this recent study from 7/1/2019 is made to the study of 5/1/2018. 5/1/2018 which noted narrowing of the disc space at C-5 with bony protuberance at right facet causing impingement. New image from 7/1/2019 shows bony protuberance has grown 5mm and is contributing to increased impingement of the nerve root. This appears to be a continuation of a natural growth process.”

In addition to the above information, when reinterpreting imaging studies, the **IME** provider must document whether they are or aren’t in agreement with original interpretation of the imaging study.

Note: Documentation such as "X-rays are negative" or "X-rays are normal", or documentation that just restates the notes/recommendations of the radiologist doesn’t fulfill the reporting requirements described in this section and the insurer **won’t pay** for the professional component in these circumstances. The provider reviewing the radiologist’s report must document their own interpretation of the diagnostic service.

Payment limits

Reinterpretation of imaging studies

Reinterpretation of imaging studies may only be billed once per panel exam. The reinterpretation is only payable for studies related to the accepted or contended condition.

In addition, services must be billed with the correct CPT® code for the specific imaging study reinterpreted, along with modifier **-26** and modifier **-7N**.

Example of how to bill for IME services including reinterpretation of imaging studies

The following example demonstrates how to bill when **IME** providers perform a reinterpretation of imaging studies. This example isn't reflective of the documentation requirements for an **IME**.

Example: A panel **IME** is performed on 7/1/21 meeting the documentation criteria for a complex **IME**. The **IME** providers review and appropriately document the review of the following imaging studies, all related to the accepted conditions:

- 1 – 3 view knee x-ray performed 6/1/19
- 2 – 2 view shoulder x-rays performed 6/1/19 and 8/2/20
- 1 – Shoulder MRI without contrast

The correct billing for the services is:

Examiner 1

Line item	Procedure code (and modifiers)	Number of Units
1	**1109M**	1
2	CPT® **73562-26-7N**	1
3	CPT® **73030-26-7N**	2
4	CPT® **73221-26-7N**	1

Examiner 2

Line item	Procedure code (and modifiers)	Number of Units
1	**1126M**	1

Note: Reinterpretation is only payable once per panel exam.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and other Washington state laws for impairment ratings	Washington Administrative Code (WAC) 296-20-19000 WAC 296-20-19030 WAC 296-20-200 WAC 296-20-2010 WAC 296-20-690 Revised Code of Washington (RCW) 51.32.080
Administrative rules for Billing procedures	Washington Administrative Code (WAC 296-20-125)
Administrative rules for IME no shows	WAC 296-20-010
Application to become an IME provider	F245-046-000
Becoming an L&I IME provider	Become an IME Provider on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services (including impairment ratings)	Fee schedules on L&I's website
How to perform an impairment rating	Medical Examiner's Handbook
Laws for Medical Aid	RCW 51.28.055
Mental Health and Behavioral Health Interventions (BHI)	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Performing **impairment ratings**	Medical Examiner's Handbook
Receiving **email updates on IMEs**	Subscribe to L&I's ListServ

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Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 12: Injections and Medication Administration

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

Table of Contents Page

Payment policy: Acupuncture services

General information

Acupuncture involves the insertion of needles or lancets, with or without electrical stimulation, to directly or indirectly stimulate acupuncture points and meridians.

The insurer only covers acupuncture for open and allowed claims with an accepted diagnosis of:

- A low back condition, *and/or*
- Chronic migraine as defined by the International Headache Society.

For the purposes of this policy, a treatment cycle is defined as a repeatable course of care consisting of a period of treatment followed by a period of rest (no treatment), the duration of which is defined by the acupuncture provider.

Who must perform these services to qualify for payment

Only Acupuncture, Eastern Medicine Practitioners (AEMP) and other providers who are licensed by the Department of Health to perform acupuncture may perform these services.

Prior authorization

For chronic migraine

Prior authorization from the insurer and a referral from the **attending provider** are required for each treatment cycle.

The acupuncture provider must include the requested number of visits for the current treatment cycle in their authorization request. The number of visits for a single treatment cycle can’t exceed 24.

For low back

Prior authorization to perform acupuncture for low back is not required. A referral from the **attending provider** is required before starting treatment.

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Services that can be billed

Code	Description	Payment Limits
99202-99215	**Evaluation and Management (E/M) service** for: • Initial evaluations, *or* • Follow up evaluations, *or* • Discharge visits.	See Chapter 9: Evaluation and Management Services for more information.
1581M	**Acupuncture treatment** with one or more needles, with or without electrical stimulation, for chronic migraine. Prior authorization is required for each treatment cycle.	**Maximum of 1 unit per day, per worker.** **Initial treatment cycle of up to 24 treatments, which must be completed within 12 months or less.** One additional treatment cycle of up to 24 visits may be considered with a new referral and prior authorization. There is no waiting period required between treatment cycles. **Maximum 48 units** per claim.
1582M	**Acupuncture treatment** with one or more needles, with or without electrical stimulation, for low back.	**Maximum of 1 unit per day, per worker.** **Maximum of 10 units** per claim.

Link: For more information on conditions of coverage, see WAC 296-23-238, L&I's coverage decisions Acupuncture for lumbar conditions and Acupuncture for chronic migraine and chronic tension-type headache.

Documentation requirements

Chart notes must contain documentation that justifies the level, type, and extent of services billed. See Chapter 2: Information for All Providers for details.

Initial and follow up evaluations must meet the documentation requirements in Chapter 9: Evaluation and Management (E/M) Services.

On the final visit, the reason for discharge of the worker must be documented.

Services that aren’t covered

CPT® acupuncture codes **97810-97814** aren’t covered.

L&I will not authorize or pay for acupuncture treatment not related to low back conditions or chronic migraine.

Acupuncture isn’t covered for chronic tension-type headaches or chronic daily headache. See L&I’s coverage decision for details.

Acupuncture services can’t be performed via **telehealth**.

Payment policy: Anesthesia services

Who must perform these services to qualify for payment

Payment for anesthesia services will only be made to:

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

Services that can be billed

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

Other services commonly performed, such as evaluation and management (E/M) services, most pain management services, and other selected services, are paid based on maximum provider fee schedule. These services must be billed with the appropriate CPT® code for the service performed.

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

- The E/M service is significantly, separately identifiable from the pain management procedure performed on the same day, *and*
- Meets the criteria for modifier **–25**.

The use of E/M CPT® codes on the days before and after the procedure is performed are subject to the global surgery package policy.

Link: For more information on billing E/M services, see Chapter 9: Evaluation and Management (E/M).

For more information on what is included in the global surgery package, see Chapter 23: Surgery.

Maximum fees for services paid by provider fee schedule are located in the Professional Services Fee Schedule.

Services that aren’t covered

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

The insurer doesn’t cover anesthesia assistant services.

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

CPT® physical status modifiers (**–P1** to **–P6**) aren't recognized by the insurer. Services billed with these modifiers will be denied.

Requirements for billing

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

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs must use the appropriate anesthesia modifiers (**–AA**, **–QK**, **–QX**, **–QY**, and **–QZ**).

Anesthesia modifiers aren't valid for services paid based on maximum provider fee schedule.

Link: For more information on anesthesia modifiers, see Appendix B: Modifiers.

Anesthesia add-on codes

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

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

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

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

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

If the total body surface area is…	Then the primary code to bill is:	And the units to bill of add-on CPT® code **01953** is:
Less than 4 percent	**01951**	None
4 - 9 percent	**01952**	None
Up to 18 percent	**01952**	1
Up to 27 percent	**01952**	2
Up to 36 percent	**01952**	3
Up to 45 percent	**01952**	4

If the total body surface area is…	Then the primary code to bill is:	And the units to bill of add-on CPT® code **01953** is:
Up to 54 percent	**01952**	5
Up to 63 percent	**01952**	6
Up to 72 percent	**01952**	7
Up to 81 percent	**01952**	8
Up to 90 percent	**01952**	9
Up to 99 percent	**01952**	10

Anesthesia base units

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

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

Anesthesia time

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

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

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Payment limits

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the maximum fee schedule amount for the procedure.

Patient acuity doesn't affect payment levels.

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

The insurer doesn't recognize physical status modifiers (**–P1** through **–P6**). Services billed with these modifiers will be denied.

Anesthesia modifiers aren't valid for services paid based on maximum provider fee schedule.

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

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

Anesthesia teaching physicians

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

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

CRNA payment limits

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

Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services. See the Team care (medical direction of anesthesia) supplemental anesthesia policy in this chapter.

Supplemental policy: How to calculate anesthesia payment paid with base and time units

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

For services provided on or after July 1, 2025 the anesthesia conversion factor is **$58.65** per 15 minutes (**$3.91** per minute).

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

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

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15, *then*
2. Add the value from step 1 to the total number of whole minutes, *then*
3. Multiply the result from step 2 by **$3.91**

Example

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

1. 3 base units x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x **$3.91** = **$410.55**.

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

For more information on how to calculate the payment for team care, see the Team care (medical direction of anesthesia) supplemental anesthesia policy in this chapter.

Supplemental policy: Team care (medical direction of anesthesia)

Requirements for medical direction of anesthesia

Physicians directing qualified individuals performing anesthesia must:

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

Direction limitations

Physicians directing anesthesia:

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

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

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

Documentation requirements

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

Requirements for billing

When billing for team care situations:

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

Team care payment calculation

To determine the maximum payment for team care services:

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

Payment policy: Botulinum toxin (BTX)

Prior authorization

Botulinum toxins are payable when authorized.

Coverage of Onabotulinumtoxin A for treatment of chronic migraine is exempt from the 2-course limit based on an HTCC coverage determination. A maximum of 5 courses may be authorized.

Link: Prior authorization criteria and L&I's coverage decision information is available online.

Requirements for billing

Billing codes

Refer to the fee schedule for current fees.

If the **injection** is…	Then the appropriate **HCPCS billing code** is:
Onabotulinumtoxin A, 1 unit (Botox® or Botox Cosmetic®)	**J0585**
Abobotulinumtoxin A, 5 units (Dysport®)	**J0586**
Rimabotulinumtoxin B, 100 units (Myobloc®)	**J0587**
Incobotulinumtoxin A, 1 unit (Xeomin®)	**J0588**

Services that aren't covered

The insurer won't authorize payment for BTX injections for off label indications.

Onabotulinumtoxin A for the treatment of chronic tension-type headache isn't a covered benefit.

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Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk nonpayment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

Link: For more information, see the L&I coverage decision on compound drugs.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA approved alternatives, on the Outpatient Drug Formulary such as:

- Oral generic nonsteroidal anti-inflammatory drugs,
- Muscle relaxants,
- Tricyclic antidepressants,
- Gabapentin, *and*
- Topical salicylate and capsaicin creams.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient.

Payment limits

No separate payment will be made for **99070** (Supplies and materials).

Payment policy: Immunizations

Prior authorization

Immunization materials are payable when authorized.

Services that can be billed

CPT® codes **90471** and **90472** are payable, in addition to the immunization materials code(s).

For each additional immunization given, add-on CPT® code **90472** may be billed.

Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a modifier **–25**.

Link: For more information on post exposure prophylaxis and testing (PEP) for bloodborne pathogens and infectious diseases, see L&I's coverage decision for bloodborne pathogens, and WAC 296-20-03005.

For PEP HIV drugs dispensed at a hospital facility, see Chapter 25: Hospitals and Ambulatory Surgical Centers (ASCs).

For PEP HIV drugs dispensed through a pharmacy, see Chapter 19: Pharmacy.

Payment policy: Immunotherapy

Services that aren't covered

Complete service codes aren’t paid.

Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- 1 of the injection codes, *and*
- 1 of the antigen/antigen preparation codes.

Payment policy: Infusion therapy services and supplies

Home infusion services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home, along with nursing services. Home infusion services can be authorized independently or in conjunction with home health services.

The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition. Home infusion services can be authorized independently or in conjunction with home health services.

Regardless of who is providing services, prior authorization is required for:

- Home infusion nurse services, *and*
- Drugs, *and*
- Any infusion supplies.

Note: An exception is **outpatient services**, which are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. See Services that can be billed.

Services that can be billed

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Anti-spasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, baclofen).

Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

Equipment and supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782-E0783**, *and*
- **E0785-E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy, as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

The following CPT® codes are payable:

- **99601-99602**

Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered with the following exceptions for accepted conditions:

- To treat pain caused by cancer or other end-stage diseases, *or*
- To administer anti-spasticity drugs when spinal cord injury is an accepted condition.

Link: For more information, see WAC 296-20-03002.

Requirements for billing

Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I **DME** provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, the rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes.

Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.

Payment limits

E/M office visits

Providers will only be paid for E/M office visits in conjunction with infusion therapy if the services provided meet the code definitions.

Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren't covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term postoperative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

Link: For more information, see WAC 296-20-03014.

Equipment and supplies

Infusion therapy supplies and related **DME**, such as infusion pumps, aren't separately payable for **RBRVS** providers. Payment for these items is **bundled** into the fee for the professional service.

Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373** and **96374**, won't be paid separately in conjunction with the IV infusion codes.

Payment policy: Injectable medications

Requirements for billing

Providers must use the HCPCS J codes for injectable drugs that are administered during an E/M office visit or other procedure. The HCPCS J codes aren't intended for self-administered medications.

When billing for a nonspecific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, **providers must bill their acquisition cost for the drugs**. To get the total billable units, divide the:

- Total strength of the injected drug, *by*
- The strength listed in the manual.

For example:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

Payment limits

Payment is made according to the published fee schedule amount, or the **acquisition cost** for the covered drug(s), whichever is less.

Payment policy: Medical foods and co-packs

Services that aren't covered

Medical food products and their convenience packs or "co-packs" aren't covered.

Examples of medical food products include:

- Deplin® (L-methylfolate), *and*
- Theramine® (arginine, glutamine, 5-hydroxytryptophan, and choline).

Examples of "co-packs" include:

- Theraproxen® (Theramine and naproxen), *and*
- Gaboxetine® (Gabadone and fluoxetine).

Link: For more information, see L&I's coverage decision on medical foods and co-packs.

Payment limits

Medical foods and co-packs administered or dispensed during office procedures are considered **bundled** in the office visit.

No separate payment will be made for **99070** (Supplies and materials), which is a **bundled** code.

Payment policy: Non-injectable medications

Services that can be billed

Providers may use distinct HCPCS J codes that describe specific non-injectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The HCPCS J codes aren't intended for self-administered medications.

Services that aren't covered

No payment will be made for pharmaceutical samples or repackaged drugs.

Requirements for billing

Providers must bill their acquisition cost for these drugs.

The name, NDC, strength, dosage, and quantity of the drug administered must be documented in the medical record and noted on the bill.

Link: For more information, see the payment policy for **acquisition cost** in Chapter 7: Durable Medical Equipment (DME) and Supplies.

Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Noninhalation drug for **DME**), *or*
- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*
- **J8499** (Oral prescription drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

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Payment policy: Spinal injections

Prior authorization

Prior authorization, including utilization review, is required for spinal injections.

Services that can be billed

Some spinal injections are covered for accepted conditions when certain criteria is met. For more information, see L&I's coverage decision.

Per L&I's coverage decision, therapeutic or diagnostic sacroiliac joint injections are covered services when all the following criteria are met:

1. Patient has an allowed condition that includes sacroiliac joint pain.
2. Failure of at least 6 weeks of conservative therapy.
3. Fluoroscopic or CT guidance is used.
4. No more than one injection without clinically meaningful improvement, as documented by a validated scale. Additional injections require clinical review.

Payment methods

Physician or CRNA/ARNP

The payment methods for physician or CRNA/ARNP are:

- Injection procedure: **–26** component of Professional Services Fee Schedule, *and*
- Radiology procedure: **–26** component of Professional Services Fee Schedule

A separate payment for the injection **won't be made** when computed tomography (CT) is used for imaging, unless documentation demonstrating medical necessity is provided.

Radiology facility payment methods

The payment methods for radiology facilities are:

- Injection procedure: No facility payment, *and*
- Radiology procedure: **–TC** component of Professional Services Fee Schedule.

Hospital payment methods

The payment methods for hospitals are:

- Injection procedure: APC or POAC (payment method depends on the payer and/or the hospital's classification), *and*
- Radiology procedure: APC, POAC or **–TC** component of Professional Services Fee Schedule. Radiology codes may be packaged with the injection procedure.

Note: See Therapeutic or diagnostic injections for additional details regarding spinal injections (SI) or SI joint requirements.

Payment policy: Therapeutic or diagnostic injections

Prior authorization

These services require prior authorization:

- Trigger point injections and dry needling (refer to guideline for limits), and
- Sympathetic nerve blocks (refer to the CRPS guideline).

Links: See L&I's coverage decision for more information on trigger point and dry needling injections and L&I's CRPS guidelines for more information on sympathetic nerve blocks.

Required along with utilization review

These services require both prior authorization and utilization review:

- Therapeutic epidural and spinal injections for chronic pain,
- Therapeutic sacroiliac joint injections for chronic pain, *and*
- Diagnostic facet and medial branch block injections (refer to neurotomy guideline).

Links: See L&I's coverage decision and guidelines on spinal injections, L&I's neurotomy guidelines, and L&I's coverage decision on discography.

Services that can be billed

These services can be billed without prior authorization:

- E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable and meet the definition of and are billed with modifier **–25**,
- Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS J code for the drug,
- Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360**, **96361**, **96365**-**96368**), *and*
- Spinal injections that don't require fluoroscopy or CT guidance:
    - CPT® code **62270** – diagnostic lumbar puncture,
    - CPT® code **62272** – therapeutic spinal puncture for drainage of CSF, and
    - CPT® code **62273** – epidural injection of blood or clot patch.

Services that aren't covered

If billed with an E/M service, providers will be paid only the injection and the appropriate HCPCS J code for the drug, unless the E/M meets the requirements to append modifier **–25**. CPT® code **99211** won't be paid separately.

Effective March 1, 2024, hyaluronic acid injections are not covered for osteoarthritis of the knee.

Perineural Injection Therapy (PIT), also known as sclerotherapy, neurofascial, subcutaneous or neural prolotherapy, are considered forms of prolotherapy. L&I does not cover any form of prolotherapy per WAC 296-20-03002. Providers may not bill or be paid for PIT. These procedures should not be confused with peripheral nerve blocks (CPT® code **64450**), which are allowed for regional anesthesia and acute pain management.

The insurer doesn't cover:

- Therapeutic medial branch nerve block injections, *or*
- Therapeutic or diagnostic intradiscal injections, *or*
- Therapeutic facet injections, *or*
- Diagnostic sacroiliac joint injections, *or*
- Therapeutic genicular nerve blocks for chronic knee pain, *or*
- Perineural injection therapy.

Links: For more information on:

- Hyaluronic acid injections, see L&I's coverage decision.
- Perinural Injection Therapy (PIT), see L&I's coverage decision.
- Therapeutic genicular nerve block for treating chronic knee pain, see L&I's coverage decision.
- Spinal injections, see L&I's coverage decision.

For information regarding use of modifier **–25**, see Chapter 9: Evaluation and Management (E/M).

Requirements for billing

Dry needling

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

Dry needling of trigger points must be billed using CPT® codes **20560** and **20561**. Dry needling isn't considered acupuncture and can't be billed using acupuncture local codes.

Effective January 1, 2025, Physical Therapists (PTs) with intramuscular needing endorsement may bill for dry needling.

Spinal injections that require fluoroscopy

For spinal injection procedures that require fluoroscopy:

- 1 fluoroscopy code must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied, *and*
- Only 1 fluoroscopy code may be billed for each injection (see table below).

Only 1 of these **CPT® fluoroscopy codes** may be billed for each injection…	…and it must be billed along with this underlying **CPT® code**:
77002, **77012**, **76942**	**62268**
77002, **77012**, **76942**	**62269**
77003	**62281**
77003	**62282**
77003, **77012**, **76942**, **72240**, **72255**, **72265**, **72270**	**62284**
72295	**62290**
72285	**62291**
72295	**62292**
77002, **77003**, **77012**, **75705**	**62294**
77003	**62320**
77003	**62322**

Only 1 of these **CPT® fluoroscopy codes** may be billed for each injection…	…and it must be billed along with this underlying **CPT® code**:
77003	**62324**
77003	**62326**

Spinal injection procedures that include fluoroscopy, ultrasound, or CT in the code description

Paravertebral facet joint injections now include fluoroscopic, ultrasound, or CT guidance as part of the description. This includes these CPT® codes:

- **64479-64480**, *and*
- **64483-64484**, *and*
- **64490-64495**.

Fluoroscopic, ultrasound, or CT guidance can't be billed separately.

Links to related topics

If you're looking for more information about…	Then see…
Acupuncture	WAC 296-20-03002(2) Acupuncture guidelines on L&I's website
Administrative rules for acupuncture services non-coverage	Washington Administrative Code (WAC) 296-20-03002(2)
Administrative rules for anesthesia	WAC 296-20
Administrative rules for drug limitations (such as opiates)	WAC 296-20-03014
Administrative rules for licensed nursing	WAC 296-23-240
Administrative rules for licensed nursing billing instructions	WAC 296-23-245
Administrative rules for pharmacy services	WAC 296-20-01002 WAC 296-20-17004 WAC 296-20-03014(6) WAC 296-20-1102 WAC 296-20-02005
Administrative rules for treatment authorization (including prolotherapy)	WAC 296-20-03002
Administrative rules for treatment guidelines for injections	WAC 296-20-03001(7)

If you're looking for more information about…	Then see…
Administrative rules for work related exposure to an infectious disease	WAC 296-20-03005
Anesthesia **conversion factor**	WAC 296-20-135
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bloodborne pathogens	Bloodborne pathogens guidelines
Botulinum toxin (BTX) injections	Botulinum toxin coverage decision
Complex Regional Pain Syndrome (CRPS) guidelines	Complex Regional Pain Syndrome guidelines
Compound drugs coverage decision	Compound drugs coverage decision
Discography guidelines	Discography guidelines
Drug coverage policies	Drug coverage policies on L&I's website
Dry needling and trigger point injections coverage decision	Dry needling and trigger point injections coverage decision
Hyaluronic acid injections	Hyaluronic acid injections coverage decision
Medical foods and co-packs coverage decision	Medical foods and co-packs coverage decision

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If you're looking for more information about…	Then see…
NCPDP payer sheet current version	NCPDP payer sheet
Neurotomy guidelines	Neurotomy guidelines
Opioid Policy	L&I's opioid policy
Outpatient formulary	Outpatient formulary
Payment policies for **acquisition cost policy**	Chapter 7: Durable Medical Equipment (DME)
Payment policies for **global surgery**	Chapter 23: Surgery Services
Payment policies for using **billing code modifier –25**	Chapter 9: Evaluation and Management (E/M) Services
PDL	Drug Formulary Endorsing PDL: Online registration through the Health Care Authority, WA State Endorsing Practitioner Customer Service 1-877-255-4637 Hotline: Open Monday through Friday, 8:00 am to 5:00 pm (Pacific Time) 1-888-443-6798
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Spinal injections coverage decision and guidelines	Spinal injections coverage decision
Therapeutic Interchange Program exception criteria	Therapeutic Interchange Program

If you're looking for more information about…	Then see…
Third Party Pharmacy Supplemental Agreements	Third party pharmacy supplemental agreement form

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 13: Laboratory and Pathology Services

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

Table of Contents

Page

General information: Laboratory and pathology services

The insurer covers certain pathology and laboratory services when needed to treat an accepted condition or establish causal relationship for a condition. Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later. An accident report (Report of Accident, Self-Insurer Accident Report, or Provider's Initial report for self-insured workers) is required before the insurer can pay for testing and treatment. Laboratories cannot file a Report of Accident, Self-Insurer Accident Report, or Provider's Initial report. See Chapter 3 for who can file these forms.

Note: Labs provided for inpatient services are paid through the hospital or ambulatory surgery center. See Chapter 26: Hospitals and Ambulatory Surgery Centers (ASCs) for details.

Prior authorization

Prior authorization is required for certain pathology and laboratory services. See fee schedule and relevant policies for details.

Who must perform these services to qualify for payment

All laboratories must have an L&I provider account number prior to rendering services. Providers drawing specimens in nursing homes, skilled nursing facilities, or homebound patients must have a provider account number. See the Payment Policy: Specimen Collection and Handling for additional details.

All labs must have CLIA accreditation.

Documentation requirements

All laboratories must submit a copy of the lab report to the insurer. The lab report must contain information needed to support services billed, and include:

- What tests were performed,
- What the results were,
- Dates of collection, date specimen was received by the lab, and report date,
- Rendering provider name,
- L&I claim number, *and*
- Referring provider name and contact information.

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Services that aren’t covered

The insurer won’t reimburse pharmacies who provide lab-grown cells to facilities for surgical implant.

Payment policy: Bloodborne pathogens

Prior authorization

The insurer may pay for post exposure testing and treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease.

Authorization of testing and treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later.

The exposed worker must submit an accident report form before the insurer can pay for testing and treatment.

Services that can be billed

For information on which diagnostic tests and procedures are covered, refer to the Professional Services Fee Schedule.

Link: See L&I's coverage decision about post exposure prophylaxis and testing (PEP)..

Treating a reaction to testing or treatment of an exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to covered treatment for a probable exposure.

Covered test protocols

Testing schedule

Testing for hepatitis B, hepatitis C, and HIV should be done:

- At the time of exposure, *and*
- At 3, 6, and 12 months post exposure.

Hepatitis B

For hepatitis B (HBV), the following test protocols are covered:

- HbsAg (hepatitis B surface antigen),
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen),
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C

For hepatitis C (HCV), the following test protocols are covered:

- Enzyme Immunoassay (EIA),
- Recombinant Immunoblot Assay (RIBA),
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services only if HCV is an accepted condition on the claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR),
- Branched chain DNA (bDNA),
- Genotyping,
- Liver biopsy.

HIV

For HIV, 2 blood tests are needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, *and*
- Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test,
- EIA test,
- Western Blot test,
- Immunofluorescent antibody.

The following tests are covered services only if HIV is an accepted condition on the claim:

- HIV antiretroviral drug resistance testing,
- Blood count, kidney, and liver function tests,
- CD4 count,
- Viral load testing.

Covered bloodborne pathogen treatment regimens

When a possible exposure to bloodborne pathogens occur, the insurer will pay for post-exposure prophylaxis (PEP) treatment in accordance with the most recent U.S. Public Health Service Guidelines.

Hepatitis B

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate for PEP.

Chronic hepatitis B

For chronic hepatitis B (HBV):

- Interferon alfa-2b,
- Lamivudine.

Hepatitis C

For hepatitis C (HCV) – acute:

- Mono therapy,
- Combination therapy.

HIV/AIDS

For HIV/AIDS, covered services are limited to those within the most recent guidelines issued by the US Department of Health and Human Services AIDSinfo. Prior authorization isn't required for HIV PEP.

When PEP is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count,
- Renal and hepatic chemical function tests.

Link: The US Department of Health and Human Services AIDSinfo guidelines are available online. For PEP HIV drugs dispensed by a Washington State hospital emergency department, see Chapter 26: Hospitals and Ambulatory Surgery Centers (ASCs). For PEP HIV drugs dispensed through a pharmacy, see Chapter 19: Pharmacy.

Payment policy: COVID-19 testing

Prior authorization

Prior authorization is required for COVID-19 tests.

Requirements for billing

U0002 is only payable to laboratories as outlined by Centers for Medicare and Medicaid Services (CMS).

High-throughput testing may only be performed and billed by pathologists.

Services that can be billed

Lab testing is covered when:

- The worker is receiving treatment or preparing for an invasive procedure that has been approved under the claim, *and*
- The provider requires the test, *and*
- The insurer authorizes the test.

Examples of procedures that may require testing in advance include:

- Approved surgeries, *or*
- Approved dental treatments.

Workers who reside in a nursing home, group home, skilled nursing facility, or are receiving home health at home may have lab testing for COVID-19 provided prior authorization is obtained.

Link: For updates on COVID-19 coverage and code changes, see the MARFS updates and corrections online.

Services that aren’t covered

Lab testing isn’t covered when:

- The provider doesn’t require the test, *or*
- The treatment or procedure hasn’t been approved under the claim, *or*
- The claim manager hasn’t authorized the test, *or*
- The employer has requested testing as a requirement for returning to work.

At-home testing kits aren’t covered for any reason and are not reimbursable to any claim party.

Payment policy: Drug screens

Prior authorization

Definitive testing HCPCs codes **G0480**, **G0481**, **G0482**, and **G0483** require prior authorization.

Services that can be billed

The insurer may pay for drug screening using the following billing codes:

- For presumptive testing billing codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

Billing codes **80305**, **80306**, and **80307** are payable to laboratories with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver.

Payment limits

HCPCS billing codes **G0480**, **G0481**, **G0482** and **G0483** are limited to 1 unit per day per patient encounter regardless of the CLIA status of the laboratory.

Who must perform these services to qualify for payment

The insurer will pay for:

- Drug screening conducted in the office setting by a laboratory with a (CLIA) certificate of waiver, *and*
- Confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

Payment policy: Non-CLIA Waived Testing

Requirements for billing

Complex or moderately complex clinical pathology procedures that aren't waived under the Clinical Laboratory Improvement Act (CLIA) must be performed in laboratories that are accredited or have a categorized status under the State Department of Health or equivalent accrediting body.

Payment limits

Payment for complex and moderately complex clinical pathology procedures won't be paid to any provider that only has a CLIA certificate of waiver or the Provider Performed Microscopic Procedure certificate.

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Payment policy: Panel tests

Services that can be billed

Automated multichannel tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both. Please refer to our fee schedule for code coverage and fees.

Refer to CPT® for a list of automated multichannel tests or panels comprised solely of automated multichannel tests.

Additional information: How to calculate payments

Automated tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient.

Calculate the payment using the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined, *then*
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day, *then*
- Any duplicated tests are denied, *then*
- The total number of remaining unduplicated automated tests is counted.

To determine the payable fee based on the total number of unduplicated automated tests performed, see the following table:

If the number of unduplicated automated tests performed is…	Then the fee is:
1 test	Lesser of the single test or **$11.44**
2 tests	**$11.44**
3-12 tests	**$14.00**
13-16 tests	**$18.71**
17-18 tests	**$20.96**

If the number of unduplicated automated tests performed is…	Then the fee is:
19 tests	**$24.27**
20 tests	**$25.04**
21 tests	**$25.85**
22-23 tests	**$26.61**

Panels with automated and non-automated tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they are priced based on the:

- Automated multichannel test fee based on the number of tests, added to
- Sum of the fee(s) for the individual non-automated test(s).

For example, CPT® code **80061** is comprised of 2 automated multichannel tests and 1 non-automated test. As shown in the table below, the fee for **80061** is **$25.55**.

If the CPT® 80061 component tests is:	And the number of automated tests is…	Then the maximum fee is:
Automated: CPT® **82465** and CPT® **84478**	2	Automated: **$14.00**
Non-automated: CPT® **83718**	n/a	Non-automated: **$11.55**
Maximum payment for CPT® code **80061**:		**$25.55**

Multiple panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be **limited to the total fee allowed for the unduplicated component tests.**

The table below shows how to calculate the maximum payment when:

- **Panel codes 80050**, **80061**, and **80076** are billed with
- **Individual test codes 82977**, **83615**, **84439**, and **85025**.

Test type	CPT® panel codes				Individual tests	Test count	Max fee
	80050	**80061**	**80076**				
Automated tests	**82040**, **82247**, **82310**, **82374**, **82435**, **82565**, **82947**, **84075**, **84132**, **84155**, **84295**, **84450**, **84460**, and **84520**	**82465** and **84478**	**82248** + these duplicated tests: **82040**, **82247**, **84075**, **84155**, **84450**, and **84460**		**82977** **83615**	= 19 unduplicated automated tests (Note the fee in previous table on fees for automated tests)	**$24.27**
	84443		—	—	—	—	**$26.69**
	85025 or **85027** and **85004** or **85027** and **85007** or **85027** and **85009**		—	—	—	—	**$10.96**
	83718		—	—	—	—	**$11.55**
	—		—	—	**84439**	—	**$12.72**

Test type	CPT® panel codes				Individual tests	Test count	Max fee
	80050	**80061**	**80076**				
Non-automated tests	—		—	—	**85025** or **85027** and **85004** or **85027** and **85007** or **85027** and duplicated test **85009**	—	**$10.96**
						Maximum payment:	**$97.15**

Payment policy: Repeat tests

Requirements for billing

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) **must be taken** from separate encounters. Also, the medical necessity for repeating the test(s) **must be documented** in the patient's record.

When billing, modifier **–91** must be used to identify the repeated test(s).

Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests payment policy section of this chapter (above).

Payment limits

Tests normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

Payment policy: Specimen collection and handling

Requirements for billing

Specimen collection

Use HCPCS billing codes:

- **P9612**, which is for “Catheterization for collection of specimen, single patient, all places of service,” *and*
- **P9615**, which is for “Catheterization for collection of specimen(s) multiple patient(s).”

For venipuncture, use CPT® billing code **36415**.

Travel

To bill for actual mileage, use HCPCS code **P9603** (1 unit equals 1 mile).

Services that can be billed

Specimen collection

Complex vascular injection procedures, such as arterial punctures and venisections, aren’t subject to this policy and will be paid with the appropriate CPT® or HCPCS billing codes.

Travel

Travel will be paid in addition to the specimen collection fee when all of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility, or homebound patient, *and*
- The provider personally draws the specimen, *and*
- The trip is solely for collecting the specimen.

Services that aren’t covered

Specimen collection

Specimen collection performed by patients in their homes isn’t paid (such as stool sample collection).

Travel

HCPCS code **P9604** (Travel allowance, 1 way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient, prorated trip charge) isn't covered.

Who must perform these services to qualify for payment

The fee for billed specimen collection services is payable only to the provider who actually draws the specimen.

Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.

Payment limits

Specimen collection

Costs for media, labor, and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection. Payment for performing the test is separate from the specimen collection fee.

A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:

- A throat culture, *or*
- Pap smear, *or*
- A routine capillary puncture for clotting or bleeding time.

Handling

Handling and conveyance won't be paid (for example, shipping, messenger, or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are integral to the process and are **bundled** into the total fee for testing service.

Travel

Travel won't be paid to nursing home or skilled nursing facility staff that performs specimen collection.

If the specimen draw is incidental to other services, no travel is payable.

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Payment policy: STAT lab fees

Requirements for billing

Tests ordered STAT should be limited only to those needed to manage the patient in a true emergency situation. Also:

- The medical record must reflect the medical necessity and urgency of the service, *and*
- The laboratory report should contain the name of the provider who ordered the STAT test(s).

Payment is limited to 1 STAT charge per episode (not once per test).

Services that can be billed

Usual laboratory services are covered under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS codes **S3600** or **S3601**.

Payment limits

The STAT charge will only be paid with these tests:

- HCPCS code **G0306** (Complete CBC, auto w/diff), *or*
- HCPCS code **G0307** (Complete CBC, auto), *or*
- For presumptive testing CPT® codes **80305**, **80306**, or **80307**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481**, **G0482**, or **G0483**.

…with these CPT® billing codes:								
80047	**80184**	**81003**	**82435**	**83874**	**84520**	**85049**	**86880**	**87210**
80048	**80185**	**81005**	**82550**	**83880**	**84550**	**85378**	**86900**	**87281**
80051	**80188**	**82009**	**82565**	**84100**	**84702**	**85380**	**86901**	**87327**
80069	**80192**	**82040**	**82803**	**84132**	**84704**	**85384**	**86902**	**87400**
80076	**80194**	**82150**	**82945**	**84155**	**85004**	**85396**	**86920**	**89051**
80156	**80197**	**82247**	**82947**	**84157**	**85007**	**85610**	**86921**	
80162	**80198**	**82248**	**83615**	**84295**	**85025**	**85730**	**86922**	
80164	**81000**	**82310**	**83663**	**84450**	**85027**	**86308**	**86923**	
80170	**81001**	**82330**	**83664**	**84484**	**85032**	**86367**	**86971**	
80178	**81002**	**82374**	**83735**	**84512**	**85046**	**86403**	**87205**	

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Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
US Department of Health and Human Services AIDS info guidelines	National Institute of Health (NIH) website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services (including pathology and laboratory services)	Fee schedules on L&I's website

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 14: Language Access Services for Spoken Languages

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

Definitions

For this chapter only, the terms listed below have the following definitions:

Appointment: A scheduled encounter between a provider and an injured worker or crime victim.

Authorized interpreter: Interpreter who has passed a screening test from one or more of the organizations below. Since the scope of the screening test isn't as comprehensive as a conventional certified test, those who meet the minimum proficiency requirements are issued an authorization letter in lieu of a certificate. Interpreters must hold an active, up-to-date credential in good standing (not revoked) from one or more of the following organizations:

If the agency or organization is…	Then the credential is a:
Washington State Department of Social and Health Services (DSHS)	Letter of authorization as a qualified social and/or medical services interpreter
Federal Court Interpreter Certification Examination (FCICE)	Letter of designation or authorization

Certified interpreter: Interpreter who holds active, up-to-date credentials in good standing (not revoked) from one or more of the following organizations:

If the agency or organization is…	Then the credential is a:
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate
Washington State Administrative Office for the Courts (AOC)	Certificate
National Board of Certification for Medical Interpreter	Certified Medical Interpreter (CMI)
Certification Commission for Healthcare Interpreters (CCHI)	Certified Healthcare Interpreter
Federal Court Interpreter Certification Test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate

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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.

Encounter: An interpretation service request initiated by the provider or their staff and scheduled by the SOS International LLC (SOSi) which has been completed (not cancelled or re-scheduled) by an LAP.

Encounter fee: A set fee for each encounter where the injured worker or crime victim, provider, and appointment are the same.

Language Access Provider (LAP): Individual providing interpretation services for injured workers or crime victims during medical and vocational visits.

On-demand appointment: Unscheduled appointment where interpretation services are necessary for emergency care, urgent care, or where the medical provider determines that advanced notice isn't feasible. Appointments for treatments which would typically be scheduled in advance don't qualify as on-demand.

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

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General information: All spoken language interpretation services

Purpose of this section

Workers or crime victims who have limited English proficiency or sensory impairments may need interpreter services to communicate effectively with healthcare or vocational providers. This section outlines requirements, expectations, and information applicable to all providers who offer spoken language access services or utilize them for the benefit of workers or crime victims.

This section contains information about:

- The roles and responsibilities of medical and vocational providers,
- The roles and responsibilities of language access providers (LAPs), *and*
- L&I's interpretation services scheduling system, operated by SOSi.

Who the policies in this chapter apply to and when

The policies in this chapter apply to all language access providers (LAPs) for all spoken languages when providing services:

- For healthcare, **independent medical examinations (IMEs)**, and vocational **encounters**,
- In all geographic locations,
- To workers and crime victims having limited English proficiency or sensory impairment, and receiving benefits from:
    - The State Fund, *or*
    - Self-insured employers, *or*
    - The Crime Victims Compensation Program.

Self-insured employers and/or their Third Party Administrators (TPAs) are required to comply with L&I's payment policies and must obtain interpreter services using L&I's contracted vendor.

Note: The policies in this chapter don't apply to sign language interpreters. See Chapter 18: Other Services for sign language interpretation policy.

Information for medical and vocational providers

Avoiding discrimination based on limited English proficiency (LEP) status

Title VII of the Civil Rights Acts of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. This includes discrimination based on limited English proficiency (LEP). As a result, recipients and sub-recipients of Federal financial assistance are responsible for taking reasonable steps to ensure meaningful access by LEP persons to the recipient's and sub-recipient's programs or activities, including the use of an interpreter. **Failure to ensure meaningful access constitutes illegal discrimination and is a violation of an individual's civil rights.**

The Americans with Disabilities Act (ADA) encourages healthcare or vocational providers serving L&I workers or crime victims to consult with the patient to identify appropriate aid or service necessary to treat them effectively. L&I covers the cost of interpretation services for approved interpreters; however, the healthcare or vocational provider is responsible for following the ADA guidance for interacting with individuals with communication challenges.

Determining when an LAP is needed

The healthcare or vocational provider will determine, with input from the worker, if the assistance of an LAP is needed for effective communication to occur.

If assistance is needed, the healthcare or vocational provider will schedule an LAP to provide interpretation during an **appointment**.

Checking claim status prior to obtaining interpretation services

Prior to requesting an LAP, providers must check claim status with the insurer. For State Fund claims, call **1-800-831-5227** for automated updates on claim status. For self-insured claims, contact the Self-insured Employer (SIE) or their Third Party Administrator (TPA).

If the interpretation services are not compensable by L&I, an SIE or their TPA, or the Crime Victims Compensation Program, the provider requesting the interpretation services will be responsible for the cost of the services.

Requesting and selecting an LAP

Visit our website for details on requesting LAPs through SOSi.

The scheduling system is responsible for connecting LAPs with providers who need their services. Providers can choose:

- The time, date, and duration of the interpretation visit,
- The language and dialect of the LAP,

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- The most appropriate method for the visit (in-person, over-the-phone, or video remote), *and*
- The preferred gender of the LAP, at worker's request.

Providers generally can't choose a specific LAP, except in certain situations (see Using the same LAP for multiple visits).

Changing LAPs or interpretation methods

SOSi will make every effort to secure an LAP in the method requested by the provider. However, if SOSi is unable to secure an LAP using the requested method within 48 hours of the scheduled start time for the visit, the system will automatically offer another method as a backup (for example, if video remote is requested but can't be filled, the system will offer over-the-phone and in-person, if available).

If the LAP provided by the scheduling system isn't meeting the interpretation needs of the visit, contact SOSi to provide feedback.

Using the same LAP for multiple visits

Healthcare and vocational providers can't select the same interpreter for every **appointment** scheduled with the worker unless there are extenuating circumstances. Situations in which the same LAP may be used for each **appointment** are limited to the following:

Crime victims

When it is necessary for continuity of care and case familiarity for a **crime victim.**

Mental health treatment by a mental health provider

If the worker has authorized coverage for **mental health** (a mental health condition must be allowed on the claim). The ability to request the same LAP is only for the mental health provider furnishing mental health treatment and/or a diagnosis to a worker, not every provider involved in the worker's care. See Chapter 17: Mental Health Services for information regarding who must perform mental health services to qualify for payment.

Pain management or brain injury program

If the worker is participating in a **pain management program** or a **brain injury rehabilitation program** where having the same LAP is beneficial to the outcome of the program, and the provider is providing services as part of an approved structured intensive pain management program (SIMP) or brain injury rehabilitation program. The program must be insurer-approved and authorized.

Languages of lesser diffusion ("rare" languages)

For workers who require interpretation in a **language of lesser diffusion** (sometimes referred to as a "rare" language). Requests for the same LAP may be allowed on a case-by-case basis and are dependent on availability of the LAP.

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Using unapproved interpreters

As a last resort, if the medical or vocational provider can't find an L&I-approved LAP and no phone or video services are available, they may use non-certified or unapproved interpreters. **The insurer won't pay for these services and strongly discourages their use.**

Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers may provide services to **clients** if the provider determines it is most appropriate for their clinic or facility to employ their own interpreter. The insurer doesn't reimburse interpreters in this case. The provider is responsible for ensuring the interpreter is credentialed and provides meaningful access to the **client**.

Information for language access providers (LAPs)

Professional conduct and ethical guidelines

L&I is responsible for ensuring workers and crime victims receive proper and necessary services. LAPs are expected to adhere to the ethics requirements set forth by their certification or WAC 388-03-050 if the certification the LAP holds doesn't have an ethics component. L&I adopts a modified version of this WAC as the ethics expectation standard for LAPs.

Required credentials

In-state LAPs must hold an active, up-to-date credential in good standing (not revoked) from one or more of the following organizations:

If the **agency or organization** is…	Then the **credential** is a…
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate, or letter of authorization as a qualified social and/or medical services interpreter
Washington State Administrative Office for the Courts (AOC)	Certificate
National Board of Certification for Medical Interpreter (NCMI)	Certified Medical Interpreter (CMI)
Certification Commission for Healthcare Interpreters (CCHI)	Certified Healthcare Interpreter
Federal Court Interpreter Certification Test (FCICE)	Certificate, or letter of designation or authorization
US State Department Office of Language Services	Verification letter or Certificate

LAPs are responsible for maintaining their credentials as required by the credentialing agency or organization. LAPs may only be paid for services in the languages for which they have provided credentials. Provisional certifications aren't accepted. See the Accepted Credentials page on our website for more details.

If the LAP's credentials expire or are revoked for any reason, the LAP must immediately notify the scheduling system vendor. Out-of-state LAPs must immediately notify L&I of the expiration or changes. Bills for services rendered after an LAP's credentials expire or are revoked will be denied.

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Out-of-state interpreters

For out-of-state interpreters, accepted credentials include those from:

- Any organization listed in the table above, *or*
- State credentialing agency or organization equivalent to WA DSHS, *or*
- State Medicaid programs, *or*
- Other nationally recognized programs.

Certifications will be reviewed on a case-by-case basis. Testing must be administered by a third-party organization whose business is to conduct certification for interpreters. L&I reserves the right to review all testing and decline certification if the certificate doesn't meet the minimum criteria.

Identification numbers

All LAPs are required to have a National Provider Identification (NPI) number. NPIs are unique 10-digit numbers used to identify specific providers. To obtain an NPI number, visit the National Plan & Provider Enumeration System website.

LAPs providing services as part of the scheduling system aren't required to have an L&I provider account.

All out-of-state LAPs must have an active L&I provider account. To obtain an L&I provider account number, out-of-state LAPs must submit credentials using the **Submission of Provider Credentials for Interpreter Services** form (F245-055-000). See our Become an Interpreter page for more details.

Additional LAP requirements for hospitals and other facilities

Hospitals, freestanding surgery and emergency centers, nursing homes, and other facilities may apply additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider isn't a contractor or a facility employee.

The facility is responsible for notifying the scheduling system of their additional requirements and managing compliance with the facility's requirements.

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Information about the interpretation services scheduling system

Using the scheduling system

L&I has a contract with SOS International LLC (SOSi) for the scheduling of:

- All on-demand and scheduled in-person interpretation (IPI) services in and near Washington State,
- Video remote interpretation (VRI) throughout the state of Washington and any other state within the United States,
- Over-the-phone interpretation (OPI) services throughout the state of Washington and any other state within the United States, *and*
- OPI services for out-of-country requests.

In order to receive covered language access services, medical and vocational providers must use the scheduling system for all interpretation requests (except out-of-state IPI).

Link: Email L&I's Interpreter Services program for general feedback regarding the scheduling system.

Types of services that can be requested

In-person interpretation (IPI) is on-site interpretation where all individuals specified for the **appointment** are physically present.

Over-the-phone (OPI) is a telecommunication service using telephonic technology hosted by SOSi that utilizes a remote or offsite LAP to provide language access services through an audio-only connection. This includes when some or all parties are located remotely.

Video remote interpretation (VRI) is a video-based interpreting event that utilizes a HIPAA-compliant video telecommunication service hosted by SOSi to connect devices such as web cameras or videophones and utilizes a remote or off-site LAP to provide language access services on screen. This includes when some or all parties are located remotely and includes telehealth **appointments**.

Check-in and check-out procedures

LAPs must check in and check out electronically using SOSi's app or website to ensure their interpretation time is accurately captured.

LAPs should check in at the start time of the **appointment** (unless arriving after the start time, in which case they should check in at the time of arrival). LAPs may only check in 15 minutes before the **appointment** if the **client** shows up early and is checked-in for the **appointment**. LAPs should promptly check out when the **appointment** ends.

The medical or vocational provider may be required to validate that services were rendered by the LAP and confirm the check-in or check-out times logged by the LAP.

Out-of-state in-person interpretation requests

IPI services provided by interpreters working strictly out-of-state and outside the border zip codes that start with 970, 971, 972, 978 in Oregon and 835 or 838 in Idaho are not included in the scheduling system and must be arranged by the provider by contacting the interpreter directly. Resources are available on our website.

International calls

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

Payment policy: Interpretation services

Prior authorization

Interpretation services don't require prior authorization on open claims.

Services that can be billed

The following services and charges are billable:

- Interpretation during the **initial visit**,
- Interpreter services which facilitate language communication between the worker and a healthcare or vocational provider,
- Time spent waiting for an **appointment** that doesn't begin at time scheduled (when no other covered services are being delivered during the **wait time**)
- Up to 15 minutes prior to the scheduled start time of an **appointment** if the LAP and worker are both checked in,
- Services related to the completion of a reopening application (if a claim is reopened, the insurer will determine which services are reimbursable),
- Interpretation during insurer-requested IMEs,
- No-show fees for IMEs, *and*
- Interpretation for family members or guardians of minor workers.

Interpretation services fee schedule

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9902M	**SOSi Encounter Fee**	Payable only to SOSi, once per in-person, video, or over-the-phone interpreter **encounter**.	1 **encounter**	**$14.95** per **encounter**

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9984M	**SOSi in-person interpreter, per minute** Direct service time between the **client** and healthcare or vocational provider.	Scheduled and on-demand in-person interpreter services (IPI) throughout the state of Washington and border zip codes that start with 970, 971, 972, 978 for Oregon, or 835 or 838 for Idaho.	1 minute	**$1.12** per minute
9990M	**SOSi video interpreter, per minute** Direct service time between the **client** and healthcare or vocational provider.	Scheduled and on-demand video remote (VRI) interpreter services throughout the state of Washington and any other state within the United States.	1 minute	**$0.90** per minute
9983M	**SOSi over-the-phone interpreter, per minute** Direct service time between the **client** and healthcare or vocational provider.	Scheduled and on-demand over-the-phone (OPI) interpreter services throughout the state of Washington, any other state within the United States, and out-of-country requests.	1 minute	**$0.72** per minute

Services that aren't covered

Any use of an interpreter who isn't part of the scheduling system and/or hasn't been approved by L&I isn't covered. Bills for services provided by interpreters who aren't part of the scheduling system and don't have active L&I provider account numbers will be denied.

Assisting the worker to complete forms required by the insurer and/or healthcare or vocational provider using **sight translation** isn't a separately billable service.

In addition, the following services and charges aren't covered:

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

Interpretation for legal counsel

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

Requirements for billing

The scheduling system will handle bills for in-state LAPs. SOSi is required to pay LAPs 15 days after receiving payment from the insurer.

Payment limits

Only time spent delivering interpretation services may be billed. Time is counted from when the **appointment** is scheduled to begin or when the interpreter arrives and the worker is present and checked in for the visit, whichever is later, to when the services end. Time spent providing **sight translation** isn't counted separately.

Exception: If the **appointment** starts early, time is counted from when the **appointment** actually begins. For example, the **appointment** is scheduled to start at 8:30 a.m. but interpreter arrives at 8:00 a.m. and **appointment** starts early at 8:15 a.m. Time is counted from 8:15 a.m. when the **appointment** actually started.

Link: Email SOSi for any billing questions regarding services rendered through the scheduling system and registration questions.

Example

The **client** goes to emergency clinic without a prescheduled **appointment**. The provider determines that an in-person LAP is appropriate for this visit due to the sensitivity of the medical services being rendered and submits a request for on-demand in-person LAP. SOSi secures an in-person LAP. However, it will take the LAP 20 minutes to get to the service address. SOSi offers the provider the use of OPI or VRI services until the in-person LAP shows up. The provider accepts the use of OPI services until the in-person LAP shows up.

SOSi will submit one bill to the insurer and include the following charges (if applicable):

- **Encounter fee**
- Actual OPI services rendered (per-minute)
- Actual IPI services (per-minute)

Encounter fees

Surgical **appointments** that exceed 8 hours may require multiple back-to-back interpretation services requests to be submitted in the system. Only in situations where the **encounter** is for more than 8 hours will the insurer compensate SOSi an **encounter fee** for each request.

In cases where the **encounter** is for a **client** who has multiple claims, the insurer will only compensate SOSi for one **encounter fee**. Furthermore, if SOSi secures multiple interpreter services (OPI, VRI, or IPI) or multiple LAPs for the same **encounter**, the insurer will only pay SOSi one **encounter fee**.

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Payment policy: Interpretation services for independent medical exams (IMEs)

Prior authorization

Prior authorization from the insurer is required for **9996M**.

Who must perform these services to qualify for payment

When an IME is scheduled, the IME provider will arrange for interpretation services through SOSi.

Interpreters who accompany the worker without being scheduled by SOSi won't be paid or allowed to interpret at the IME.

Services that can be billed

In addition to the codes outlined in Payment policy: Interpretation services, SOSi or the out-of-state interpreter may bill for a no-show if the **client** fails to appear at an insurer-requested IME.

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9996M	**Interpreter "IME no-show"** **Wait time** when **client** doesn't attend the insurer requested IME, flat fee.	Only 1 no-show per **client** per day.	1 **client** no-show at IME	**$65.37**

Link: For more information, see WAC 296-20-010(5) which states, "L&I or self-insurers will not pay for a missed appointment unless the appointment is for an examination arranged by the department or self-insurer."

Services that aren't covered

Interpretation services provided by persons (including interpreters through SOSi) who meet any of the following criteria aren't covered:

- Those related to the worker or crime victim, *or*
- Those with an existing personal relationship with the worker or crime victim, *or*
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative, *or*

- The employer's legal or lay representative or employees of the legal or lay representative, *or*
- Any person who couldn't be an impartial and independent witness, *or*
- Persons under age 18.

Link: See WAC 296-23-362(3), which states, "The worker may not bring an interpreter to the examination. If interpreter services are needed, the insurer will provide an interpreter."

Payment limits

Only one no-show fee per **client** per day is payable.

For IME panel **appointments** only, provider may request the same LAP for the duration of the **appointment** time. Breaks in the schedule aren't covered by the insurer.

Additional information

If SOSi is unable to fill a request for an LAP and 24 or fewer hours remain before the scheduled **appointment** time, the request will be escalated. Every effort will be made to fill the **appointment** using the requested method (in-person, over-the-phone, or video remote); however, if the request for the desired method can't be filled, SOSi will offer other methods, if available.

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Payment policy: Out-of-state interpretation services

General information

This policy applies to interpretation services rendered outside of Washington State. Interpretation services are covered regardless of the location of the worker.

The rules outlined in General information: All spoken language interpretation services section also apply to out-of-state interpreters.

Services that can be billed

For in-person interpretation services outside of Washington State and outside border zip codes that start with 970, 971, 972, 978 in Oregon and 835 or 838 in Idaho, healthcare or vocational providers must arrange services with a local interpreter. Interpreters must have a unique L&I provider account number and submit an **ISAR** with their bill.

Out-of-state interpretation services fee schedule

Code	Description	Payment limits and authorization requirements	1 unit of service equals…	Maximum fee
9991M	**Out-of-state in-person spoken language interpreter, per minute**	**ISAR** required. Payable to individual interpreters registered with L&I to provide in-person interpreter (IPI) services out-of-state.	1 minute	**$1.12** per minute

Billing requirements

An Interpreter Services Appointment Record (**ISAR**) form (F245-056-000) is required for each visit. All **ISAR** forms must be signed by the healthcare or vocational provider or the provider's staff to verify services. All **ISAR** forms must submitted in the claim file without crossed-out information, comments, or notes in margins.

If the **appointment** involves multiple claims, a separate **ISAR** must be submitted for each claim and the healthcare or vocational provider or their staff must verify services on each **ISAR**.

All services provided to a worker on the same date for the same claim must be billed together. However, a separate **ISAR** must be completed for each visit.

For self-insured claims, contact the employer for their specific billing requirements. See Chapter 2: Information for All Providers for more details about identifying self-insured claims.

Link: For more information about billing, see the General Provider Billing Manual.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for interpreter services	Washington Administrative Code (WAC) 296-20-010(5) WAC 296-23-362(3) WAC 296-23-302
Administrative rules for missed appointments	WAC 296-20-010(5)
Becoming an L&I interpreter provider	Become an Interpreter on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing adjustments	Billing adjustments on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Common Errors on the Interpreter Services Appointment Record (ISAR)	F245-436-000
DES Telephone and Video Interpreter Services contract	Washington State Government DES website
Ethics for Interpreters	WAC 388-03-050
Federal laws relevant to interpreter services	Civil Rights Act of 1964
Fee schedules for all healthcare professional services (including interpreter services)	Fee schedules on L&I's website
How providers **arrange interpreter services**	How to arrange for interpreter services on L&I's website
Interpreter Services Website	Interpreter services
Interpreter Services Appointment Record (ISAR) form	F245-056-000
L&I's **General Provider Billing Manual**	F245-432-000

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If you're looking for more information about…	Then see…
National Provider Identification number	Centers for Medicare and Medicaid Services website
Sign up for **L&I provider news and updates through GovDelivery**	Sign up for GovDelivery
Statement for Miscellaneous Services form	F245-072-000

Need more help?

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Washington State Department of
Labor & Industries

Chapter 15: Lodging, Transportation, and Travel

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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Payment policy: All ambulance services

General information

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

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

Proper facilities

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

To be a place of proper treatment, the facility must:

- Be generally equipped to provide the needed medical care for the worker, *and*
- Have a bed available when inpatient medical services are required.

Who must perform these services to qualify for payment

Ambulance providers may only bill the codes using the table in the “Services that can be billed” section in this specific payment policy.

Ambulance providers can’t bill codes listed in the Taxis, wheelchair van and other transportation services payment policy under their ambulance provider account.

Ambulance providers who separately provide non-medical transportation services (e.g. wheelchair vans) should reference the *Who must perform these services* section under the Payment policy: Taxi, wheelchair van and other transportation services section later on in this chapter.

How mileage is paid

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

Vehicle and crew requirements

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

Key sections of this WAC include:

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

Services that can be billed

HCPCS code	Description	Fee schedule
A0425	Ground mileage, per statute mile	**$15.71** per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	**$778.53**
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	**$808.05**
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	**$425.28**
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	**$680.47**
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	**$6,943.39**
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	**$8,072.69**

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HCPCS code	Description	Fee schedule
A0433	Advanced Life Support, Level 2 (ALS 2)	**$1,169.56**
A0434	Specialty care transport (SCT)	**$1,382.20**
A0435	Fixed wing air mileage, per statute mile	**$38.64** per mile
A0436	Rotary wing air mileage, per statute mile	**$89.79** per mile
A0999	Unlisted ambulance service	**By report** restrictions: 1. Reviewed to determine if a more appropriate billing code is available, *and* 2. Reviewed to determine if medically necessary.

Requirements for billing

Multiple patient transportation

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

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

Payment limits

Multiple patient transportation

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

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

Arrival of multiple providers

When **multiple providers** respond to a call for services:

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

Emergency air ambulance transport

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

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

Non-emergency transport

Only medical providers may arrange for non-emergency ambulance transportation if the following medical necessity requirements are met.

Non-emergency transportation by ambulance is appropriate if:

- The worker is bed confined (unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair) and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated, *or*
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

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

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

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

Note: Workers can't arrange non-emergency ambulance transportation.

Payment policy: Lodging providers

General information

A lodging provider is a company, person, or group offering temporary housing, such as hotels, motels, and other temporary short-term rental locations. This policy describes how lodging providers should document and bill for services provided to claimants (workers and crime victims).

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.

For the purposes of this policy, an authorized companion is a person authorized by L&I to accompany the claimant and share their accommodations for the authorized stay.

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

Note: Routine housekeeping can't be billed separately. These charges are included within the maximum fees for lodging provider reimbursement.

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 26: Rehabilitation Facilities and Programs.

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	**$103.02**

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 above and beyond routine housekeeping for damage to the room, or
- Cancellations made by the **lodging provider**, or
- Any expenses incurred by a claimant'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 above and beyond routine housekeeping for damage to the room, *or*
- Lodging, **meals** and/or fees outside the authorized period or above per diem if worker is notified in advance of the charge.

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**, or billed amount, whichever is less. 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: Mileage and travel expenses for nurse case managers

General information

The mileage and travel expense codes exist to reimburse nurse case managers (NCMs) for costs associated with driving, attending visits with providers and workers, and performing other necessary travel duties while completing a nurse case management referral or annual assessment.

Prior authorization

Mileage

Prior authorization is not required.

Travel expenses

For State Fund, prior authorization from an ONC is required.

For Self-Insurance, prior authorization from the insurer is required.

Failure to obtain prior authorization may result in denial of bills or recoupment of payment.

Services that can be billed

Code	Description and notes	Maximum fee
1224M	**Mileage, per mile**. 1 unit = 1 mile Mileage is paid on a portal-to-portal basis (from your office to the next address related to the referral) and does not include side trips.	State Rate
1225M	**Travel expenses.** Prior authorization is required. NCMs may bill for case-related travel costs resulting from parking, ferries, tolls, cabs, lodging, and airfare. An itemized receipt is required.	By report

Mileage and travel expenses must be incurred while in the course of performing a nurse case management visit (1221M) or billing travel/wait time (1223M) related to an active referral.

Documentation requirements

Mileage

For each trip, submit an invoice to the claim file that includes:

- Worker's name,
- Claim number,
- Travel date and time,
- Starting address,
- Ending address,
- Number of miles, *and*
- Reason for the trip (such as "attend appointment with worker" or "one-on-one visit with provider").

For multiple trips made on the same date of service for the same worker, you may combine all trips into a single invoice and bill, but you must clearly note each trip separately on your invoice.

Separate documentation is required for each date of service. Do not use reports or case notes as documentation for mileage billing.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your documents are properly entered into L&I's systems.

Travel expenses

Submit an itemized receipt to the claim file when billing.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your documents are properly entered into L&I's systems.

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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 **$5.96** per mile.

Services that can’t be billed

1046M isn’t payable to mobile clinics or providers who use mobile clinics for care. For details, see Chapter 24: Telehealth, Remote, and Mobile Services.

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Payment policy: Taxi, wheelchair van and other transportation services

General information

The insurer pays for transportation services when workers require transportation to medical appointments or **Independent Medical Exam**s (IMEs) when an insurer provided trip ticket is given to the provider. These are non-medical (non-ambulance) transportation services.

For workers who require medical transportation services (ambulance), see Payment policy: All ambulance services.

Who must perform these services

The following provider types may provide non-medical transportation:

- Taxis,
- Wheelchair vans (may be known as cabulances),
- Buses, *or*
- Airlines.

Ambulance providers who provide non-medical transportation services (e.g. wheelchair vans) must have a separate provider account to bill the insurer for non-medical transportation services. Such providers must separately bill their usual and customary charges for non-medical transportation services they provide under their appropriate provider account.

Emergency and non-emergency ambulance services must use the procedure codes in Payment policy: All ambulance services.

Prior authorization

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

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Requirements for billing

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

Taxi providers may bill the insurer **1269M** for a worker missed appointment no show for an insurer arranged **Independent Medical Exam** (**IME**) or an insurer arranged **consultation**. For the insurer's authority to reimburse taxi providers for an insurer arranged **IME** or an insurer arranged **consultation** no show, see WAC 296-20-010(5). No other no show fees will be reimbursed by the insurer to taxi providers. A copy of F248-374-000 noting the worker missed the trip as well as a copy of the department provided trip ticket is required for payment. The insurer must confirm the worker missed the arranged trip for an **IME** to reimburse the provider.

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

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

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

Services that aren't covered

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

How mileage is paid

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

Documentation requirements for billing

Taxis

To be eligible to be paid for non-emergent transportation services for workers, the provider must submit F248-374-000. A copy of the department provided trip ticket must be attached to this form to validate the insurer's approval of services.

All other transportation

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

- Claim number
- Worker name (name of worker transported)
- Date of trip
- Pick up time
- Pick up address
- Destination (drop off) address (note that the destination must be the nearest place of proper treatment)
- **Wait time**
- Drop off time
- Driver name (First, Last)
- Driver operator or cab number
- Rates (see WAC 296-20-01002 Definitions - "**By report**")
- Total cost of trip

Note: For transportations other than taxis, a trip ticket (if provider by the department) may be used as an itemized statement.

Services that can be billed

HCPCS Code	Description	Fee schedule
A0100	Taxi, non-emergency	**By report**
A0110	Transportation and bus, intra or interstate carrier, non-emergency	**By report**
A0120	Mini-bus, mountain area transports, or other transportation systems, non-emergency	**By report**
A0130	Wheel-chair van, non-emergency	**By report**
A0140	Air travel (private or commercial) intra or interstate, non-emergency	**By report**
A0170	Transportation ancillary: parking fees, tolls, other	**By report**
0304R	Vocational Retraining Plan Transportation (Taxi)	**By report**
1269M	Taxi no show fee for insurer arranged **Independent Medical Examination (IME)** or insurer arranged **consultation** 1 unit per claimant per day authorized	**$55.55**
1270M	Insurer arranged **Independent Medical Examination (IME)** or insurer arranged **consultation** Transportation (Taxi) Services	**By report**

Note: For all **by report** (BR) procedure codes, providers must bill their usual and customary charges and describe in detail any service rendered. The insurer may adjust reimbursement for BR procedures when such action is indicated. The provider may be required by the insurer to furnish additional documentation to validate any specific charge is part of their usual and customary fees. For the legal definition of **by report** (BR), see WAC 296-20-01002.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for ambulance services	Washington Administrative Code (WAC) 246-976
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers Chapter 21: Reports and Forms
Fee schedules for all healthcare professional services (including ambulance services)	Fee schedules on L&I's website
Payment policy for mobile clinics	Chapter 24: Telehealth, Remote, and Mobile Services

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 16: Medical Testimony

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Medical testimony and depositions

Who arranges testimonies and depositions

The Office of the Attorney General, the self-insured employer (SIE), the state-fund employer, the retrospective rating group, the injured worker, or attorneys representing them makes arrangements with expert witnesses to provide testimony or deposition.

Responsibilities of providers

Any provider who treated or consulted the injured worker, per Chapter 296-20 WAC, or examined the worker at the request of the Department or Self-Insured Employer, per RCW 51.36.070, must:

- Abide by the fee schedule, *and*
- Testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General, the self-insurer, the state fund employer, the retrospective rating group, the injured worker, or attorneys representing them.

Link: For more information, see RCW 51.04.050.

Reasonable availability

The Office of the Attorney General, the self-insurer, the state fund employer, the retrospective rating group, the injured worker, or attorneys representing them and the provider must schedule a reasonable time for the provider's testimony during business hours.

Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeals.

Cancellation fees

If the **cancellation notice** for the testimony or deposition is…	Then the Attorney General/SIE:
3 working days or less than 3 working days before a hearing or deposition	**Will pay a cancellation fee** for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days before a hearing or deposition	**Won't pay** a cancellation fee.

Services that can be billed

The medical witness fee schedule (see below) is set by the Department in **consultation** with the Office of the Attorney General. Whoever schedules the testimony, record review, conference, etc. is responsible for payment pursuant to this fee schedule.

In the fee schedule below, 1 unit equals 15 minutes of actual time spent, rounded up to the nearest unit.

Fee schedule for testimony and related fees

If the service provided by a **doctor**, **attending ARNP, chiropractor, attending physician assistant, or psychologist** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	**$200.00**/unit* (maximum of 17 units)
Record review	**$200.00**/unit* (maximum of 25 units)
Conferences (live or by telephone)	**$200.00**/unit* (maximum of 9 units)
Travel (See note below)	**$200.00**/unit* (maximum of 17 units)

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If the service provided by **all other healthcare providers** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	**$46.00**/unit* (maximum of 17 units)
Record review	**$46.00**/unit* (maximum of 25 units)
Conferences (live or by telephone)	**$46.00**/unit* (maximum of 9 units)
Travel (See note below)	**$46.00**/unit* (maximum of 17 units)

If the service provided by a **vocational provider** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition), regular vocational services Medical testimony (live or by deposition), forensic vocational services	**$46.00**/unit* **$55.00**/unit* (maximum of 17 units)
Record review, regular vocational services Record review, forensic vocational services	**$46.00**/unit* **$55.00**/unit* (maximum of 25 units)
Conferences (live or by telephone), regular vocational services Conferences (live or by telephone), forensic vocational services	**$46.00**/unit* **$55.00**/unit* (maximum of 9 units)
Travel, regular vocational services Travel, forensic vocational services (See note below)	**$46.00**/unit* **$55.00**/unit* (maximum of 17 units)

If the injured worker was examined outside of Washington State and the service provided by a **doctor** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	**$250.00**/unit* (maximum of 17 units)
Record review	**$250.00**/unit* (maximum of 25 units)
Conferences (live or by telephone)	**$250.00**/unit* (maximum of 9 units)
Travel (Justification for travel must be provided in advance to the requesting party. Out of state travel is payable on a case-by-case basis.)	**$250.00**/unit* (maximum of 17 units)

Link: See WAC 296-20-01002 for further details.

Services that aren't covered

Requests for a nonrefundable amount will be denied.

Pre-payment

L&I can't provide pre-payment for any of these services.

Requirements for billing

For testimony or conferences, etc. arranged by the Office of the Attorney General:

- Providers shouldn't use the CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the Office of the Attorney General. State Fund uses a separate voucher **A19 form**, which will be provided to you by the Office of the Attorney General.

For testimony or conferences, etc., arranged by self-insured employers or their attorneys:

- SIEs must allow providers to use CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the SIE/TPA.

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For testimony or conferences, etc. arranged by injured workers, state fund employers, retrospective rating groups, or their attorneys:

- Bills for these services should be submitted directly to the injured worker, the state fund employer, the retrospective rating group, or their attorneys.

Documentation requirements

To be eligible for reimbursement for travel, the provider must submit an itemized statement (invoice) documenting the following:

- Claim number,
- Worker name,
- Date of trip,
- Starting address,
- Ending address,
- Total travel time

Submit this invoice to the Office of the Attorney General, the self-insurer, the state fund employer, the retrospective rating group, the injured worker, or attorneys representing them.

Payment limits

Calculating timed fees

The time calculation for testimony, deposition, or related work performed in the provider's office or by phone is based upon the actual time used for the testimony or deposition. Unit limits can only be exceeded upon prior approval of the party requesting testimony.

Note: If travel is necessary to get to the location of testimony, travel time will be paid from the nearest location the provider provides services to the location of the testimony and back. No side trips will be paid for. If testimony occurs where the provider provides services, telephonically, or via video, no travel time will be paid.

Interpretive services

The party requesting interpretive services for depositions or testimony is responsible for payment.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for definitions	Washington Administrative Code (WAC) 296-20-01002
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services	Fee schedules on L&I's website
Legal statute (Washington State law) for physician or licensed advanced registered nurse practitioner's **testimony not privileged**	Revised Code of Washington (RCW) 51.04.050

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 17: Mental Health and Behavioral Health Interventions (BHI)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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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)	**$46.86**
1401W	Activity Coaching Reassessment	5 units per day 10 units maximum (1 unit = 15 min)	**$45.40**
1402W	Activity Coaching Intervention	4 units per day 40 units maximum (1 unit = 15 min)	**$43.21**
1160M	PGAP® Workbook/EBook/Video	1 maximum	**$114.24**

Telephone calls with worker attorneys

One-on-one telephone calls with a worker's attorney are payable to approved PGAP® Activity Coaches only when:

- The Activity Coach personally participates in the call,
- The participant is the worker's legal representative identified in the claim file,
- The nature of the call includes providing outreach, education, and facilitating services,

- Administrative discussions regarding authorization, resolution of billing issues, and routine requests for appointments aren't covered.

Telephone calls with a worker's attorney by an Activity Coach are payable regardless of when the previous or next office visit occurs.

Required documentation

The required documentation includes:

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

This information can be included in a session note or documented separately.

Code & Description	Limits
1725M PGAP® Attorney Telephone Call	1 unit per provider, per worker, per day, regardless of length of call

Note: For more information on telephonic communication with persons other than the worker's attorney, see the Case management telephone call policy in Chapter 5: Care Coordination. Don't use **1725M** for calls other than one-on-one with the worker's attorney.

PGAP® services via telehealth and audio-only

Activity coaching (PGAP®), including **1400W-1402W** and **1160M**, may be performed in person, via audio-only, or **telehealth**. For more information on coverage and additional requirements for services provided via **telehealth** or audio-only, see Chapter 24: Telehealth, Remote, and Mobile Services.

Services that aren't covered

Voicemails aren't covered, even if a detailed message is left for the recipient.

Payment policy: All mental health services

General information

This policy is applicable to all mental health services. (This doesn't include Behavioral Health Interventions (BHI) or activity coaching (PGAP®)).

When mental health services are performed concurrently with one or more providers, the **attending provider** must coordinate care.

Prior authorization

All outpatient mental health services require prior authorization, unless it is the **initial visit** to open a mental health only claim.

Who the policies in this chapter apply to

The mental health services payment policies in this chapter apply to workers covered by the State Fund and self-insured employers.

The policies related to mental health services in this chapter don't apply to crime victims.

Links: For more information on mental health services for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300.

For information about mental health services policies for the Crime Victims' Compensation Program, see WAC 296-31.

Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

- Psychiatrist (MD or DO),
- Psychiatric Advanced Registered Nurse Practitioner (ARNP); an ARNP who is certified and credentialed as a Psychiatric Mental Health Nurse Practitioner (PMHNP),
- Licensed clinical psychologist (PhD or PsyD), *or*
- Master's Level Therapists (MLTs), limited to Licensed Independent Clinical Social Workers (LICSW), Licensed Marriage and Family Therapists (LMFT), or Licensed Mental Health Counselors (LMHC).

Attending providers are required to join the Medical Provider Network (MPN) and have a provider account number prior to treating a worker, except for initial office or emergency visits per WAC 296-20-015. Effective July 1, 2025, Psychologists are required to join the MPN in order to become an **AP** on a claim or continue treating past the **initial visit**.

Link: For more information regarding provider accounts, see Chapter 2: Information for All Providers, Become a Provider, and Psychologists as Attending Providers, on our website.

Service	Psychiatrist (MD/DO)	Psychiatric ARNP	Psychologists (PsyD/ PhD)	MLTs
Attending Provider	Yes	Yes	Yes, for mental health only claims	**No**
Mental health evaluation	Yes	Yes	Yes	**No**
Psychotherapy	Yes	Yes	Yes	Yes
Prescribing psychotropic medications	Yes	Yes	**No**	**No**
Consultations for mental health conditions, including in lieu of an **IME**	Yes	Yes	Yes	**No**
Neuropsychological testing & evaluation	**No**	**No**	Yes	**No**
Psychological testing & evaluation	Yes	**No**	Yes	**No**
Narcosynthesis/ Electroconsulsive therapy	Yes	**No**	**No**	**No**
Transcranial Magnetic Stimulation (TMS)	Yes	Yes	**No**	**No**
Eligible IME Examiner	Yes	**No**	**No**	**No**
Impairment Rating/ Permanent Partial Disability	Yes	**No**	**No**	**No**

Mental health providers as attending providers (APs)

A mental health provider may only be an **attending provider** on a claim when the insurer has an accepted psychiatric condition and it is the only condition being treated, commonly referred to as mental health only claims. Mental health only claims don't include those that have previously had a physical condition, which has since been resolved or claims with a concurrent physical condition.

Attending providers can complete the Report of Accident (ROA), time loss certification and other reports and forms applicable to **APs**. For more information on who can be an **AP** and what forms are applicable, see WAC 296-20-01002, Chapter 21: Reports and Forms, and Chapter 3: Attending Providers.

Master's Level Therapists (MLTs)

Mental health evaluation (CPT® **90791** or **90792**) isn't covered when provided by Licensed Independent Clinical Social Workers (LICSW), Licensed Marriage and Family Therapists (LMFT), and Licensed Mental Health Counselors (LMHC), even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. These providers may provide treatment only, after the worker has seen a a psychiatrist (MD/DO), psychiartric ARNP, or psychologist (PhD, PsyD) for evaluation.

Psychological and Neuropsychological testing & evaluation

Qualified technicians (such as a psychometrist) may administer psychological or neuropsychological testing and scoring under the supervision of a provider qualified to administer the evaluation. The psychiatrist or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*
- Bill for the psychological or neuropsychological test administration and scoring performed by their qualified technicians.

Links: For more information and requirements for mental health testing, see the Psychological and Neuropsychological testing and evaluation policies in this chapter.

Services that can be billed

Interactive complexity

The add-on code for interactive complexity (CPT® **90785**) is only payable according to the limits found in CPT®. It isn't payable solely for the use of a language access provider. Documentation must include an explanation of the increased complexity and why it is required for proper treatment. Must be billed with CPT® code **90791**, **90792**, **90832**, **90833**, **90834**, **90836**, **90837**, **90838**, or **90853**.

Mental health services via telehealth and audio-only

Audio-only treatment is limited to mental health evaluation (CPT® **90791**) and psychotherapy services only. Mental health services may be performed via **telehealth** in most circumstances. For more information on coverage and additional requirements for

services provided via **telehealth** or audio-only, see Chapter 24: Telehealth, Remote, and Mobile Services.

Case management services

Psychiatrists, psychiatric ARNPs, licensed clinical psychologists, and MLTs are eligible to bill for case management services (telephone calls, team conferences, and online communications), but only when mental health services are authorized. For more information on restrictions and requirements, see Chapter 5: Care Coordination.

Rehabilitation facilities and programs

For more information on mental health rehabilitation facilities and programs, see Chapter 27: Rehabilitation Facilities and Programs.

Links: Brief emotional/behavioral screens and risk assessments (CPT® **96127**) aren't covered with other mental health CPT® codes, such as psychotherapy and mental health evaluations. For more information, see Chapter 21: Reports and Forms.

Services that aren't covered

Tests and measures, such as the Mini Mental State Examination (MMSE) and Minnesota Multiphasic Personality Inventory (MMPI) performed in isolation without additional testing aren't separately billable from an evaluation.

Psychologists can't bill E/M CPT® codes for mental health evaluations or **consultations**. They must use mental health evaluation CPT® code **90791**.

MLTs can't perform or bill for mental health evaluations or **consultations**.

App-based and texting therapy, such as Better Help, Talkiatry, Talkspace, and other similar services aren't covered.

Requirements for billing

Mental health providers must follow the reporting requirements in CPT® for the service billed.

Documentation requirements

Mental health providers are required to submit documentation to the insurer and the **attending provider**.

As outlined in Chapter 2: Information for All Providers, the insurer requires the addition of ER (Employment and Restrictions) to the SOAP format. Chart notes must document the worker's status at the time of each visit. In addition, documenation must also include the requirements in the following locations:

- Mental Health Services: Authorization & Reporting webpage
- Chapter 2: Information for All Providers
- Specific service documentation requirements in the appropriate payment policy.

Mental health providers must submit documentation on the following schedule:

Frequency	Documentation	Additional Information
Every visit	Chart notes	Must contain all required information, as noted above, in order for the insurer to make appropriate decisions regarding coverage and payment.
Every 30 days	Report	A separate report is required and payable only upon request from the insurer when treating an unrelated mental health condition that is impacting recovery for an accepted condition (see WAC 296-20-055). **This report isn't required if this information is clear and submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements.
Every 60 days	Report	A separate report is required and payable only upon request from the insurer when treating an accepted mental health condition when chart notes don't contain enough information to provide a clear picture of progress. **This report isn't required if this information is clear and submitted within visit chart notes.** Refer to Mental Health Authorization and Reporting for report requirements and WAC 296-20-06101.

Payment limits

These following CPT® codes and their services are **bundled** and aren't payable separately:

- **90885**,
- **90887**,
- **90889**.

99080 is payable only when requested by the insurer. Interval reports (30 and 60 days) shouldn't be requested if the information is clear and included in chart notes submitted for treatment.

Split billing

When evaluating and/or treating 2 or more separate conditions that aren't related to the same claim at the same visit, the split billing policy applies.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Payment policy: Behavioral health interventions (BHI)

General information

Behavioral health interventions (BHI), also known as Health Behavior Assessment and Interventions, are 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.

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 cannot 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 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. For details, see the mental health policies in this chapter and the Treating Mental Health Conditions webpage.

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

Who this policy applies to

This policy on BHI applies to workers covered by the State Fund and self-insured employers.

The policies related to mental health services and BHI in this chapter don't apply to crime victims.

Links: For more information on mental health services for State Fund and self-insured claims, see WAC 296-21-270 and WAC 296-14-300.

For information about mental health services policies for the Crime Victims' Compensation Program, see WAC 296-31.

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 and may only hold one role on a claim. 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.

Prior authorization

Prior authorization is not required for BHI for the first 16 visits. Prior authorization is required for additional individual BHI visits.

Services that can be billed

BHI may be performed in-person or via **telehealth**. For more information on coverage and additional requirements for services provided via **telehealth**, see Chapter 24: Telehealth, Remote, and Mobile Services.

CPT® Code(s)	Description and notes
96156 **96158, +96159**	**Assessment, Re-assessment, and Individual Behavioral Health Interventions (BHI)** No prior authorization required. Combined maximum of 16 visits per worker for assessments and individual BHI. 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 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 27: Rehabilitation Facilities and Programs 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. **Evaluation and Management (E/M) Service** BHI is a **bundled** service when performed as part of an evaluation and management (E/M) service. See Chapter 9: Evaluation and Management (E/M) for details.

For online communications and other case management services, see Chapter 5: Care Coordination.

Services that aren't covered

Services beyond 16 visits per worker aren't covered, unless prior authorization is obtained for 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 the All mental health services policy in this chapter for details on treating mental health conditions. If a mental health condition has been accepted or denied on a claim, BHI isn't appropriate and can't be billed. Don't perform or bill for BHI on claims with accepted or denied mental health conditions.

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

- **90885**,
- **96130**-**96131**,
- **96136**-**96137**,
- **96160**,
- **96161**,
- **96170**-**96171**, *and*
- **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 Master's Level Therapist (MLT) such as a 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 not performed on the same day as BHI.
An **attending provider** (except psychologists) or a **consultant**	The appropriate evaluation and management service (E/M) CPT® code(s), within their scope of practice. Stand-alone BHI follows the same limits as MLTs and psychologists above.

Link: For more information on E/M services, see Chapter 9: Evaluation and Management (E/M).

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 9: Evaluation and Management (E/M) 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: Mental health consultations and evaluations

General information

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Authorized mental health **consultations** and evaluations must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP),
- Licensed clinical psychologist (PhD or PsyD).

Prior authorization

Prior authorization is required for all mental health services, unless it is the **initial visit** to open or reopen a mental health only claim. This requirement includes referrals for mental health **consultations** and evaluations.

Services that can be billed

When an authorized mental health referral is made to an appropriate provider, they may bill:

CPT® Code	Description	Psychiatrist (MD/DO)	Psychiatric ARNP	Psychologist (PhD/PsyD)	MLT
90791	Psychiatric diagnostic evaluation	Yes	Yes	Yes	**No**
90792	Psychiatric diagnostic evaluation, with medical services	Yes	Yes	**No**	**No**
Appropriate E/M code	Evaluation and Management (E/M) service	Yes	Yes	**No**	**No**

Mental health providers with E/M in their scope of practice (psychiatrists, psychiatric ARNPs) may choose to bill either psychiatric diagnostic evaluation CPT® codes or the appropriate level evaluation and management (E/M) service, based on what is most reflective of the service provided. Psychologists must bill CPT® **90791**.

Telehealth and audio-only

Some **telehealth** mental health services are covered. Audio-only mental health services are covered in limited circumstances. For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

Mental health evaluation codes (CPT® **90791**) may be used for initial and periodic evaluations, mental health **consultations**, evaluations to satisfy the 6-month in-person requirement, or as a precursor to more comprehensive psychological testing and evaluation.

Services that aren't covered

Master's level therapists (MLTs) can't evaluate or consult on a mental health evaluation. MLTs must refer to a psychiatrist, psychiatric ARNP, or a psychologist for these services.

MLTs aren't authorized to provide mental health evaluations. CPT® **90791**, **90792**, and E/M services aren't covered for MLTs.

Requirements for billing

All mental health **consultations**, regardless of CPT® code billed, must follow the requirements outlined in the **Consultations** policy in Chapter 3: Attending Providers.

Mental health providers using E/M CPT® codes to bill for their services must also follow the requirements outlined in Chapter 9: Evaluation and Management (E/M).

Telehealth 6 month in-person requirement

Once every 6 months, workers receiving **telehealth**-based mental health care must receive an in-person mental health evaluation to continue **telehealth**-based mental health care.

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for an in-person evaluation to satisfy the 6-month in-person visit requirement.

Documentation requirements

Chart notes and reports must contain documentation that justifies the level, type and extent of services billed. For details, see the Mental Health Services: Authorization & Reporting webpage.

Services must be documented using the SOAPER format as described in Chapter 2: Information for All Providers.

Payment limits

Psychiatric diagnostic evaluation CPT® codes **90791** and **90792** are limited to 1 occurrence every 6 months, per worker, per provider.

Evaluation and Management (E/M) services are limited to 1 per worker, per provider, per day.

When a psychiatric diagnostic evaluation (CPT® **90791**, **90792**) is performed as a stand-alone service, in the absence of a corresponding psychological testing & evaluation episode, it includes test administration, scoring, interpretation, and report. In these instances, test administration codes (CPT® **96136**-**96139**, **96146**) can't be billed.

CPT® codes **90791** and **90792** can't be billed with neuropsychological testing & evaluation episodes (CPT® **96132**-**96133**).

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Payment policy: Narcosynthesis and electroconvulsive therapy

Prior authorization

Prior authorization applies for all mental health services. Narcosynthesis and electroconvulsive therapy require additional prior authorization.

Who must perform these services to qualify for payment

Authorized services are payable only to psychiatrists.

Services that can be billed

Use CPT® codes **90865** (narcosynthesis) and **90870** (electroconvulsive therapy).

Link: For more information, see L&I's coverage decision for electroconvulsive therapy.

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Payment policy: Neuropsychological testing and evaluation

General information

Neuropsychological testing and evaluation consists primarily of individually administered tests that comprehensively sample domains that are known to be sensitive to the functional integrity of the brain.

Neuropsychological testing involves administration of standardized tests, for intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensoriomotor function, emotional and personality features, and/or adaptive behavior to evaluate the worker's neurocognitive function. The assumption is that these processes have been altered due to a change in the worker's neurological condition as a result of their injury.

The specific tests required to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

These codes aren't appropriate when simply administering and/or scoring screening questionnaires, such as a PHQ-9, GAD-7, or PCL-5. See the Brief Emotional/Behavioral Screens & Risk Assessments policy in Chapter 21: Reports and Forms.

Note: Additional resources for service requirements may be available from the American Medical Association, Centers for Medicare and Medicaid Services (CMS), or professional psychological associations.

See the Psychological testing and evaluation policy in this chapter for details on psychological testing.

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Only a neuropsychologist (PhD or PsyD) may provide neuropsychological testing and evaluation.

Qualified technicians (such as a psychometrist) supervised by a neuropsychologist may administer neuropsychological testing and scoring. The neuropsychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*

- Bill for the neuropsychological test administration and scoring performed by their technicians.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform neuropsychological testing and evaluation services. When requesting authorization, providers must provide an explanation to support the need for more comprehensive testing than can be provided as part of a neurobehavioral status exam.

Only 1 type of testing (neuropsychological or psychological) will be authorized at a time. There is a limit of 1 episode of each type of testing per worker, per claim.

Requirements for billing

Neuropsychological testing and evaluation will be considered for authorization when it is medically necessary based on one or more of the following indications:

- Cognitive or behavioral deficits related to known or suspected central nervous system impairment, trauma, or neuropsychiatric disorders (such as traumatic brain injury, brain hypoxia, or due to toxic or chemical exposures),
- A treatment plan is required to measure functional abilities or impairments in individuals with known or suspected central nervous system impairment,
- Substance impact on cognitive impairment,
- Pre-surgery or treatment-related measurements of cognitive function to determine if it's appropriate to proceed with a medical or surgical procedure (such as deep brain stimulation, epilepsy surgery, stem cell or organ transplant) that may affect brain function,
- Determine through measurement of cognitive abilities if a worker's medical condition impairs their ability to comprehend and participate in treatment regimens, or to function independently after treatment,
- Testing the outcomes of cognitive rehabilitative procedures, *or*
- Evaluate primary symptoms of impaired attention and concentration that can occur due to neurological or psychiatric conditions.

Neuropsychological evaluations and neurobehavioral status examinations may be completed via **telehealth**, however, test administration and scoring must be performed in person. Direct supervision of technicians via **telehealth** isn't covered (modifier **–FR**). For more information, see Chapter 24: Telehealth, Remote, and Mobile Services.

Note: Occupational therapists (OT) or Speech Language Pathologists (SLP) may provide standardized cognitive performance testing (CPT® **96125**) to assist in identifying the worker's baseline function and treatment strategies. Formal neuropsychological testing may be referred to licensed clinical neuropsychologist (PhD or PsyD).

Services that can be billed

A single neuropsychological testing and evaluation episode of care includes separate services: a precursor evaluation (CPT® 96116, 96121), if necessary, the evaluation (CPT® 96132-96133), and test administration and scoring (CPT® 96136-96139, 96146). Each part of the episode is described below in more detail.

Neurobehavioral status examination (precursor evaluation)

A neurobehavioral status examination may be performed in-person or via **telehealth** prior to neuropsychological testing and evaluation as part of the episode of care, if necessary, to perform a clinical interview and/or to help determine what type of tests are needed and develop a plan for administration. This type of evaluation may also be performed as a stand-alone service in the absence of a corresponding neuropsychological testing & evaluation episode.

CPT® code(s) and Description	Additional information	Limit
Neurobehavioral Status Examination **96116** (1st hour) **+96121** (each additional hour)	May be completed independent of or **prior to neuropsychological testing** in-person or via **telehealth**. As a stand-alone service, this examination includes test administration, scoring, interpretation, and report, though it is insufficient to diagnose mild cognitive impairment. Mini mental state examinations (MMSE), MoCA cognition or other similar tests, when done without additional neurobehavioral testing, don't meet the definition of CPT® **96116** or **96121**.	**Up to a 4-hour maximum**; 1 unit of **96116**, 3 units of **96121.** Separate from limits for neuropsychological evaluation & testing. Can't be billed with psychological evaluation & testing.

Neuropsychological evaluation

Neuropsychological evaluation may be completed in-person or via **telehealth** and includes:

- Record review, *and*
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, *and*
- Clinical decision making, *and*
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), *and*
- Creation of a clinical report, *and*
- Treatment planning, *and*
- Interactive feedback to worker, and if appropriate the family member(s) or caregiver(s).

Note: Neuropsychological evaluation codes don't include test administration and scoring.

CPT® code(s) and Description	Additional information	Limit
Neuropsychological Evaluation **96132** (1st hour) **+96133** (each additional hour)	The assumption is that the processes being examined have been altered due to a change in a neurological condition as a result of the worker's injury.	**Up to an 8-hour maximum**; 1 unit of **96132**, 7 units of **96133.** Separate from limits for precursor evaluation & testing.

Test administration & scoring

Test administration and scoring are separately billable from the evaluation and include the administration and scoring of 2 or more tests performed on same or different days. This set of codes are applicable to neuropsychological and psychological testing services.

Tests must be administered in compliance with the rules and manuals provided by the test manufacturer and must be performed in-person.

Bill only 1 type of test administration and scoring codes (by provider, by qualified technician, or electronic platform) per episode. When testing is provided by a combination of these types, only the lowest level of testing can be billed. For example, if some testing & scoring was performed by a provider and the rest by a qualified technician, they must bill for the total test administration and scoring time under the technician CPT®

codes. Test administration and scoring must be billed by the neuropsychologist, regardless of who administered the tests.

Note: Test administration and scoring doesn't include interpretation of results. The interpretation must be performed by a qualified provider and is included in the neuropsychological evaluation (CPT® **96132**, **96133**).

CPT® code(s) and Description	Additional information	Limit
Test administration & scoring by a qualified provider **96136** (1st 30 minutes) **+96137** (each additional 30 minutes)	Neuropsychologist personally performs the test administration and scoring.	**Up to an 8-hour maximum**; 1 unit of **96136**, 15 units of **96137.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with technician or automated testing.
Test administration & scoring by a qualified technician **96138** (1st 30 minutes) **+96139** (each additional 30 minutes)	The neuropsychologist must bill and is responsible for supervision and evaluation of the tests (test selection, data oversight, clinical interview, feedback session, interpretation and analysis, reporting and **consultation**).	**Up to an 8-hour maximum**; 1 unit of **96138**, 15 units of **96139.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or automated testing.

CPT® code(s) and Description	Additional information	Limit
Test administration & scoring by electronic platform (automated) **96146**	Automated testing via an electronic platform, such as a computer, which includes automatic generation of results.	**1 unit, per worker, per episode of care**. Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or technician testing.

How to bill for neuropsychological evaluation & testing

All services performed as part of neuropsychological evaluation and testing are billed as a single episode of care (package). In order to ensure appropriate reimbursement, providers must bill according to the following guidelines:

- All services provided during the episode of care must be submitted on the **same bill**,
- All services on the bill must have the **same date of service**, which is the last day any work was completed for that episode of care. Don't bill using a range or different dates of service for each code, even if the episode of care was spread out over multiple days,
- Service **time and units are cumulative over the episode of care**, even if the episode is spread out over multiple visits. In order to bill 1 unit of service, total time must exceed the half way point for the codes time descriptor.
- **Time is calculated for each service (CPT® code) separately and can't be included in the time spent performing other billable services.** For example, test administration (CPT® **96136-96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under neuropsychological testing evaluation (CPT® **96132-96133**).

Example

A worker presents to a neuropsychologist's office for neuropsychological testing and evaluation. The evaluation and testing was completed over several days, including a neurobehavioral status examination related to the episode of care. This example is intended to assist in understanding proper billing of these services. Each episode of care will vary depending on the individual worker's condition. The following shows this scenario broken down by task and how it would be billed.

Date of Service	Service(s) Provided (CPT®)	Description	Time
07/01/2025	Neuropsychological evaluation (**96132**/**96133**)	Record review and preliminary test selection.	**30 minutes**
07/01/2025	Neurobehavioral status exam (**96116**/**96121**)	Clinical interview via **telehealth**.	**75 minutes**
07/01/2025	Neuropsychological evaluation (**96132**/**96133**)	Modification of test selection based on neurobehavioral status exam via **telehealth**.	**10 minutes**
07/02/2025	Test administration & scoring by the provider (**96136**/**96137**)	In-person administration of series of tests. Recording of behavioral observations during testing. Scoring and transcribing of scores into data summary.	**195 minutes**
07/03/2025	Neuropsychological evaluation (**96132**/**96133**)	Integration of relevant clinical data and interpretation of testing results. Report generation.	**120 minutes**
07/05/2025	Neuropsychological evaluation (**96132**/**96133**)	Interactive feedback with the worker via **telehealth**.	**65 minutes**

Total time for the episode of care was **8 hours and 75 minutes**; neurobehavioral status exam 75 minutes (**1 hour and 15 minutes**), neuropsychological evaluation 225 minutes (**3 hours and 45 minutes**), and test administration and scoring 195 minutes (**3 hours and 15 minutes**).

The provider finalized the report on July 5, 2024, which is the last day work was completed on this episode of care. Correct billing for the services documented is:

- 07/05/2025 – **96116** (Neurobehavioral status exam) **–GT** x 1 unit,
- 07/05/2025 – **96132** (Neuropsychological evaluation) **–GT** x 1 unit,
- 07/05/2025 – **96133** (Neuropsychological evaluation, add-on) **–GT** x 3 units,
- 07/05/2025 – **96136** (Test administration & scoring by provider) x 1 unit, *and*
- 07/05/2025 – **96137** (Test administration & scoring by provider, add-on) x 5 units.

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Note: Neurobehavioral status exams (CPT® **96116, 96121**) have separate limits from the evaluation and testing codes. For limits, see the Neurobehavioral status examination section above.

Services that aren't covered

Psychiatric diagnostic evaluations (CPT® **90791**) can't be billed with neuropsychological evaluation and testing.

Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- **The duration of each service provided (such as neurobehavioral status examination, neuropsychological evaluation, and test administration and scoring),**
- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or **independent medical exam**iner (**IME**),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores,
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *and*
    - Test materials such as:
        - Test protocols,
        - Manuals,
        - Test items,

    - Scoring keys or algorithms, *and*
    - Any other materials considered secure by the test developer or publisher.
- Integration of sources of information (such as summary and impressions),
- Diagnosis, *and*
- Treatment recommendations and planning.

Note: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

Payment policy: Pharmacological evaluation and management

Prior authorization

All mental health services require prior authorization.

Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs.

Services that aren't covered

Pharmacologic management with psychotherapy using CPT® **90863**.

Requirements for billing

Services conducted on the same day

When a pharmacological evaluation is conducted on the same day as psychotherapy, the psychiatrist or psychiatric ARNP can bill:

- One of the add on psychotherapy codes (CPT® **90833**, **90836**, or **90838**) *and*
- Appropriate level evaluation and management (E/M) service.

Services not conducted on the same day

When a pharmacological evaluation is the only service conducted on a given day, the provider must bill the appropriate E/M code.

Links: See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Payment policy: Psychological testing and evaluation

General information

Psychological testing is intended to test general psychological processes which are assumed to have an emotional, behavioral, environmental, and/or health etiology but are not directly mediated by the central nervous system as result of the worker's injury.

Psychological testing involves administration of several types of psychometrically standardized tests for measuring emotional and interpersonal functioning, intellectual functioning, thought processes, personality and psychopathology. A mini mental state examination (MMSE) or MoCA cognition or similar tests may be appropriate but can't be the only tests performed.

The specific tests a worker requires to complete the evaluation is at the discretion of the provider, but requires a minimum of 2 tests.

These codes aren't appropriate when simply administering and/or scoring screening questionnaires, such as a PHQ-9, GAD-7, or PCL-5. See the Brief Emotional/Behavioral Screens & Risk Assessments policy in Chapter 21: Reports and Forms.

Note: Additional resources for service requirements may be available from the American Medical Association, Centers for Medicare and Medicaid Services (CMS), or professional psychological associations.

See the Neuropsychological testing and evaluation policy for details on neuropsychological testing.

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Only psychiatrists (MD or DO) or licensed clinical psychologists (PhD or PsyD) may provide psychological testing.

Qualified technicians (such as a psychometrist) supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing and scoring. The psychiatrist or licensed clinical psychologist must:

- Interpret the results, *and*
- Prepare the reports, *and*
- Bill for the psychological test administration and scoring performed by their technicians.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required to perform psychological testing services. When requesting authorization, providers must provide an explanation to support the need for more comprehensive testing than can be provided as part of a psychiatric diagnostic evaluation.

Only 1 type of testing (neuropsychological or psychological) will be authorized at a time. There is a limit of 1 episode of each type of testing per worker, per claim.

Requirements for billing

Psychological testing and evaluation will be considered for authorization when it is medically necessary based on one or more of the following indications:

- To aid in determining psychological disorder and its severity and functional impairments; to determine a psychiatric diagnosis when a mental health condition is suspected; or to achieve a differential diagnosis from a range of medical or psychological disorders that present with similar symptoms,
- Measure behavioral factors that impact disease management, including but not limited to: pre-surgical evaluation, assessment of emotional or personality factors impacting physical disease management, assessment of psychological factors in chronic pain workers, or adherence to treatment regimens,
- Measure functional capacity to delineate specific cognitive, emotional or behavioral bases of functional complaints or disability,
- Measure psychological barriers and strengths to aid in treatment planning,
- Measure risk factors to determine a workers' risk of harm to self and/or others,
- Perform symptom measurement to objectively measure treatment effectiveness, and/or determine the need for referral for pharmacological treatment,
- Measure and confirm or refute clinical impressions obtained from interactions with the worker, *or*
- Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions.

Psychological evaluations and psychiatric diagnostic evaluations may be completed via **telehealth**, however, test administration and scoring must be performed in person. Direct supervision of technicians via **telehealth** isn't covered (modifier **–FR**). For more information see Chapter 24: Telehealth, Remote, and Mobile Services.

Note: Any one of these could be encompassed into a standard mental health evaluation (CPT® **90791**, **90792** psychiatric diagnostic evaluation). Psychological testing & evaluations

include more comprehensive tests and typically a larger question than what can be answered in a psychiatric diagnostic evaluation.

Services that can be billed

A single psychological testing and evaluation episode of care includes separate services; a precursor evaluation (CPT® 90791), if necessary, the evaluation (CPT® 96130-96131), and test administration and scoring (CPT® 96136-96139, 96146). Each part of the episode is described below in more detail.

Psychiatric diagnostic evaluation (precursor evaluation)

A psychiatric diagnostic evaluation may be performed in-person or via **telehealth** prior to psychological testing and evaluation as part of the episode of care, if necessary, to perform a clinical interview and/or to help determine what type of tests are needed and develop a plan for administration. This type of evaluation may also be performed as a stand-alone clinical interview in the absence of a corresponding psychological testing & evaluation episode.

CPT® code(s) and Description	Additional information	Limit
Psychiatric Diagnostic Evaluation **90791**	May be completed independent of or **prior to psychological testing** evaluation. As a precursor to a psychological testing & evaluation episode, this might include the clinical interview and various screening measures.	**1 occurrence every 6 months, per worker, per provider.** Separate from limits for evaluation & testing. Can't be billed with neuropsychological evaluations.

Psychological evaluation

Psychological evaluation may be completed in-person or via **telehealth** and includes:

- Record review, *and*
- Test selection, at the provider's discretion based on the individual worker's need, goals of the evaluation, and clinical decision making during the evaluation, *and*
- Clinical decision making, *and*
- Interpretation and integration of test results with other sources of clinical data (including relevant history and collateral information from other sources), *and*
- Creation of a clinical report, *and*

- Treatment planning, *and*
- Interactive feedback to worker, and if appropriate the family member(s) or caregiver(s).

Note: Psychological evaluation codes don't include test administration and scoring.

CPT® code(s) and Description	Additional information	Limit
Psychological Evaluation **96130** (1st hour) **+96131** (each additional hour)	The assumption is that the processes being examined have an emotional, behavioral, environmental and/or health etiology related to the worker's injury but are not directly mediated by the central nervous system.	**Up to an 8-hour maximum**; 1 unit of **96130**, 7 units of **96131.** Separate from limits for precursor evaluation & testing.

Test administration & scoring

Test administration and scoring are separately billable from the evaluation and include the administration and scoring of **2 or more tests** performed on same or different days. This set of codes are applicable to neuropsychological and psychological testing services.

Tests must be administered in compliance with the rules and manuals provided by the test manufacturer and must be performed in-person.

Bill only 1 type of test administration and scoring codes (by provider, by qualified technician, or electronic platform) per episode. When testing is provided by a combination of these types, only the lowest level of testing can be billed. For example, if some testing & scoring was performed by a provider and the rest by a qualified technician, they must bill for the total test administration and scoring time under the technician CPT® codes. Test administration and scoring is billed under the psychiatrist or psychologists, regardless of who administered the tests.

Note: Test administration and scoring doesn't include interpretation of results. The interpretation must be performed by a qualified provider and is included in the psychological evaluation (CPT® **96130**, **96131**).

CPT® code(s) and Description	Additional information	Limit
Test administration & scoring by a qualified provider **96136** (1st 30 minutes) **+96137** (each additional 30 minutes)	Neuropsychologist, psychologist, or psychiatrist personally performs the test administration and scoring.	**Up to an 8-hour maximum**; 1 unit of **96136**, 15 units of **96137.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with technician or automated testing.
Test administration & scoring by a qualified technician **96138** (1st 30 minutes) **+96139** (each additional 30 minutes)	The qualified provider must bill and is responsible for supervision and evaluation of the tests (test selection, data oversight, clinical interview, feedback session, interpretation and analysis, reporting and **consultation**).	**Up to an 8-hour maximum**; 1 unit of **96138**, 15 units of **96139.** Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or automated testing.
Test administration & scoring by electronic platform (automated) **96146**	Automated testing via an electronic platform, such as a computer, which includes automatic generation of results.	**1 unit, per worker, per episode of care**. Separate from limits for precursor evaluation & neuropsychological evaluation. Can't be billed with provider or technician testing.

How to bill for psychological evaluation & testing

All services performed as part of neuropsychological evaluation and testing are billed as a single episode of care (package). In order to ensure appropriate reimbursement, providers must bill according to the following guidelines:

- All services provided during the episode of care must be submitted on the **same bill**,
- All services on the bill must have the **same date of service**, which is the last day any work was completed for that episode of care. Don't bill using a range or different dates of service for each code, even if the episode of care was spread out over multiple days,
- Service **time and units are cumulative over the episode of care**, even if the episode is spread out over multiple visits. In order to bill 1 unit of service, total time must exceed the half way point for the codes time descriptor,
- **Time is calculated for each service (CPT® code) separately and can't be included in the time spent performing other billable services.** For example, test administration (CPT® **96136**-**96139**) time can't be included in the face-to-face time the provider spent evaluating and communicating the test results under psychological testing evaluation (CPT® **96130**-**96131**).

Example

A worker presents to a psychiatrist's or psychologist's office for psychological testing and evaluation. The evaluation and testing was completed over several days, including a psychiatric diagnostic evaluation related to the episode of care. The majority of test administration and scoring was performed by a pyschometrist with the provider performing a smaller portion. This example is intended to assist in understanding proper billing of these services. Each episode of care will vary depending on the individual worker's condition. The following shows this scenario broken down by task and how it would be billed.

Date of Service	Service(s) Provided (CPT®)	Description	Time
07/01/2025	Psychological evaluation (**96130**/**96131**)	Record review and preliminary test selection.	**30 minutes**
07/01/2025	Psychological diagnostic evaluation (**90791**)	Clinical interview via **telehealth**.	**75 minutes**
07/01/2025	Psychological evaluation (**96130**/**96131**)	Modification of test selection based on psychological diagnostic evaluation via **telehealth**.	**10 minutes**

Date of Service	Service(s) Provided (CPT®)	Description	Time
07/02/2025	Test administration & scoring by the provider (**96136**/**96137**)	Administration of series of tests. Recording of behavioral observations during testing. Scoring and transcribing of scores into data summary.	**30 minutes**
07/02/2025	Test administration & scoring by qualified technician (**96138**/**96139**)	Provider directs and supervises the continued administration and scoring of tests by the technician.	**180 minutes**
07/03/2025	Psychological evaluation (**96130**/**96131**)	Integration of relevant clinical data and interpretation of testing results. Report generation.	**120 minutes**
07/05/2025	Psychological evaluation (**96130**/**96131**)	Interactive feedback with the worker.	**65 minutes**

Total time for the episode of care was **8 hours and 30 minutes**; psychological diagnostic evaluation 75 minutes (**1 hour and 15 minutes**), psychological evaluation 225 minutes (**3 hours and 45 minutes**), and test administration and scoring 210 minutes (**3 hours and 30 minutes**).

The provider finalized the report on July 5, 2024, which is the last day work was completed on this episode of care. Correct billing for the services documented is:

- 07/05/2025 – **90791** (Psychological diagnostic evaluation) **–GT** x 1 unit,
- 07/05/2025 – **96130** (Psychological evaluation) **–GT** x 1 unit,
- 07/05/2025 – **96131** (Psychological evaluation, add-on) **–GT** x 3 units,
- 07/05/2025 – **96138** (Test administration & scoring by technician) x 1 unit, *and*
- 07/05/2025 – **96139** (Test administration & scoring by technician, add-on) x 6 units.

Note: Psychological diagnostic evaluation (CPT® **90791**) is not a timed code and is limited to 1 unit regardless of total time spent performing the service.

Because both the provider and a technician performed the test administration and scoring, the total time for this service must be billed under the appropriate technician codes.

Services that aren't covered

Neurobehaviroal status examinations (CPT® **96116**, **96121**) can't be billed with psychological evaluation and testing.

Documentation requirements

The following documentation and test data must be sent to L&I or self-insured employer by the provider who performs the service:

- **The duration of each service provided (such as psychiatric diagnostic evaluation, psychological evaluation, and test administration and scoring),**
- Relevant medical and psychosocial history,
- Sources of information (such as worker interview, record review, behavioral observations),
- Tests administered,
- Clinical decision making,
- Interpretation of test data and other clinical information, including:
    - The worker's test results with scores, scales, and profiles,
    - Raw test data that is sufficient to allow reassessment by a panel or **independent medical exam**iner (**IME**),
    - Records,
    - Written/computer-generated reports,
    - Global scores or individual's scale scores, *and*
    - Worker responses to test questions or stimuli,
    - Providers' notes concerning worker statements and behavior during an examination, *and*
    - Test materials such as:
        - Test protocols,
        - Manuals,
        - Test items,
        - Scoring keys or algorithms, *and*
        - Any other materials considered secure by the test developer or publisher.
- Integration of sources of information (such as summary and impressions),

- Diagnosis,
- Treatment planning.

Note: The provider is responsible for releasing test data to the insurer per WAC 296-21-270.

Payment policy: Psychotherapy

General information

See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Who must perform these services to qualify for payment

Psychiatrists and psychiatric ARNPs

Psychotherapy performed with an E/M service may be billed by psychiatrists and psychiatric ARNPs when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation, *or*
- Drug management, *or*
- Writing physician orders, *or*
- Interpreting laboratory or other medical tests.

Psychotherapy services without an E/M component may also be billed.

Clinical psychologists

Clinical psychologists may only provide psychotherapy without an E/M component. They can't bill psychotherapy codes with an E/M component CPT® **90833**, **90836**, or **90838** because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license in Washington State.

Master's Level Therapists (MLT)

Master's Level Therapists (MLTs) may only provide psychotherapy without an E/M component. MLTs can't diagnose a mental health condition.

Prior authorization

Prior authorization applies for all mental health services.

Group psychotherapy

Group psychotherapy treatment is only authorized in conjunction with other mental health or individual psychotherapy treatment.

If authorized, the worker may participate in group therapy as part of the individual treatment plan.

Services that can be billed

CPT® Code	Description
90832	Individual psychotherapy, 16-37 minutes
90834	Individual psychotherapy, 38-52 minutes
90837	Individual psychotherapy, 53+ minutes
+90833	Individual psychotherapy, with an E/M service, 16-37 minutes (add-on to E/M)
+90836	Individual psychotherapy, with an E/M service, 38-52 minutes (add-on to E/M)
+90838	Individual psychotherapy, with an E/M service, 53+ minutes (add-on to E/M)
90839	Crisis psychotherapy, first 60 minutes
+90840	Crisis psychotherapy, each additional 30 minutes (add-on)
90847	Family psychotherapy, worker present, 50+ minutes
90853	Group psychotherapy (other than a multi-family group)

Services that aren't covered

The following CPT® codes and their services aren't covered:

- Psychoanalysis (CPT® **90845**),
- Family psychotherapy, without the worker present (CPT® **90846**),
- Multiple-family group psychotherapy (**90849**),
- Pharmacologic management with psychotherapy (CPT® **90863**). Use E/M CPT® codes, if appropriate.

Prolonged Services

Prolonged services (CPT® **99417**, **99418**) can't be billed with psychotherapy and are no longer allowed per CPT®.

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Requirements for billing

Psychiatrists and psychiatric ARNPs may only bill an E/M service (CPT® **99202**-**99255**, **99304**-**99316**, **99341**-**99350**) for visits on the same day psychotherapy is provided.

The time spent performing psychotherapy can't be included in selecting the E/M level of service. The provider must clearly document each service (E/M and psychotherapy), including time spent on each service.

Documentation requirements

In addition to the other CPT® requirements, chart notes must document time spent performing psychotherapy.

Payment limits

Individual psychotherapy (CPT® **90832**-**90834**, **90836**-**90838**) is limited to 1 unit per day, per worker, per claim.

Group psychotherapy services

If group psychotherapy is authorized and performed on the same day as individual goal-oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions and documentation requirements for each service.

The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers. Individual psychotherapy must occur in conjunction with group therapy.

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Payment policy: Transcranial Magnetic Stimulation (TMS) for treatment-resistant depression

General information

The insurer covers transcranial magnetic stimulation (TMS) on a limited basis. Authorization for this treatment is dependent upon the conditions of coverage noted in the coverage decision for TMS therapy.

Links: See the All mental health services policy in this chapter for more information on requirements and limits applicable to all mental health services.

Prior authorization

Prior authorization applies for all mental health services. Additional prior authorization is required before initiating TMS treatment. Each course of treatment requires separate prior authorization.

Who must perform these services to qualify for payment

TMS must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Certified technician under the supervision of one of the provider types above.

Requirements for billing

Billing of TMS codes must be in accordance with CPT® code definitions and requirements.

Evaluation and Management (E/M) service activities related to cortical mapping, motor threshold determination, and/or delivery and management of TMS aren't separately payable.

Services that can be billed

Transcranial magnetic stimulation (TMS) is covered for workers with treatment resistant major depressive disorder when the conditions of coverage are met as outlined in L&I's coverage decision.

Bill TMS using CPT® codes **90867**, **90868**, or **90869**.

If a significant separately-identifiable E/M service (which may include medication management or a psychotherapy service) is performed, then an E/M or psychotherapy code may be billed in addition to CPT® codes **90867**-**90869**. Use modifier **–25** for a separately identifiable E/M service. Use modifier **–59** for a separately identifiable psychotherapy service.

Services that aren't covered

TMS protocol that isn't FDA-approved isn't covered.

Bills for services performed without prior authorization will be denied.

Documentation requirements

Documentation must include the specific protocol used. The insurer must receive documentation including a copy of the treatment plan.

Chart notes must contain documentation that justifies the level, type, and extent of services billed.

When billing a significant separately-identifiable service using either modifier **–25** or **–59**, the services must be documented separately.

Payment limits

The total number of combined sessions allowed for CPT® codes **90867**, **90868** and **90869** is 30 per course of treatment. Each course of treatment requires separate prior authorization. Additional treatment courses must meet the guidelines described in L&I's coverage decision.

CPT® **90869** may be billed up to a max of 2 units per treatment course.

Treatment related to multiple claims for the same worker is subject to split billing. See Chapter 2: Information for All Providers for more information.

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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 attending providers	Washington Administrative Code (WAC) 296-20-01002
Administrative rules for consultations and consultation requirements	WAC 296-20-045 WAC 296-20-051
Administrative rules for mental health services	WAC 296-21-270 WAC 296-14-300
Authorization and Reporting Requirements for Mental Health Specialists	Authorization and reporting rules on L&I's website
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
Mental health services payment policies for **crime victims**	Crime Victims program on L&I's website WAC 296-31
Mental health services website	Mental health services on L&I's website
Payment policies for **case management services**	Chapter 9: Evaluation and Management (E/M)

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 18: Other Services

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS) Codes.

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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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 local code **1086M** (best practices incentive – surgical).

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	$158.90
Medium adoption	$235.78
High adoption	$497.20
Sustaining adoption	$538.21

Documentation requirements

SQCP providers are required to document their participation in the program in their chart notes when billing **1086M**. 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: Claimant (worker) reimbursement

General information

The insurer may reimburse claimants directly for expenses incurred as a result of their industrial injury, but only certain expenses, in certain circumstances, and when all requirements are met. Only claimants with an accepted and allowed industrial insurance claim may request reimbursement. Bills must be submitted within 1 year from the date the expenses are incurred. Claimants must bill the insurer directly for reimbursable services using the codes found in Services that can be billed.

Providers can't charge the worker any fees or equipment costs related to a worker's accepted and open industrial insurance claim and must bill the department directly for services provided. Workers won't be reimbursed for care or equipment provided by providers who refuse to obtain an L&I provider number or who refuse to bill the insurer.

Link: For more information, see WAC 296-20-1103, WAC 296-20-010, and RCW 51.36.085.

Prior authorization

All reimbursement require prior authorization from the insurer. The claimant is responsible for obtaining authorization for all expenses (see Services that can be billed).

Travel authorization is separate to any authorization required for medical or vocational services. Breaks in treatment or lodging provided for home modification greater than 2 days requires new travel authorization by the insurer.

Reimbursement for certain pharmacy medications require prior authorization. See the Drug Lookup tool for details, or for State Fund claims, contact the claims manager. For self-insured claims, contact the self-insured employer or third party administrator.

Services that can be billed

The insurer may only authorize reimbursement to claimants when travel or personal property expenses are incurred as a result of an industrial injury and are paid for by the claimant. Claimants should use the most economical route when traveling.

Claimant Expense	Code(s)	Additional information	Max fee
Private vehicle (POV) mileage	Medical Services **0401A**	Mileage may be payable when: • The nearest provider is further than 15 miles one way from the claimant's home (30 miles round trip), *and* • There are no providers within 15 miles of the claimant's home that could treat the accepted condition(s).	**State Rate**
	Vocational Services **V0028**		
	Retraining **0301R**		
Parking	Medical or Vocational Services **0402A**	Receipts are not required for parking expenses under $10.	**By report**
	Retraining **0302R**		
Bridge and Ferry Toll	Medical or Vocational Services **0403A**	Receipts are required for tolls $10 or more.	**By report**
	Retraining **0303R**		
Commercial Transportation	Medical or Vocational Services **0405A**	Receipts are required for commercial transportation for $10 or more.	**By report**
	Retraining **0304R**		

Claimant Expense	Code(s)	Additional information	Max fee
Taxi	Medical or Vocational Services **0414A**	Receipts must include details of pickup and drop off including, date, times, addresses, driver's name, driver operator or cab number, and total cost of trip.	**By report**
	Retraining Contact Vocational Counselor		
Lodging	Medical or Vocational Services **0406A**	Extensions of stay must be prior authorized by the claim manager to be payable. It's the claimant's responsibility to obtain this authorization. For lodging as part of home modification requests, accommodations must be provided in the state of residency.	**State Rate**
	Retraining Contact Vocational Counselor		
Breakfast	Medical or Vocational Services **0407A**	Limited to 1 **meal** per authorized person per day when travel is over 100 miles or appointments last more than 4 hours. On days treatment isn't provided, only payable when the insurer has approved lodging for that day and onsite **meals** aren't provided.	**State Rate** (includes taxes & gratuity)
	Retraining Contact Vocational Counselor		
Lunch	Medical or Vocational Services **0408A**	Limited to 1 **meal** per authorized person per day when travel is over 100 miles or appointments last more than 4 hours. On days treatment isn't provided, only payable when the insurer has approved lodging for that day and onsite **meals** aren't provided.	**State Rate** (includes taxes & gratuity)
	Retraining Contact Vocational Counselor		

Claimant Expense	Code(s)	Additional information	Max fee
Dinner	Medical or Vocational Services **0409A** Retraining Contact Vocational Counselor	Limited to 1 **meal** per authorized person per day when travel is over 100 miles or appointments last more than 4 hours. On days treatment isn't provided, only payable when the insurer has approved lodging for that day and onsite **meals** aren't provided.	**State Rate** (includes taxes & gratuity)
Personal Property	Use procedure code provided by dispensing provider. If the code is unknown, a description of the service provided is acceptable.	For loss or damaged during the workplace accident. Coverage is limited to: • Prescription eye glasses or contacts, • Clothing, • Shoes or boots, *and* • Personal protective equipment.	**By report**
Obesity support group fees	**0440A** (Weight loss program, joining fee, worker reimbursement) **0441A** (Weight loss program, weekly fee, worker reimbursement)	Submit a Miscellaneous Services Form and your receipt(s) to the claim file. Contact your claim manager for help.	**By report**

When traveling out of state for medical treatment or an **Independent Medical Exam**, the maximum fee is based on the location of the travel and the U.S. General Services Administration's rates for **lodging** and/or **meals** for that location.

Link: Current state reimbursement rates for lodging, **meals**, and privately-owned vehicle (POV) mileage can be found on the Office of Financial Management (OFM) website.

Claimants may seek reimbursement for some pharmacy prescription purchases.

Services that aren't covered

Claimants won't be reimbursed by the insurer for:

- Missed appointment fees,
- No shows, *or*
- Late cancellations.

Lodging, transportation, and medical providers may bill claimants for these services per the applicable payment policy or rule.

Rental cars and associated fees aren't covered.

For lodging, the insurer won't reimburse claimants for:

- Incidental fees,
- Additional cleaning fees above and beyond usual housekeeping for room damage during the stay,
- Out of state lodging or travel when there is no planned medical treatment or an **Independent Medical Exam**,
- Expenses outside the authorized period, *or*
- Expenses above the maximum **state rate** are not reimbursable to the claimant.

Care provided to injured workers and Crime Victims by providers who do not have L&I provider numbers will not be reimbursed. Reimbursement for these services will not be paid to workers or Crime Victims. All services rendered by providers should be billed by providers, not workers or Crime Victims.

Links: For more information, refer to RCW 51.04.030, RCW 51.36.010, WAC 296-20-010, WAC 296-20-020, and WAC 296-20-022.

Documentation requirements

Claimants must fully complete and submit the following forms for reimbursement:

- Travel reimbursement form (F245-145-000) for mileage, lodging, **meals**, parking, tolls, and other travel expenses.
- Statement for Miscellaneous Services (F245-072-000) for personal property lost or damaged during a workplace accident.
- Statement for Pharmacy Services (F245-100-000) for prescription reimbursement.

Claimants must use place of service **–99** when completing the forms above. For more information, see Appendix C: Place of Service (POS) Codes.

Receipts are required for all goods and services, except for parking services less than $10 as noted in the Services that can be billed section. Receipts must be itemized and legible; credit card receipts aren't acceptable.

Itemization of **meals** must be broken out into breakfast, lunch, and dinner by date and charge.

All pharmacy reimbursement requests require documentation from the pharmacy detailing the amount paid and payment method (such as a cash register receipt) in addition to a completed statement for pharmacy services form. Pharmacy prescription filled receipts with no payment information aren't acceptable.

Include the additionally required documentation with submission of the appropriate form.

Note: A screenshot of an Uber, Lyft, or other transportation receipt without mileage isn't considered sufficient documentation and may result in non-payment.

Payment policy: Document 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. 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**

Payment policy: Obesity treatment

General information

Obesity doesn't meet the definition of an industrial injury or occupational disease. Temporary treatment may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

To be eligible for obesity treatment services, the worker must have severe obesity. For the purposes of providing obesity treatment services, L&I defines severe obesity as a BMI of 35 or greater.

Prior authorization

All obesity treatment services require prior authorization.

Requesting weight reduction programs

The **attending provider** should contact the insurer to request a weight reduction program if the worker meets **all** of the following criteria:

- Is severely obese (BMI 35 or greater), *and*
- Obesity is the primary condition retarding recovery from the accepted condition, *and*
- Weight reduction is necessary to undergo required surgery, participate in physical rehabilitation, and/or return to work.

The **attending provider** who believes that the worker may qualify for a weight reduction program:

- Must advise the insurer of the worker's weight and level of function prior to the injury and how it has impacted rehab and recovery, *and*
- Must submit medical justification for obesity treatment, including tests, **consultations**, or diagnostic studies that support the request, *and*
- **Attending Providers** may request nutrition counseling with a Certified Dietician (CD) or Certified Registered Dietician Nutritionist (RDN) when it has been determined that weight reduction nutrition counseling is appropriate for the worker.

Required treatment plan

Prior to receiving authorization for weight reduction services, a treatment plan must be prepared for the worker. The plan can be developed by:

- The **attending provider**, *or*
- A Certified Dietician or Certified Registered Dietician Nutritionist.

The **attending provider** and worker must approve the final treatment plan. The plan must include:

- The amount of weight the worker must lose to undergo surgery, participate in physical rehabilitation, and/or return to work, *and*
- The estimated length of time needed for the worker to lose the weight, *and*
- A diet and exercise regimen, including a weight loss goal, approved by the **attending provider** as safe for the worker, *and*
- Specific program or other weight loss method requested, *and*
- Plan for monitoring weight loss, *and*
- Documented weekly weigh-ins, *and*
- Counseling and education provided by trained staff.

For State Fund claims, the **attending provider** must sign an authorization letter generated by the Claim Manager, which serves as a memorandum of understanding between the insurer, the worker, and the **attending provider**.

Attending provider's responsibilities

Upon approval of the obesity treatment plan, the **attending provider**'s role is to:

- Examine the worker every 30 days to monitor and document weight loss, *and*
- Coordinate care with any CD or RDN involved in the patient's care, *and*
- Notify the insurer when:
  - The worker reaches the weight loss goal, *or*
  - Obesity no longer interferes with recovery from the accepted condition, *or*
  - The worker is no longer losing the weight needed to meet the weight loss expectations and plan of care.

Restrictions

A weight reduction treatment plan may include participation in a group weight loss program, but this isn't a requirement.

Weight reduction services won't include requirements to buy supplements or special foods.

Authorization

The insurer authorizes obesity treatment for **up to 90 days at a time** as long as the worker does all of the following to ensure continued compliance with the obesity treatment plan:

- Loses at least 5 pounds over the course of 6 weeks of treatment *and*
- Regularly attends weekly treatment sessions *and*
- Complies with the approved weight reduction plan, *and*
- Is evaluated by the **attending provider** at least every 30 days, *and*
- Sends the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

The insurer will no longer authorize obesity treatment when any one of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan (if the worker chooses to continue the weight loss program for general health, it will be at their own expense), *or*
- Obesity no longer interferes with recovery from the accepted condition (see Link below), *or*
- The worker isn't losing the 5 pound minimum requirement over 6 weeks of treatment *or*
- The worker isn't cooperating with the approved weight reduction services plan of care.

Link: For more information about why it is prohibited to treat an unrelated condition once it no longer retards recovery of the accepted condition, see WAC 296-20-055.

Who must perform these services to qualify for payment

Nutrition counseling

Only Certified Dieticians or Certified Registered Dietician Nutritionists will be paid for nutrition counseling services.

Providers practicing in a state other than Washington that are similarly certified or licensed may apply to be considered for payment.

Services that can be billed

Nutrition counseling

Certified Dieticians and Certified Registered Dietician Nutritionists may bill for authorized services using these CPT® billing codes:

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- **97802** at **initial visit**, with a maximum of 12 units, *and if necessary*
- **97803** for re-assessment with a maximum of 4 units per visit and a maximum of 5 visits. Additional visits may be authorized by the insurer if the minimum weight loss is met.

For CPT® **97802** or **97803,** 1 unit equals 15 minutes. These services may occur remotely (via **telehealth**).

Expenses for an attending provider-recommended group support setting

The **worker** will be reimbursed for **attending provider**-recommended group support meetings when billing using the following local codes:

- **0440A** (Weight loss program, joining fee, worker reimbursement), and
- **0441A** (Weight loss program, weekly fee, worker reimbursement).

The worker may participate in these meetings remotely (via **telehealth**).

Services that aren't covered

The insurer doesn't pay the group support weight loss provider directly. Workers must pay the fees and request reimbursement. See Payment policy: Claimant (worker) reimbursement for details.

The insurer doesn't pay for:

- Apps or app subscription fees,
- Drugs or medications used primarily to assist in weight loss (for example, GLP-1s),
- Educational materials (such as food content guides and cookbooks),
- Exercise classes or exercise equipment,
- Food scales or bath scales,
- Gym or fitness club memberships,
- Medical weight loss programs,
- Special foods (including liquid diets),
- Supplements or vitamins, *or*
- Surgical treatments of obesity (for example, gastric stapling, or jaw wiring).

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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 or vocational provider. Teleinterpretation means 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.

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 isn't 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 in Chapter 24: Telehealth, Remote, and Mobile Services.

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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 examination**s (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.

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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. Interpreters may bill for no-shows at IMEs using **9976M**. No-shows at other appointments aren't billable.	Doesn't require prior authorization.	1 visit. Each separate appointment for an individual worker/crime victim is considered 1 visit.	**By Report**

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 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,

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- 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.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for treating conditions unrelated to the accepted condition	Washington Administrative Code (WAC) 296-20-055
Attending provider information	Chapter 3: Attending Providers
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including obesity treatment services)	Fee schedules on L&I's website
How to **calculate BMI**	National Institute of Health's website
Rules for **telehealth**	Chapter 24: Telehealth, Remote, and Mobile Services

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 19: Pharmacy

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All pharmacy services

General information

For the purposes of this policy, the average wholesale price (AWP) refers to a pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

Who must perform pharmacy services to qualify for payment

The pharmacy services fee schedule applies to pharmacy providers only. It doesn't apply to medical providers administering drugs in the office. Please see Chapter 16: Medication Administration.

Prior authorization

If a drug requires prior authorization but approval isn't obtained before filling the prescription, the drug won't be covered by the insurer.

Non-preferred drugs

To obtain authorization for **non-preferred drugs**:

If the **non-preferred drug** is part of the…	And you are a **PDL endorsing provider**, then:	Or you are a **non-endorsing provider**, then:
Preferred drug list (PDL)	Change to the **preferred drug**, *or* Write DAW for **non-preferred drug**.	Change to the **preferred drug**, *or* For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.
Wrap-around classes	Change to the **preferred drug**, *or* For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.	Change to the **preferred drug**, *or* For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.

Links: The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm (Pacific Time), and the toll free contact number is 1-888-443-6798.

A list of Self-Insured Employers (SIEs)/TPAs is available online.

Filling prescriptions after hours

If a pharmacy receives a prescription for a **non-preferred drug** when authorization can't be obtained, the pharmacist may dispense an **emergency supply** of the drug by entering a value of 6 in the DAW field. An emergency supply is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

The insurer must authorize additional coverage for the **non-preferred drug**.

Services that can be billed

The Outpatient Drug Formulary is a list of therapeutic classes and drugs that are covered under L&I's drug benefit. L&I uses a subset of the Washington State PDL and a wrap-around formulary (a formulary the department uses for the drug classes that aren't part of the PDL but are part of the department's allowed drug benefit) for the remaining drug classes. Drugs or therapeutic classes listed on the formulary do not guarantee coverage and may be subject to specific L&I policy and determination of appropriateness for the accepted conditions.

Links: The Drug Lookup tool gives current coverage status for all non-injectable drugs, as well as a list of formulary alternatives and links to coverage policies, when applicable.

The outpatient formulary can be found online.

L&I's website has a list of policies relating to drug coverage, including limitations, criteria for coverage and treatment guidelines.

Requirements for writing prescriptions

Prescription forms

Orders for over the counter drugs or non-drug items must be dispensed pursuant to a prescription from an authorized prescriber for coverage consideration.

Recordkeeping for prescriptions

Records must be maintained for audit purposes for a minimum of 5 years.

Link: For more information on recordkeeping requirements, see WAC 296-20-02005.

Requirements for billing

NCPDP payer sheet, version D.0 and 5.1

For State Fund claims, L&I currently accepts versions D.0 and 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system.

POS hours:

- 6 a.m. to midnight Sunday through Friday.
- 6 a.m. to 10 p.m. on Saturday.

Link: The current version of the NCPDP payer sheet is available online.

Payment methods

Payment for drugs and medications, including all oral over the counter drugs, will be based on these pricing methods:

If the **drug type** is…	Then the **payment method** is:
Generic	AWP less 50% (+) **$4.50** professional fee
Single or multisource brand	AWP less 10% (+) **$4.50** professional fee
Brand with generic equivalent (dispense as written only)	AWP less 10% (+) **$4.50** professional fee
Compounded prescriptions	Allowed cost of ingredients (+) **$4.50** professional fee (+) **$4.00** compounding time fee (per 15 minutes)

Pricing details

Orders for over the counter non-oral drugs or nondrug items are priced on a 40% margin.

Prescription drugs and oral or topical over the counter medications are nontaxable.

No payment will be made for repackaged drugs.

Links: For more information on tax exemptions for sales of prescription drugs, see RCW 82.08.0281. For a definition of Average Wholesale Price (AWP), see WAC 296-20-01002.

Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk non-payment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, and
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

Link: For more information, see L&I's coverage decision on compound drugs.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA-approved alternatives, such as oral generic non-steroidal anti-inflammatory drugs, muscle relaxants, tricyclic antidepressants, gabapentin and topical salicylate and capsaicin creams on the Outpatient Drug Formulary.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient. No separate payment will be made for this service:

- **99070** (Supplies and materials)

Payment policy: Emergency contraceptives and pharmacist counseling

Services that can be billed

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, *and*
- The ECP and/or counseling service is sought by the worker, *and*
- The claim manager authorizes payment for the ECP and/or the counseling, *and*
- The pharmacist is approved by the Department of Health Pharmacy Quality Assurance Commission to follow this particular protocol.

Requirements for billing

Once the Coverage policy conditions listed above have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code **S9445**.

Payment policy: Endorsing practitioner and Therapeutic Interchange Program

Requirements for writing prescriptions

An endorsing practitioner is one who has notified the Health Care Authority that he or she has agreed to allow therapeutic interchange.

Endorsing practitioners may indicate “dispense as written” or DAW on a prescription for a **non-preferred drug** on the PDL, and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates “substitution permitted” on a prescription for a **non-preferred drug** on the PDL:

- The pharmacist will interchange a **preferred drug** for the **non-preferred drug**, *and*
- A notification will be sent to the prescriber.

Additional information: When therapeutic interchange won’t occur

Therapeutic interchange won’t occur if the endorsing practitioner indicates “dispense as written” on the non-preferred prescription; if the prescription is a refill of:

- An antipsychotic,
- An antidepressant,
- An antiepileptic,
- Chemotherapy,
- An antiretroviral,
- Immunosuppressive drug,
- Immunomodulator/antiviral treatment for hepatitis,
- If the pharmacy and therapeutics committee has determined therapeutic interchange isn’t clinically appropriate for a specific drug or drug class on the Washington **preferred drug** list, *or*
- If the prescription is for a schedule II controlled substance.

Link: For exception criteria, see L&I’s website.

Payment policy: Initial prescription drugs or “first fills” for State Fund claims

General information

An initial prescription drug (or “first fill”) is any drug prescribed for an alleged industrial injury or occupational disease during the **initial visit**. L&I will pay pharmacies or reimburse workers for prescription drugs prescribed during the **initial visit** for State Fund claims regardless of claim acceptance.

Payment for “first fills” will be based on L&I’s fee schedule including but not limited to:

- Drug utilization review (DUR) criteria, *and*
- **Preferred drug list (PDL)** provisions, *and*
- Supply limit, *and*
- Formulary status.

Links: For definitions of “initial prescription drug” and “initial visit,” see WAC 296-20-01002.

For billing and payment for initial prescription drugs information, see WAC 296-20-17004.

Requirements for billing

Your bill must be received by L&I within 1 year of the date of service.

For non-state fund claims, pharmacies should bill the appropriate federal or self-insured employer. If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

Link: For additional information and billing instructions, visit the Pharmacy Services website.

A list of Self-Insured Employers (SIEs)/TPAs is available online.

Payment limits

L&I won’t pay:

- For refills of the initial prescription before the claim is accepted, *or*
- For a new prescription written after the **initial visit** but before the claim is accepted, *or*
- If it is a federal or self-insured claim.

Payment policy: Opioids

Services that can be billed

When treating an acute injury, generic short-acting opioids will be covered without authorization for up to 6 weeks from the date of injury.

Prior authorization

Providers must seek authorization from the insurer for opioid coverage beyond the acute phase of the injury (>6 weeks). Coverage will depend on documented use of specific best practices.

For post-surgical pain medication, contact the insurer so that post-surgical opioids can be authorized.

Link: For more information, see L&I's opioid policy.

Services that aren't covered

Long-acting opioids (such as OxyContin, MS ER, MS Contin, methadone, Opana ER) aren't covered for acute post-injury or post-surgical pain.

Requirements for billing

The number of days' supply of opioids prescribed for acute and subacute pain are subject to Department of Health rules.

Prescriptions for opioids from dental providers are limited to a maximum of a 3-day supply.

Prescriptions for chronic opioids are limited to a maximum of a 28-day supply.

Payment policy: Third party billing for pharmacy services

Requirements for billing

Pharmacy services billed through a third party pharmacy biller will be paid using the pharmacy fee schedule **only when**:

- A valid L&I claim exists, *and*
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I, *and*
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

Pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement, *and*
- Allow third party pharmacy billers to route bills on their behalf, *and*
- Agree to follow L&I rules, regulations and policies, *and*
- Ensure that third party pharmacy billers use L&I's online POS system, *and*
- Review and resolve all online POS system edits using a licensed pharmacist during the dispensing episode.

Payment limits

Third party pharmacy billers **can't resolve** POS edits.

Additional information: Third Party Pharmacy Supplemental Agreements

Third Party Pharmacy Supplemental Agreements can be obtained either:

- Through the third party pharmacy biller, *or*
- By contacting L&I's Provider Credentialing (see contact info, below).

The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I.

Links: To contact L&I's Provider Credentialing, email PACMail@Lni.Wa.gov.

For more information about these agreements, refer to the Pharmacy Services website.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for pharmacy services	Washington Administrative Code (WAC) 296-20-01002 WAC 296-20-17004 WAC 296-20-03014(6) WAC 296-20-1102 WAC 296-20-02005
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Drug coverage policies	Drug coverage policies on L&I's website
PDL	Drug Formulary
Endorsing the PDL	Online registration through the Health Care Authority WA State Endorsing Practitioner Customer Service: 1-877-255-4637
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website
NCPDP payer sheet current version	NCPDP payer sheet
Opioid Policy	L&I's opioid policy
Outpatient formulary	Outpatient formulary
PDL Hotline	Open Monday through Friday, 8:00 am to 5:00 pm (Pacific Time): 1-888-443-6798
Therapeutic Interchange Program exception criteria	Therapeutic Interchange Program

If you're looking for more information about…	Then see…
Third Party Pharmacy Supplemental Agreements	Third party pharmacy supplemental agreement form

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 20: Physical Medicine

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

General information: Physical medicine CPT® codes billing guidance

Timed codes

Some physical medicine services (such as ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as "timed services" and are billed using "timed codes".

Timed codes can be identified in CPT® by the code description. The definition will include words such as "each 15 minutes."

Providers must document in the daily medical record (chart note and flow sheet, if used):

- The amount of time spent for each time based service performed, *and*
- The specific interventions or techniques performed, including:
    - Frequency and intensity (if appropriate), *and*
    - Intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (for example, flow sheets, chart notes, and reports). See Chapter 2: Information For All Providers for more details.

The number of units you can bill is:

- Determined by the time spent performing each "timed service," and
- Constrained by the total minutes spent performing these services on a given day.

To obtain the number of units of timed services that can be billed, add together the minutes spent performing each individual timed service and reference the table below.

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

If the combined duration of all time based services **is at least**…	**and less than**…	**Then**, **when billing**, **report**:
8 minutes	23 minutes	1 unit
23 minutes	38 minutes	2 units
38 minutes	53 minutes	3 units
53 minutes	68 minutes	4 units
68 minutes	83 minutes	5 units
83 minutes	98 minutes	6 units
98 minutes	113 minutes	7 units
113 minutes	128 minutes	8 units

How to use this table

The above schedule of times doesn‘t imply that any of the first 8 minutes should be excluded from the total count. The total time of active treatment counted includes all direct treatment time.

Use the table above to determine the maximum number of units that can be billed for the date of service. Begin with applying the maximum number of units to the service performed for the longest amount of time and continue assigning units to each timed service, based on length of service performed, until the maximum number of billable units has been reached.

Pre and post delivery services (for example, warmup and cool down) aren’t counted in determining the treatment time. See what time counts towards timed codes. Detailed examples can be found below.

Examples of how to document and bill timed codes

The following examples show how the required elements of interventions can be documented and billed. These examples aren’t reflective of a complete medical record for the patient’s visit. The other elements of reporting (SOAPER) **also must be documented**.

Example 1

Procedural intervention	Specific intervention	Purpose	Treatment time
Ultrasound performed with attended E-stim simultaneously	5mA right forearm 1.5 W/cm2 ; 100% right forearm	Increase joint mobility	**12 minutes**
Therapeutic exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping	**14 minutes**
			Total treatment time = **26 minutes**
			Total timed intervention (treatment time spent performing timed services) = **26 minutes**

At 26 total minutes of timed services, a maximum of **2 units** of timed services can be billed. When both a timed and untimed service are performed simultaneously, only one of the services can be billed. In this case, only ultrasound would be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97035** (Ultrasound) x 1 unit.

Example 2

Procedural intervention	Specific intervention	Purpose	Treatment time
Therapeutic exercise	Left leg straight leg raises x 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting	**20 minutes**
Neuromuscular reeducation	1 leg stance, 45 seconds left; 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead	**15 minutes**
Cold pack	Applied to left knee	Decrease edema	**10 minutes**
			Total treatment time = **45 minutes**
			Total timed intervention (treatment time spent performing timed services) = **35 minutes**

At 35 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, and
- **97112** (Neuromuscular reeducation) x 1 unit.

Note: Cold packs are an untimed service, but are considered **bundled**.

Example 3

Procedural intervention	Specific intervention	Purpose	Treatment time
Manual therapy	Soft tissue mobilization to medial knee - right	Mobilization	**12 minutes**
Therapeutic exercises	Prone hip extension 10 reps x 2 sets; hamstring stretch 3 reps x 2 sets; right single leg stance 3 sets of 5 for 15 second hold	Increase strength and range of motion	**25 minutes**
Cold pack	Applied to right knee	Decrease edema	**10 minutes**
			Total treatment time = **47 minutes**
			Total timed intervention (treatment time spent performing timed services) = **37 minutes**

At 37 total minutes of timed services, a maximum of **2 units** of timed services can be billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercise was performed for 25 minutes, which equates to 2 units of timed service. Because no additional units of timed services are allowed, manual therapy isn't billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units

Note: Cold packs are an untimed service, but are considered **bundled**.

Example 4

Procedural intervention	Specific intervention	Purpose	Treatment time
Neuromuscular re-education	Squats on Airex Balance pad 10 reps x 2 sets; tandem balance on Bosu Ball 2 sets 30 seconds each; single stance on Airex Balance pad 2 sets x 5	Normalize balance for reaching overhead	**8 minutes**
Manual therapy	Soft tissue mobilization to medial knee - right	Mobilization	**12 minutes**
Therapeutic exercises	Hamstring curls 10 reps x 2 sets; short arc quads 3 sets of 5 for 5 second hold; straight leg raise 3 sets of 5 for 15 second hold	Increase strength and range of motion	**25 minutes**
Cold pack	Applied to right knee	Decrease edema	**10 minutes**
			Total treatment time = **55 minutes**
			Total timed intervention (treatment time spent performing timed services) = **45 minutes**

At 45 minutes of timed services, a maximum of **3 units** of timed services can billed. Begin with applying the maximum number of units to the service performed for the longest time. Therapeutic exercises was performed for 25 minutes, which equates to 2 units of timed service. The balance of billable units is 1 unit. Since more time was spent performing manual therapy, assign the last unit of service to manual therapy. Because no additional units of timed services are allowed, neuromuscular re-education isn't billable. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 2 units
- **97140** (Manual therapy) x 1 unit

Note: Cold packs are an untimed service, but are considered **bundled**.

Prohibited pairs: Which CPT® codes can't be billed together

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to 1 or more patients **for the same time period**:

- Any 2 codes for "therapeutic procedures" requiring direct, one-on-one patient contact, *or*
- Any 2 codes for modalities requiring "constant attendance" and direct, one-on-one patient contact, *or*
- Any 2 codes requiring either constant attendance or direct, one-on-one patient contact, as described above (for example, any CPT® codes for a therapeutic procedure with any attended modality CPT® code), *or*
- Any code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy code (for example, CPT® code **97150** with CPT® code **97112**), *or*
- Any code for modalities requiring constant attendance with the group therapy code (for example, CPT® code **97150** with CPT® code **97035**), *or*
- An untimed evaluation or reevaluation code with any other timed or untimed codes, including constant attendance modalities, therapeutic procedures, and group therapy.

Determining what time counts towards timed codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services:

- Pre and post delivery services (for example, warmup and cool down services) aren't counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist is working directly with the patient to deliver treatment services.
- The patient should already be in the treatment area (for example, on the treatment table or mat or in the gym) and prepared to begin treatment.
- The time counted is the time the patient is treated.
- The time the patient spends not being treated because of the need for toileting or resting can't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

Link: More information about L&I's PT, OT, and massage therapy policies is available online.

Payment policy: Chiropractic care visits

General information

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

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

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

Prior authorization

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

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

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

Documentation requirements

Chiropractors must document all body regions treated each visit. Documentation must support the level of service billed as described in Determining the level of a chiropractic care visit.

All other standard documentation rules apply for chiropractic care visits performed. See Chapter 2: Information for All Providers for details.

When treating subluxations and/or segmental dysfunction adjacent to areas that have been accepted on a claim, the provider must document how the adjacent areas are related to the injury or if they are a separate area of injury that has not already been accepted.

Note: For documentation of E/M services, see Chapter 9: Evaluation and Management (E/M).

Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** account for both professional management (clinical complexity) and the technical service (manipulation and adjustment).

Expectations for chiropractic care visits

When performing a chiropractic care visit, billable using codes **2050A**, **2051A**, and **2052A**, it's expected that the provider will perform the following pre-, intra-, and post- services:

- Education of the patient, which may include:
  - How the treatment will affect the patient,
  - What the patient should do to improve recovery, *and/or*
  - Asking the patient if they understand the intended treatment and consent to it,
- Brief review of employment issues and work restrictions,
- Review of physical abilities/restrictions,
- Pre-manipulation patient assessment, including deciding which areas to adjust,
- Manipulation (adjustment), *and*
- Post-treatment service, which includes:
  - Instructions for patient to help improve their recovery and avoid re-injury,
  - Inform patient of things to watch out for that might indicate a problem,
  - Evaluation of effectiveness of treatment,
  - Evaluation of patient response, *and*
  - Review of the treatment plan with the patient.

Determining the level of chiropractic care visit

Treatment must meet or exceed at least **3** factors in one column to bill that level. The appropriate level of service to bill is equal to the highest 3 out of 5 factors. If no information is documented about a given factor, it defaults to Straightforward.

Factor	Straightforward (2050A)	Low (2051A)	Moderate (2052A)
Severity of condition(s)	Simple condition(s)	Multiple conditions or a single complex condition	Multiple complex conditions and/or a condition with neurological findings
Body regions treated	Up to 2 body regions (incl. spine and/or extremities)	Up to 3 or 4 body regions (incl. spine and/or extremities)	Up to 5 or more regions (incl. spine and/or extremities)
Time spent	Up to 10 minutes of face-to-face time	11-20 minutes of face-to-face time	Over 20 minutes of face-to-face time
Co-morbidities	None or not affecting recovery	One or two comorbidities impeding recovery	Multiple comorbidities or psychosocial factors impeding recovery
Treatment plan	No changes needed to plan	Minor changes needed to plan	Major changes needed to plan

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Factor examples

Treatment plan

Minor changes include contact points/segments, method/technique, visit frequency, or home care instruction alterations in a condition progressing as expected.

Major changes include alterations that require new informed consent for expected outcomes or adverse events, new home care routines, or changes because of prior adverse events post-treatment or new data/test results.

Severity of condition

Straightforward: Condition is progressing as expected. Lumbar strain with acute localized back pain and segmental dysfunction.

Low: Uncertain prognosis or challenges in diagnostic certainty, two or more conditions. Lumbar and thoracic strain with referred pain to flank/glute.

Moderate: Severe exacerbation/aggravation of condition, two or more conditions that involve multiple areas and have potential for significant negative outcomes for the patient, which may include neurologic involvement. Diabetic patient with Lumbar strain and pain/tingling in upper leg with myotome/dermatome deficit.

When billing E/M is appropriate

When services provided exceed the expectations for a chiropractic care visit and meet the CPT® criteria, an evaluation and management (E/M) code may be appropriate. For example:

- Establishing a diagnosis, history, and treatment plan during an **initial visit**,
- Reevaluating the patient's physical condition, obtaining interval history, and updating patient progress,
- Reviewing and discussing diagnostic testing results, and/or notes from other providers with the worker, which may result in adjusting the treatment plan,
- Counseling and educating above and beyond what is necessary to complete an adjustment, *and/or*
- Referring for tests or diagnostics.

The E/M code must be billed with modifier **–25** when billed with **2050A**, **2051A**, or **2052A**. The patient must be present for any E/M services to be billable; record review alone is not sufficient to bill E/M. See Chapter 9: Evaluation and Management (E/M) for additional details.

Services that aren't covered

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

Instead of using CMT codes, L&I uses local codes developed in collaboration with the Washington State Chiropractic Association and the University of Washington (see Services that can be billed, above).

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

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

Payment limits

Only 1 chiropractic care visit per day is payable.

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

Providers can only bill a **new patient** or **established patient** E/M code and a chiropractic care local code (**2050A**, **2051A**, or **2052A**) for the same date of service when the E/M service is significantly separately identifiable and meets the requirements to use modifier **–25**. Time spent or treatment performed as part of a chiropractic care visit can't be counted when determining which level of E/M to bill; all E/M services need to be assessed for billing level separately from the chiropractic care services. For details, see Services that can be billed (above) and Chapter 9: Evaluation and Management (E/M).

Payment policy: Electrical stimulators (including TENS)

Prior authorization

These HCPCS codes for **electrical stimulator devices for home use or surgical implantation** require prior authorization:

HCPCS code	Brief description	Additional coverage information
E0745	Neuromuscular stimulator for shock	This code is covered for **muscle denervation only**.
E0747	Electrical osteogenesis stimulator, not spine	—
E0748	Electrical osteogenesis stimulator, spinal	—
E0749	Electrical osteogenesis stimulator, implanted	Authorization for this code is subject to **utilization review**.
E0760	Osteogenesis ultrasound, stimulator	This code is covered for appendicular skeleton only (**not the spine**).
E0764	Functional neuromuscular stimulator	—

Services that can be billed

For electrical stimulator devices **used in the office setting**:

- When it is within the provider's scope of practice, a provider may bill professional services for application of stimulators with the CPT® physical medicine codes.
- **Attending providers** who aren't board qualified or certified in physical medicine and rehabilitation must bill local code **1044M**, which is limited to 6 units per claim. For more information, see the Physical medicine services for **attending providers** policy in Chapter 3: Attending providers.

For electrical stimulator devices and supplies for **home use or surgical implantation**, HCPCS code **E0761** (Nonthermal electromagnetic device) is covered.

Services that aren't covered

For **use outside of medically supervised facility settings** (including home use and purchase or rental of **durable medical equipment** and supplies), the insurer doesn't cover:

- Transcutaneous Electrical Nerve Stimulators (TENS) units and supplies, or
- Interferential current therapy (IFC) devices, or
- Percutaneous neuromodulation therapy (PNT) devices.

Note: Use of these therapies will continue to be covered during hospitalization and in clinical settings.

For **home use or surgical implantation devices and supplies**, these HCPCS codes aren't covered:

- **E0731** (Conductive garment for TENS),
- **E0740** (Incontinence treatment system),
- **E0744** (Neuromuscular stimulator for scoliosis),
- **E0755** (Electronic salivary reflex stimulator),
- **E0762** (Transcutaneous electrical joint stimulation device system),
- **E0765** (Nerve stimulator for treatment of nausea and vomiting),
- **E0769** (Electric wound treatment device, not otherwise classified),
- **L8680** (Implantable neurostimulator electrode),
- **S8130** (Interferential current stimulator, 2 channel),
- **S8131** (Interferential current stimulator, 4 channel).

For home use or in medically supervised facility settings, CPT® code **64555** (Peripheral nerve neurostimulator) isn't covered.

Treatment of chronic migraine or chronic tension-type headache with trigger point injections or massage therapy isn't a covered benefit. See L&I's coverage decision for more details.

Payment limits

These supplies are **bundled and not payable separately for office use**:

- **A4365** (Adhesive remover wipes),
- **A4455** (Adhesive remover per ounce),
- **A4556** (Electrodes, pair),
- **A4557** (Lead wires, pair),
- **A4558** (Conductive paste or gel),
- **A5120** (Skin barrier wipes box per 50),
- **A6250** (Skin seal protect moisturizer).

Additional information: Why the insurer doesn't cover TENS

Based on extensive review of the evidence for use of Electrical Nerve Stimulation (ENS), including TENS, interferential current therapy (IFC), and percutaneous neuromodulation therapy (PNT) as treatment for acute and chronic pain, the State Health Technology Clinical Committee (HTCC) determined that ENS isn't covered for use outside of medically-supervised facilities. Purchase or rental of TENS, IFC, or PNT equipment is also not covered. For more details, see the HTCC decision paper.

Payment policy: Functional capacity evaluations (FCEs)

Prior authorization

Requires prior authorization by the claim manager.

Who must perform these services to qualify for payment

To qualify for payment, a functional capacity evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

Services that can be billed

Each provider must bill independently for their time using the following codes:

Code	Description and notes	Maximum fee
1045M	**Standard Functional Capacity Evaluation** Must involve a minimum of 3 hours of face-to-face time between all evaluating providers.	**$288.97** per unit 1 unit = 1 hour Maximum 6 units total per worker, not to exceed **$866.91**.
1098M	**Supplemental Functional Capacity Evaluation** When the Standard FCE evaluation exceeds 6 hours. This may be appropriate when: • Additional testing is required for multiple jobs with opposite physical demands, • Performing a whole body and upper extremity focused evaluation, *or* • Symptomatic neurological conditions impact testing tolerance and/or When follow up testing is indicated after completion of a Standard FCE in order for an **Attending Provider** or vocational provider to facilitate return to work decisions.	**$145.02** per unit 1 unit = 1 hour Maximum 6 units total per worker.

Example of billing for multiple provider evaluations

Scenario: The Occupational Therapist (OT) performed 3.2 hours of direct time and the Physical Therapist (PT) performed 0.8 hours of direct time for a Standard FCE.

OT:	3 units of **1045M**
PT:	1 unit of **1045M**
Total units billed: 4 Maximum fee of **$866.91**	

Services that aren't covered

Supplemental Functional Capacity Evaluations using **1098M** can't be billed for:

- Additional time to perform missed or forgotten testing, or
- Updates to an incomplete or conflicting report.

Requirements for billing

When billing, 1 hour of direct face-to-face time = 1 unit of service. If the service is 31 minutes or greater, this meets the requirement for 1 unit of service. Time accumulates regardless of the number of days the FCE is performed over.

Eligible providers must bill their usual and customary fee for Standard Functional Capacity Evaluations and Supplemental Functional Capacity Evaluations.

When the service is performed by multiple providers, each provider must bill for the amount of direct one-on-one time they spent performing the evaluation using their individual provider account number.

These services include testing, a summary of findings, and a full evaluation report. **All summary reports must be submitted within 10 days of when the service was performed and full evaluation reports within 30 days**.

Note: Ensure all documentation is submitted before billing or the bill may be denied.

Documentation requirements

Documentation for any Functional Capacity Evaluation (FCE) must include:

- Date of service,
- Worker name,
- Claim number,
- Duration of the evaluation. Each provider must also separately document the amount of direct one-on-one time they spent performing the service,
- Signature and date of all evaluators, and
- Completed Capacity Form (F245-434-000) for State Fund (in-state claims) or an equivalent summary of findings for out-of-state and self-insured claims.

For a Standard FCE, documentation must also include L&I's minimum evaluation elements.

For a Supplemental FCE, documentation must also include a list of all tests performed and all results of those tests.

Note: Although the department allows joint chart notes for FCEs, the documentation must clearly note who performed each service and how much time each individual provider spent providing the direct one-on-one evaluation. Include this information on both the summary of findings and full evaluation report.

Payment limits

Standard and Supplemental Functional Capacity Evaluations (**1045M** and **1098M**) may only be billed once per worker every 30 days.

Multiple providers

If the FCE is performed by multiple providers, the maximum fee applies once per worker regardless of how many providers and/or provider types performed the evaluation.

Multiple claims

If the worker has multiple claims, the maximum fee for the FCE applies once per worker regardless of the number of claims a worker may have. When this occurs, therapists must appropriately bill the portion of the visit related to each accepted claim. For more information, refer to the physical medicine split billing policy in this chapter.

Multiple days

Standard and Supplemental Functional Capacity Evaluations may be provided over multiple days. If this occurs, the bill must span the dates of service to reflect the actual dates in which the evaluation was performed. For example, if the evaluation began on January 1 and was completed on January 3, the bill will reflect the “From Date of Service” as January 1 and the “To Date of Service” as January 3.

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Payment policy: Low level laser therapy (LLLT)

Services that can be billed

Low level laser therapy (LLLT) is a covered benefit when performed in a clinical setting.

Physical therapy (PT) providers, occupational therapy (OT) providers, board-qualified physiatrists, and board-certified physiatrists must bill for low level laser therapy using **S8948**.

Non-board certified/qualified physical medicine **attending providers** must bill for low level laser therapy using local code **1044M**. For more information, see the Physical medicine services for **attending providers** policy in Chapter 3: Attending Providers.

Services that aren't covered

Low level laser therapy isn't covered outside of a clinical setting or for home use.

CPT® code **97037** isn't covered.

HCPCS code **0552T** isn't covered.

Payment limits

Low level laser therapy is **bundled** with other physical medicine services (CPT® codes **97010** through **97799**). The insurer won't pay an additional fee for low level laser therapy billed using **S8948**.

The insurer won't pay an additional fee for low level laser therapy beyond the maximum fee for **1044M**.

Code **1044M** has a limit of 6 units per claim. The insurer won't authorize additional visits for laser therapy. For more information, see the Physical medicine services for **attending providers** policy in Chapter 3: Attending Providers.

Low level laser therapy must be performed in conjuction with other physical medicine treatment at the same visit. Bills for visits where only LLLT is performed without other treatment may result in denial of the bill or recoupment of payment.

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Payment policy: Massage therapy

Who must perform these services to qualify for payment

To qualify for payment, massage therapy services must be performed by:

- A licensed massage therapist, *or*
- Other covered provider whose scope of practice includes massage techniques.

Prior authorization

Massage therapy services require prior authorization after the 6th visit.

Link: For more information, see WAC 296-23-250.

Services that can be billed

Massage therapy services must be billed using CPT® code **97124** for all forms of massage therapy, regardless of the technique used. The insurer won't pay massage therapists for additional codes.

Requirements for billing

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. Massage therapists must also use CPT® code **97124** for evaluations and reevaluations. All other providers must bill the code most reflective of the technique being used.

Massage therapists must bill their usual and customary fee and document the duration of the massage therapy treatment. Bill the appropriate units based on the length of time the service is rendered, per CPT® code description.

Documentation must support the units of service billed. Document the amount of time spent performing evaluations and reevaluations as well as the treatment. See additional information about Timed Codes for more details.

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

Massage Therapist Progress Reports

Massage therapists are required to submit progress reports following every 6 treatment visits or after each month, whichever comes first. Documentation must include:

- an outline of the proposed treatment program, *and*
- the expected restoration goals, *and*
- the expected length of treatment, *and*
- substantiation of improvement during the most recent treatment period, such as:
    - signs of treatment progress (e.g. range of motion, sitting and standing tolerance, reduction in medication), *and/or*
    - self-reported functional outcome measures from L&I's recommended scales (such as the patient-specific functional scale).

Failure to submit a progress report after each set of 6 visits or 1 month of treatment, whichever comes first, may result in denial of bills and/or revocation of authorization for treatment.

Link: See pages 16-20 in Options for Documenting Functional Improvement in Conservative Care for more examples of appropriate functional scales.

Payment limits

Massage therapy is paid at **75%** of the maximum daily rate for PT and OT services.

The daily maximum allowable amount is **$112.09**.

Link: For more information, see WAC 296-23-250.

Services that aren't covered

These items are **bundled** into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices,
- Lubricants (for example, oils, lotions, emollients).

Massage therapy isn't a covered benefit for the treatment of chronic migraine or chronic tension-type headaches. See L&I's coverage decision for more details.

Payment policy: Osteopathic manipulative treatment (OMT)

General information

For the purposes of this policy, body regions are defined as:

- Head,
- Cervical,
- Thoracic,
- Lumbar,
- Sacral,
- Pelvic,
- Rib cage,
- Abdomen and viscera regions, *and*
- Lower and upper extremities.

Who must perform these services to qualify for payment

Only osteopathic (DO) or naturopathic (ND) physicians may bill for OMT services.

Requirements for billing

OMT includes pre and post service work (for example, cursory history and palpatory examination). The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of an E/M service in addition to OMT services on the same day.

An E/M office visit service may be billed in conjunction with OMT **only when all** of the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included with OMT, *and*
- The worker's record contains documentation supporting the level of E/M service billed, *and*
- The E/M service is billed using modifier **–25**. Without modifier **–25**, the insurer won't pay for E/M codes billed on the same day as OMT.

For details, see Chapter 9: Evaluation and Management (E/M).

Payment limits

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level, type and extent of service billed. The MARFS and CPT® book describes the requirements that must be present for each level of service.

For OMT services, only 1 CPT® code is payable per treatment. This is because CPT® codes for body regions ascend in value to accommodate the additional body regions involved. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

Services that aren't covered

Manual therapy billed under CPT® code **97140** or local code **1044M** isn't covered for osteopathic physicians.

Payment policy: Physical therapy (PT) and occupational therapy (OT)

Prior authorization

No authorization is needed for less than 12 visits as long as the claim is open and allowed, treatment is for accepted conditions on the claim, and referral is from the **attending provider** per WAC 296-20-030.

Prior authorization is required for additional visits beyond the initial 12, except for physiatrists. Physiatrists don't need authorization to provide physical therapy services.

To request authorization for visits 13-24, first submit to the insurer:

- A referral for ongoing treatment,
- The initial evaluation report,
- Daily chart notes, *and*
- All progress reports.

Then fax the Physical/Occupational/Massage Therapy Provider Hotline Service Authorization Request form to the department for consideration.

For beyond 24 visits, request Utilization Review from Comagine Health directly.

Physical and Occupational therapy visits accumulate separately. Visit counts are the total number of visits per claim. New referrals, restart of therapy following surgery, or treatment of new conditions on the same claim don't start again at visit 1.

Learn more about these services on the L&I PT/OT webpage.

Who must perform these services to qualify for payment

Physical Therapy (PT)

PT services must be ordered by the worker's **attending provider**. The services must be provided by a:

- Licensed physical therapist, *or*
- Physical therapist assistant serving under a licensed physical therapist's direction, *or*
- Athletic trainer serving under a licensed physical therapist's direction.

For details about **students** performing PT services, see the Therapy student and therapy assistant payment policy.

Link: For more information, see WAC 296-23-220.

Occupational Therapy (OT)

OT services must be ordered by the worker's **attending provider**. The services must be provided by a:

- Licensed occupational therapist, *or*
- Occupational therapy assistant serving under a licensed occupational therapist's direction.

For details about **students** performing OT services, see the Therapy student and therapy assistant payment policy.

Link: For more information, see WAC 296-23-230.

Physical medicine services by other providers

Physical medicine services may also be provided by:

- Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation (physiatry) and billed under CPT® 97010-97799, or
- Attending doctors who aren't board qualified or certified in physical medicine and rehabilitation and billed under local code **1044M**. For non-board certified/qualified providers, special payment policies apply. See the Physical medicine services for **attending providers** policy in Chapter 3: Attending providers.

Link: For more information, see WAC 296-21-290.

Who won't be paid for physical medicine services

- Exercise physiologists, *or*
- Kinesiologists, *or*
- Physical or occupational therapist aides, *or*
- Gym supervisors.

Services that can be billed

Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation as well as physical and occupational therapists must use CPT® and HCPCS codes **97010**-**97799** for physical medicine services. These providers may also bill for miscellaneous materials and supplies using HCPCS codes. Some of these CPT® and HCPCS codes aren't covered or are **bundled**. Refer to the professional provider fee schedule for coverage.

If more than 1 patient is treated at the same time, use CPT® code **97150**.

Only medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation and physical therapists may bill **95992**.

Evaluation

For an evaluation performed by a physiatrist or therapist to establish a plan of care, use CPT® codes **97161**-**97163** or **97165**-**97167**.

To revise the plan of care of a patient who has been under a plan of care established by the physician or therapist, use CPT® codes **97164** or **97168**. CPT® codes **97164** and **97168** have no limit on how often they can be billed.

Link: For information on Surgical dressings dispensed for home use, see Chapter 7: Durable Medical Equipment (DME) and Supplies.

For billing requirements for prosthetic and orthotic devices, see Chapter 7: Durable Medical Equipment (DME).

For information on billing for telephone calls, online communications, or team conferences, see Chapter 9: Evaluation and Management (E/M)

Other physical medicine services

Non-board certified/qualified physical medicine **attending providers** may perform physical medicine modalities and procedures described in CPT® codes **97010**-**97750** if their scopes of practice and training permit it, but for these services they must bill local code **1044M**. The description for local code **1044M** is "AP provider physical medicine services".

For more information, see the Physical medicine services for **attending providers** policy in Chapter 3: Attending providers.

Services that aren't covered

Physical medicine CPT® codes **97033** and **97169**-**97172** aren't covered.

Cryotherapy devices with or without compression for home use aren't covered as **Durable Medical Equipment**. These devices used in a clinical setting are considered **bundled** into existing physical medicine services. For more information, please review L&I's coverage decision for Cryotherapy Devices With or Without Compression.

Non-vasopneumatic compression devices without a cryotherapy component aren't a covered benefit. For more information, please review L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component.

Services defined by CPT® Category III codes that aren't covered on the professional fee schedule can't be billed using any of the physical medicine codes.

Documentation requirements

Progress reports are due following 12 treatment visits or every 1 month, whichever comes first. PT and OTs treating workers covered by state-fund must use the Physical Medicine Progress Report form F245-453-000 and submit this to the insurer and the **attending provider**. Progress reports must include functional outcome measures.

Providers can use the Documenting Functional Improvement resource to help prepare these progress reports.

Link: For more information, see WAC 296-23-220 and WAC 296-23-230.

Payment limits

Physical medicine services

Non-board certified/qualified physical medicine providers won't be paid for CPT® codes **97010**-**97799**.

Bundled items or services

Bundled items or services include, but aren't limited to:

- Activity supplies used in work hardening, such as leather and wood,
- Application of hot or cold packs (this includes all forms of cryotherapy with or without compression. **97016** may not be used to bill for these services),
- Electrodes and gel,
- Exercise balls,
- Ice packs, ice caps, and ice collars,
- Thera-tape,
- Wound dressing materials used during an office visit and/or PT treatment.

Daily maximum for services

The daily maximum allowable fee for PT and OT services is **$149.45**.

If PT, OT, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type. See the Massage Therapy payment policy in this chapter for the daily maximum fee that applies to massage therapists.

When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **20560**-**20561**, **95992**, and **97010**-**97799**.

If the worker receives PT or OT services for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

The daily maximum allowable fee doesn't apply to:

- Speech language pathologists, *or*
- Physicians board certified in physical medicine (physiatrists), *or*
- Functional capacity evaluations (FCEs), *or*
- Work rehabilitation services, *or*
- Work evaluations, *or*
- Job modification/pre-job accommodation **consultation** services.

Links: For more information, see WAC 296-23-220 and WAC 296-23-230.

Split billing – unrelated conditions

When treating 2 or more separate conditions that aren't related to the same claim at the same visit, the split billing policy applies.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to 1 unit per day. Refer to CPT® and HCPCS to determine whether a service is time-based or untimed.

Providers must document the actual service provided including frequency and intensity (if appropriate), and the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

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Payment policy: Powered traction therapy

Services that can be billed

When performed as part of a physical medicine modality, the use of powered traction devices are covered. The insurer won't reimburse separately for the use of the device, only for the service delivery.

Payment limits

The insurer won't pay any additional cost when powered devices are used.

Additional information: Why the insurer won't pay additional cost when powered devices are used

Published literature hasn't substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. See L&I's coverage decision for more details.

Payment policy: Physical and occupational therapy student supervision

General information

L&I has adopted a modified version of Medicare Part B's policy on physical and occupational therapy **students**. L&I considers supervised **students** an extension of their supervising therapist.

Please refer to the Appendix A: Definitions appendix to see the definitions of **student**, supervising therapist, and student supervision.

Services that can be billed

Supervising therapists will direct all care provided by their **students** to injured workers and must bill for these services under the supervising therapist's provider account number.

All billed services must meet the billing and documentation requirements applicable to the supervising therapist.

Services that aren't covered

Any service provided by a **student** that is unsupervised (including in skilled nursing facilities) isn't payable.

Students can't independently:

- Make clinical judgements,
- Provide evaluations, re-evaluations or assessments, *or*
- Develop, manage, or deliver services.

Any service that deviates from the requirements outlined in Medical Aid Rules and Fee Schedules isn't covered.

Direct supervision in accordance with **student** licensures must be provided in-person, even if the service is provided to the worker via **telehealth**. Modifier **–FR** is not covered.

Note: Direct supervision of therapy assistants may occur via **telehealth** (modifier **–FR**) when the service to the worker is allowed via **telehealth**. Certain services require in-person care. These services require in-person direct supervision in alignment with DOH requirements for the assistant licensure.

Requirements for billing

All chart notes and documentation must be signed by the **student** and co-signed by the supervising provider, indicating they have reviewed and approved of the documentation. All services must be billed by the supervising therapist under their provider account number and must comply with supervision and documentation requirements for physical medicine services.

Supervising therapist responsibilities

Supervising therapists are responsible for all services provided to injured workers by their **students**. This means they must:

- Ensure that the work **students** perform does not exceed their education, skills, and abilities, nor the supervising therapist's scope of practice,
- Provide supervision to the **student** regardless of what setting care is being rendered in (clinic, hospital, or skilled nursing facility),
- Ensure that all documentation requirements are met,
- Co-sign all documentation for services rendered to injured workers, *and*
- Keep a copy of the private agreement between them and the **student** in accordance with WAC 296-20-02005.

Payment limits

Students won't be directly reimbursed for their time or services.

Link: For more information, see WAC 296-20-015.

Payment policy: Work rehabilitation (WR)

General information

Work rehabilitation (WR) is a special individualized program to assist a worker in meeting the demands of a specific job using progressive exercise, work simulation tasks, and education. It consists of two intensity levels: work rehabilitation – conditioning (WRC) and work rehabilitation – hardening (WRH).

For general program details, visit our work rehabilitation website. You can also find specific information about the program in our work rehabilitation standards.

Prior authorization

Initial evaluations

Initial evaluations for work rehabilitation programs don't require prior authorization.

Work rehabilitation programs

Work rehabilitation programs require a referral from the worker's **attending provider** (AP). For State Fund, utilization review (UR) is also required. For self-insurance, the self-insured employer's representative grants prior authorization.

Additional services

Providing separate and additional rehabilitation outpatient physical therapy (PT) or occupational therapy (OT) services to the worker while they're participating in a work rehabilitation program is atypical and must be authorized by the insurer. Documentation must support the clinical necessity of additional services.

Program extensions

The insurer must authorize program extensions in advance. Extensions are based on documentation of progress and the worker's ability to benefit from a program extension. Program extensions apply to **1023M**, **1024M**, **97545**, and **97546**. To request a program extension:

- For State Fund claims, use My L&I to email WRvisitadditions@Lni.wa.gov. Don't send confidential worker information via email. You may also fax the Therapy Services unit at **360-902-5035**.
- For self-insured claims, contact the self-insured employer or their representative.

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Who must perform these services to qualify for payment

Only L&I-approved work rehabilitation providers will be paid for work rehabilitation services.

Link: Visit our website to apply to become a work rehabilitation provider.

Services that can be billed

Work rehabilitation evaluation

Service	Code	Details
WR evaluation	**1001M**	Work rehabilitation – evaluation and plan of care. 1 unit = 1 hour Doesn't require prior authorization. Use of this code may be allowed to complete re-evaluations at any point during a work rehabilitation program (limit 6 units total).

Work rehabilitation – conditioning (WRC)

Service	Code	Details
WRC program, first 2 hours	**1023M**	Work rehabilitation – conditioning, first 2 hours of treatment per day. 1 unit = 1 hour Requires prior authorization. A minimum of 2 hours of treatment per day (2 units) is required; see below for details.
WRC program, each additional hour	**1024M**	Work rehabilitation – conditioning, each additional hour of treatment per day. 1 unit = 1 hour Requires prior authorization.

Work rehabilitation – hardening (WRH)

Service	Code	Details
WRH program, first 2 hours	**97545**	Work rehabilitation – hardening, first 2 hours of treatment per day. 1 unit = 2 hours Requires prior authorization. A minimum of 2 hours of treatment per day (1 unit) is required; see below for details.
WRH program, each additional hour	**97546**	Work rehabilitation – hardening, each additional hour of treatment per day. 1 unit = 1 hour Requires prior authorization.

Requirements for billing

Billing portions of an hour using 1001M

Each unit of **1001M** equals 1 hour of evaluation services. If the worker completes less than 38 minutes of a given hour, round down to the nearest whole number unit. If the worker completes 38 or more minutes, round up to the nearest whole number unit. For example, if the worker is evaluated for 2 hours and 47 minutes, the provider would bill 3 units of **1001M**.

Billing less than 2 hours of treatment in a day with CPT® 97545 or 1023M

Services provided for less than 2 hours of total program time (2 units of **1023M** or 1 unit of **97545**) on any day don't meet the work rehabilitation program standards and can't be billed using WR codes. The services must be billed with other physical medicine codes. Failure to complete at least 2 hours of a WR program should be counted as an absence when determining worker compliance with the program.

Billing portions of an additional hour using CPT® 97546 or 1024M

After completion of the requirements for **97545** or **1023M**, each additional hour is billed using **97546** or local code **1024M**. A full hour is billed as 1 unit at your usual and customary rate, but if the worker completes less than 38 minutes of an hour of program work:

- The charged amount for the incomplete hour of service must be prorated, *and*
- You must bill a line of **97546** or **1024M** at the prorated rate with modifier **–52**.

Example: Worker completes 4 hours and 25 minutes of WRH treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged amount	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	**–52**	42% of usual and customary (completed 25 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the number of hours they perform. Both PT and OT providers may bill for the same date of service.

Examples of billing for services in multidisciplinary programs

Example 1: Standard treatment (Work rehab – Hardening)

Scenario: The OT performs treatment that lasts 4 hours. On the same day, the worker is also treated by the PT for 2 hours.

The providers could bill for the 6 hours of services in the following ways:

Billing example A		
PT:	1 unit **97545**	2 hours
OT:	4 units **97546**	4 hours
Total hours billed:		**6 hours**

Billing example B		
PT:	2 units **97546**	2 hours
OT:	1 unit **97545** + 2 units **97546**	2 hours 2 hours
Total hours billed:		**6 hours**

Example 2: Standard treatment (Work rehab – Conditioning)

Scenario: The OT performs 1 hour of treatment for a worker. A PT provider then performs an additional 2 hours of treatment.

The providers could bill for the 3 hours of services in the following ways:

Billing example A		
PT:	1 unit **1023M** + 1 unit **1024M**	1 hour 1 hour
OT:	1 unit **1023M**	1 hour
Total hours billed:		**3 hours**

Billing example B		
PT:	2 units **1023M**	2 hours
OT:	1 unit **1024M**	1 hour
Total hours billed:		**3 hours**

Example 3: Reduced treatment hours (Work rehab – Conditioning)

Scenario: The PT performs 2 hours of treatment with the worker. The OT performs an additional 1.5 hours of treatment.

The providers could bill for the 3.5 hours of services in the following ways:

Billing example A		
PT:	2 units **1023M**	2 hours
OT:	1 unit **1024M**	1 hour
	1 unit **1024M** (prorated) with modifier **–52**	30 minutes
Total hours billed:		**3.5 hours**

Billing example B		
PT:	1 unit **1023M**	1 hour
	1 unit **1024M**	1 hour
OT:	1 unit **1023M**	1 hour
	1 unit **1024M** (prorated) with modifier **–52**	30 minutes
Total hours billed:		**3.5 hours**

Documentation requirements

Documentation for both WRC and WRH must meet the requirements listed in the Work Rehabilitation Standards. For additional documentation requirements, see Chapter 2: Information for All Providers.

A report is required when billing **1001M**. This report must include any results of tests or measurements performed and/or document the worker's progress through the program.

If a worker fails to complete the minimum treatment duration for WRC or WRH on a given day, this should be documented as an absence from the program for that day. Services will need to be billed using other CPT® physical medicine codes; billing and documentation requirements for these codes can be found in other sections of this chapter.

Payment limits

Providers may only bill for the time that services are performed while the worker is in the clinic participating in their program. The reimbursement rates of CPT® **97545** and **97546** and local codes **1023M** and **1024M** account for the fact that some work occurs outside of the time the worker is present (for example, creation of the initial plan of care or documentation of worker progress).

Code	Description	Daily unit limit	Program unit limit	Notes
1001M	Evaluation	None	6 units	May be performed at any time throughout the program.
1023M	Work conditioning, first 2 hours	2 units (2 hours)	80 units	Minimum of 2 units per day.
1024M	Work conditioning, each additional hour	2 units (2 hours)	80 units	Add-on code. Won't be paid as a standalone procedure. Must be billed with **1023M**.
97545	Work hardening program, first 2 hours	1 unit (2 hours)	40 units	Minimum of 1 unit per day.
97546	Work hardening, each additional hour	6 units (6 hours)	240 units	Add-on code. Won't be paid as a standalone procedure. Must be billed with CPT® **97545**.

Payment policy: Wound care

Prior authorization

Electrical stimulation for chronic wounds

If electrical stimulation for chronic wounds is requested for use on an outpatient basis, prior authorization is required using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy, *and*
- In addition to electrical stimulation, standard wound care must continue.

Note: In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Services that can be billed

Debridement

Therapists must bill CPT® **97597**, **97598**, or **97602** when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies sent home with the patient for self-care may be billed with HCPCS codes appended with local modifier **–1S**.

Link: For more information on billing with local modifier **–1S**, see the Surgical dressings for home use section (Requirements for billing and Payment limits) of Chapter 7: Durable Medical Equipment (DME) and Supplies and Appendix B: Modifiers.

Electrical stimulation for chronic wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is covered for the following chronic wound indications:

- Stage III and IV pressure ulcers,
- Arterial ulcers,
- Diabetic ulcers,
- Venous stasis ulcers.

To bill for electrical stimulation for chronic wounds, use HCPCS code **G0281**.

Link: For more information, see the Electrical Stimulation for Chronic Wounds coverage decision.

Requirements for billing

Debridement

When performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool), therapists must bill CPT® **97597**, **97598**, or **97602**.

Electrical stimulation for chronic wounds

In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Payment limits

Debridement

Wound dressings and supplies used in the office are **bundled** and aren't payable separately.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for naturopathic physicians	Washington Administrative Code (WAC) 296-23-205
Administrative rules for physical medicine	Washington Administrative Code (WAC) 296-21-290
Administrative rules for treatment requiring prior authorization	WAC 296-20-03001(1)
Becoming an Chiropractic Consultant	Become a Chiropractic Consultant on L&I's website
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Chiropractic Services including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources	IICAC website
Dynamic Spinal Visualization coverage decision	Dynamic Spinal Visualization coverage decision
Electrical stimulation for chronic wounds	Electrical stimulation for chronic wounds
Fee schedules for all healthcare professional services	Fee schedules on L&I's website
Keeping of records	WAC 296-20-02005
L&I's coverage decision for Chronic Migraine and Chronic Tension-type Headaches	Chronic migraine headache coverage decision

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If you're looking for more information about…	Then see…
L&I's coverage decision for Cryotherapy Devices with or without Compression	Cryotherapy devices with or without compression coverage decision
L&I's coverage decision for low level laser therapy	Low level laser therapy coverage decision
L&I's coverage decision for Non-vasopneumatic Devices without a Cryotherapy Component	Non-vasopneumatic devices without cryotherapy component coverage decision
L&I's general policies and rules for **PT**, **OT**, and **massage therapy**	PT, OT, and massage rules on L&I's website
Manipulation/ Manual therapy treatment of chronic tension-type headache coverage decision	Chronic Migraine and Chronic Tension-type Headache coverage decision
Massage therapy administrative rules	WAC 296-23-250
Occupational therapy administrative rules	WAC 296-23-230
Payment policies for **case management services**	Chapter 9: Evaluation and Management (E/M)
Payment Policies for **diagnostic X-ray services**	Chapter 8: Electrodiagnostics and Radiology
Payment policies for **durable medical equipment (DME) and supplies**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Payment Policies for **Evaluation and Management (E&M) and case management services**	Chapter 9: Evaluation and Management (E/M)
Payment policies for **impairment ratings and IMEs**	Chapter 11: Impairment Rating Services and Independent Medical Exams (IMEs)

If you're looking for more information about…	Then see…
Payment Policies for **mental health services**	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Payment policies for **supplies**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Payment policies for **supplies, materials, and bundled services**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Physical Medicine Progress Report Form	Form F245-453-000
Physical therapy administrative rules	WAC 296-23-220
Powered traction devices for intervertebral decompression	Powered traction devices for intervertebral decompression
TENS coverage decision	State Health Technology Clinical Committee (HTCC) published TENS decision
Work rehabilitation program at L&I	**Program reviewer**: therapy@lni.wa.gov Work Rehabilitation on L&I's website

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 21: Reports and Forms

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

Payment policy: All reports and forms

General information

This chapter is not a comprehensive list of all reports and forms. Many L&I forms are available and can be downloaded from L&I's website and all reports and forms may be requested from the Provider Hotline by emailing PHL@Lni.wa.gov. There you can also find Spanish versions of these documents.

For more information on the reports and forms listed in this appendix, see WAC 296-20-06101.

Who must complete the document to qualify for payment

Some reports and forms are restricted to certain provider types or their role in the claim. Refer to the specific report for details on who must complete the form to qualify for payment.

Links: For more information on the differences between an **attending provider** type and an **AP** on the claim, see Chapter 3: Attending Providers.

Requirements for billing

To bill for a special report or form required by the insurer, use the appropriate CPT® or local billing code. The fees listed in the fee schedules for these reports and forms include postage for sending documents to the insurer. The insurer may send a special report or form. In these cases, the provider must complete the special report or form as requested.

Documentation requirements

In addition to the specific reports and forms requirements noted in this chapter, the documentation must also include:

- The name and title of the person completing the form (either with a hand-written signature, signature stamp, or electronic signature), *and*
- The date it was completed.

These are required even if the report or form doesn't have a field for it.

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 provided doesn't match the procedure code billed, or is not proper and necessary. Refer to WAC 296-20-015.

Changes to **medical records** after bill submission won't be considered in determining appropriate payment.

Links: For more information on documentation requirements, see Chapter 2: Information for All Providers and WAC 296-20-01002.

Payment policy: Attending Provider type reports and forms

Who must complete to qualify for payment

Only **attending provider (AP)** types with a valid provider number may sign and complete the following forms. Some forms are restricted to only the **AP** on the claim, while others may also be completed by **consultants** or concurrent care providers, which are also **attending provider** types.

Requirements for billing

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Activity Prescription Form (APF) (F242-385-000)	**1073M**	Only **attending provider** types, acting as the **AP** on the claim, a concurrent care provider, or a **consultant.** APFs are only payable to psychologists when they are the **AP** on a mental health only claim. Can be submitted with Report of Accident (ROA/PIR) when there are work related physical restrictions, or when documenting a change in the worker's medical status or capacities. **APFs aren't payable when submitting reopening applications.** An office visit isn't required to complete an APF in certain circumstances. Limit of 1 per provider, per worker, per day. Up to 6 within first 60 days. Up to 4 times per 60 days thereafter. Insurer will review for determination of additional allowances over the limit. When requested by the insurer, properly completed APFs are payable, even if the limits have been reached. **1073M** can't be billed with **9918M** or **9919M** when the communications are to transmit or simply reiterate the information on the the APF.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
AP Final Report	**1026M**	**Must be requested by insurer or submitted by the AP**. Only the **AP** on the claim can sign and be paid for completion of this form. Limit of 1 per day.
AP response to VRC/ Employer request about RTW	**1074M**	**AP response to written communication with vocational counselors and employers**, such as questionnaires. Only the **AP** on the claim can sign and be paid for completion of this form. A copy of the written communication must be sent to the insurer. Not payable when performed on the same day as a team conference, office visit, or online communication with a VRC or employer.
AP Concurrence of Independent Medical Exam (IME)	**1063M**	**Must be requested by insurer.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or a concurrent care provider can sign and be paid for completion of this form. Not payable to Master Level Therapist (MLT). Limit of 1 per request. The **AP** must respond to the request using the letter sent by the claim manager.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
AP Supplemental Review of IME with written report	**1065M**	**Must be requested by insurer.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or a concurrent care provider can sign and be paid for completion of this form. The **AP** must submit a separate report of the **IME** review. This report expands upon the provider's response from **1063M** and can't refer only to a prior chart note. Limit of 1 per request.
Loss of Earning Power (LEP) (F242-209-000)	**1027M**	**Must be requested by insurer.** Only the **AP** on the claim may sign and be paid for completion of this form. Limit of 1 per day.
Occupational Disease History Report (F242-071-000 or for hearing loss F262-013-000)	**1055M**	**Must be requested by insurer.** Only **APs** may sign and be paid for completion of this form. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s). Visit our website for instructions. Limit of 1 per worker.
Review of FCE Reports/ Summary	**1097M**	**Must be requested by insurer, employer, or vocational counselor.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or an **IME** examiner can sign and be paid for completion of this form. Limit of 1 per day, per provider, per worker

Payment policy: Brief emotional/behavioral screens & risk assessments

General information

This policy covers initial or repeat screening (such as the PHQ-9, GAD-7, or PCL-5) to determine if a worker should be referred for mental health treatment.

These assessments aren't for diagnosing a mental health condition, but may be necessary to determine the need for more in-depth assessment or further intervention.

Service that can be billed

Use CPT® code **96127** for brief emotional/behavioral screens and risk assessments. Bill 1 unit per standardized instrument. Includes scoring and documentation.

Payment limits

CPT® code **96127** is limited to 3 assessments per day, per provider, with a maximum of 6 assessments per provider, per worker.

Brief emotional/behavioral screens & risk assessments can't be billed separately from active mental health treatment, including during psychotherapy or mental health evaluation. Monitoring of diagnosed mental health conditions, including provider time associated with these types of screens, is already included within mental health services. For re-assessments during active treatment of a diagnosed mental health condition, use the appropriate evaluation CPT® code.

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Payment policy: Job analysis (JA) or job descriptions

General information

Job analyses (JA) and **job descriptions** identify the physical requirements of a potential job for the worker. The **AP** reviews the **JA** or **job description(s)** to determine whether the worker can perform a specific job. The provider sends the insurer (and vocational provider, if applicable) a response, indicating whether the worker can perform the job described or not. If not, the provider must specify any modifications needed to enable the worker to do the job.

Within their scope of practice, **APs** must review the physical and/or mental requirements documented in the **job description** or **job analysis** of any **job offer** submitted by the employer of record and determine whether the worker can perform that job. The provider must send a copy of each **job description** or **job analysis** reviewed to the insurer.

Note: Reviews requested by other than the department, self-insurer, Third Party Administrator (TPA), employer or vocational counselor (for example, attorneys or workers) won't be paid.

Requirements for billing

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Review of Job Descriptions or JA or **On-the-job recovery agreement (OTJ-RA)**	**1038M**	**Must be requested by insurer, employer or vocational counselor.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or an **IME** examiner can sign and be paid for completion of both forms. Psychologists can only sign and complete when there is a covered mental health condition on the claim. Not payable to **IME** examiner when **IME** performed on the same day. Limit of 1 per day.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Review of Job Descriptions or JA or **On-the-job recovery agreement (OTJ-RA), each additional review**	**1028M**	**Must be requested by insurer, employer or vocational counselor.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or an **IME** examiner can sign and be paid for completion of both forms. Psychologists can only sign and complete when there is a covered mental health condition on the claim. **IME** examiner limits – Day of exam, may be billed for each additional **JA** after the first 2. After day of exam, may be billed for each additional JA after the initial (**1038M**).

Payment policy: Reports and forms for all providers

Requirements for billing

If the **report or form** is…	Then bill using this **code**...	Also, be aware of these **special notes** about the report or form:
30-Day Report	**99080**	1 per provider, per 30 days, per claim. Per WAC 296-20-0555, when treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and accepted industrial conditions. Not payable for records required to support billing, for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Not payable if the report is completed as part of another service.
60-Day Report	**99080**	1 per provider, per 60 days, per claim. Not required unless requested by the insurer or if legible comprehensive chart notes are submitted and include the required information per WAC 296-20-06101. Not payable for records required to support billing, for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Not payable if the report is completed as part of another service.

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If the **report or form** is…	Then bill using this **code**...	Also, be aware of these **special notes** about the report or form:
Department of Transportation (DOT) Medical Examination & Certification	**99499**	For performing a DOT Medical Examination and completing the certification form. Must be conducted by a licensed "medical examiner" with the Federal Motor Carrier Safety Administration (FMCSA); MD, DO, ND, ARNP, PA eligible in Washington State. Prior authorization required. Limit of 1 per day.
Provider Review of Video Materials with written report	**1066M**	**Must be requested by insurer.** Report must include actual time spent reviewing the video materials, and findings and observations gained from the review. Limit of 1 per provider, per day. Not payable in addition to CPT® code **99080** or local codes **1104M** or **1198M**.
Special Report	**99080**	**Must be requested by insurer or vocational counselor.** Not payable for records or reports required to support billing or for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Don't use this code for forms or reports with assigned codes. Bill this code for starring a work history form. Can't be billed with **1055M**. Limit of 1 per day.

Opioid forms

Providers who are prescribing opioids to injured workers within their scope of practice may complete and bill for the following forms.

If the **report or form** is…	Then bill using this **code**...	Also, be aware of these **special notes** about the report or form:
Opioid Request Form for Chronic Pain	**1078M**	Chronic phase (>12 weeks) and ongoing chronic opioid therapy requirements, see WAC 296-20-03057 and WAC 296-20-03058.
Subacute Opioid Request Form for Pain with Documentation	**1077M**	Use when copies of all required screenings (urine drug test, risk of opioid addiction, current or former substance use disorder and depression, if indicated) are submitted with the form – increased reimbursement. Opioid requirements for the subacute phase (6-12 weeks), see WAC 296-20-03056.
Subacute Opioid Request Form for Pain without Documentation	**1076M**	Use when results of screenings are documented in the medical record but aren't submitted with the form. Opioid requirements for the subacute phase (6-12 weeks), see WAC 296-20-03056.

Payment policy: Report of Accident (ROA/PIR/SIF-2)

General information

Filing of a State Fund Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) to initiate an L&I claim is required for work-related injuries, illnesses, or conditions requiring treatment beyond basic first aid as defined in WAC 296-800-099. If the worker, employer, or provider have reason to believe the injury or illness is work-related, a ROA/PIR is required. For self insured employers, the worker must also complete an SIF-2 to assist in claim initation.

The provider who completes and signs the ROA/PIR is listed as the **AP** on the claim until a written transfer of care is received.

No employer, worker, or provider can exempt themselves from filing a ROA/PIR by any contract, agreement, rule, or regulation, when an injury or occupational disease has occurred.

Workers have the right to file a claim if they have reason to believe their injury or illness is work-related, even if the provider and/or employer disagrees.

Providers who first treat an injured worker must inform them of their rights to file a workers compensation claim, if they have not already filed one. Even if the worker objects after hearing their rights, the provider is still required file a ROA/PIR under penalty of law, within 5 days of treatment.

A ROA is always required if the worker has received any treatment, is hospitalized, disabled from work, or has died as an apparent result of a work accident and injury.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The employer or their designee may not direct or require the worker to use a specific medical provider.

In accordance with RCW 51.48.060, failing to comply with all ROA requirements may result in penalties.

Link: For more information, see Deciding When to File an Accident Report on L&I's website, WAC 296-20-025, RCW 51.48.095, RCW 51.28.025, and RCW 51.28.020.

Who must complete to qualify for payment

Only **attending provider (AP)** types with a valid provider number may sign and complete these forms.

Mental health only claims

Clinical psychologists (PhD or PsyD) can only complete and sign these forms when the sole condition(s) on the claim is a psychiatric condition. Mental health only claims do not include those that have previously had a physical condition, which has since been resolved.

Requirements for billing

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”).

Examinations to complete an ROA/PIR

A ROA/PIR can **only** be filed as part of an in-person physical examination of the injured worker by an **attending provider**. The examination necessary to complete a ROA/PIR **can’t** be done via **telehealth**, except for mental health only claims. For more information on distant and **originating site** restrictions, see the **telehealth** policies in Chapter 9: Evaluation and Management (E/M) and Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

How to file

For **state fund claims**, complete the ROA using the instructions on the paper form. These forms aren’t available for download. See F242-130-000 (English) for information on how to order paper copies. Fax completed ROAs to **360-902-6690** or **800-941-2976.** Hot ROA fax for hospital admissions is **360-902-4980**.

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**).

To ensure correct payment and qualify for the $10 financial incentive, make sure the ROA/PIR form is filled out completely. All information voluntarily provided by the worker in the Worker and Employer sections and all fields in the provider section of the ROA must be completed and included in electronic data submissions.

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

For **self insured claims**, complete the PIR using instructions on the back of form. An electronic version of the form is available here: 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.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Report of Accident (ROA) Workplace Injury, or Occupational Disease – State Fund (F242-130-000 or electronically via FileFast)	**1040M**	**Must be initiated by the worker or by an AP**. Only **APs** may sign and be paid for completion of these forms. Payment delays may occur until claim determination is made. Limit of 1 per claim. For more on billing procedures, see WAC 296-20-125. For filling out the ROA, see L&I's website. For self insured employers, the worker must also complete an SIF-2 to assist in claim initation. See L&I's website for more information on ordering SIF-2 Forms.
Provider's Initial Report (PIR) – Self Insured (F207-028-000)		
Application to Reopen Claim (F242-079-000)	**1041M**	**Must be initiated by the worker or by the insurer**. Only **APs** may sign and be paid for completion of this form. Payment delays may occur until claim determination is made. Limit of 1 per request. For more on reopenings, see WAC 296-20-097.

Payment Limits

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.

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). **L&I's State Fund payment system automatically reduces the ROA payment for ROAs received more than 5 business days from "This exam date".**

Max Fee when submitted via:	Within 5 days	6-8 days	9 days or more
Paper or fax	**$46.47**	**$36.47**	**$26.47**
FileFast/HIE – State Fund only (additional $10 incentive; add on to your billed charges when submitting)	**$56.47**	**$46.47**	**$36.47**

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).

Additional payment incentive on State Fund claims

Payments are increased for participation in the Centers of Occupational Health and Education (COHE). Providers must bill their usual and customary charges, even when eligible for payment incentives.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for information in this chapter	Washington Administrative Code (WAC) 296-20-01002 WAC 296-20-015 WAC 296-20-025 WAC 296-20-06101 WAC 296-20-065 WAC 296-20-097 WAC 296-20-03056 WAC 296-20-03057 WAC 296-20-03058 WAC 296-20-125 WAC 296-800-099
Activty Prescription Form (APF) information	Activty Prescription Form webpage
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions	Chapter 2: Information for All Providers
Centers for Occupational Health and Education (COHE) payment incentive information	COHE webpage
Fee schedules for all healthcare services	Fee schedules on L&I's website
FileFast	FileFast
L&I forms	L&I's website
Occupational Disease History Report instructions	How to Bill for an Occupational Disease History Report
Payment policies for attending providers	Chapter 3: Attending Providers

If you're looking for more information about…	Then see…
Payment policies for evaluation and management (E/M) services	Chapter 9: Evaluation and Management (E/M)
Payment policies for mental health services	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Penalty for failing to file accident reports and assist injured workers	Revised Code of Washington (RCW) 51.28.025 RCW 51.48.060
Penalty adjusted for inflation	RCW 51.48.095
Report of Accident information	Deciding When to File an Accident Report

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of
Labor & Industries

Chapter 22: Resource-based Relative Value Scale (RBRVS)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Basis for calculating RBRVS payment levels

Payment methods

Relative value units (RVUs)

Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

- The work,
- Practice expense, and
- Liability insurance (malpractice expense).

A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

Link: A list of current RVUs can be accessed on Medicare's website.

Fee development

RBRVS fee schedule allowances are based on:

- Relative value units (**RVUs**),
- Geographic adjustment factors for Washington State, *and*
- A conversion factor

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU (see RVU geographic adjustments, below).

The maximum fee for a procedure is obtained by multiplying the adjusted RVUs by the conversion factor. The maximum fees are published as dollar values in the Professional Services Fee Schedule.

The conversion factor has the same value for all services priced according to the **RBRVS**. L&I may annually adjust the conversion factor.

Links: The conversion factor is published in WAC 296-20-135, and the process for adjusting the conversion factor is defined in WAC 296-20-132.

RVU geographic adjustments

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State.

The Washington State geographic adjustment factors for July 1, 2025 are:

- 101.3% of the work component RVU,
- 107.8% of the practice expense RVU, *and*
- 78.5% of the malpractice RVU.

Calculation for maximum fees

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor, then
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth, then
3. Multiply the rounded sum by L&I's **RBRVS** conversion factor, and finally
4. Round to the nearest penny.

Note: L&I and Health Care Authority (HCA) use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

Place of service payment differential

Based on where the service was performed, the insurer will pay professional services at the **RBRVS** rates for:

- Facility settings (such as hospitals and ASCs), *and*
- Non-facility settings.

The place of service payment differential is based on CMS's payment policy.

Link: Payment rates for each place of service (POS) code are available in Appendix C: Place of Service (POS) Codes.

The maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

Requirements for billing

Due to the site of service payment differential (see above), it is required to include a valid 2-digit place of service code on your bill.

Payment policy: Facility setting services paid at the RBRVS rate

Payment methods

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

- 1 to the professional provider, *and*
- 1 to the facility.

Payment to the provider includes medical procedures and services provided by a licensed individual provider. The payment to the facility includes resource costs such as:

- Labor,
- Room and board,
- Operating rooms,
- Medical materials & supplies, *and*
- Medical equipment.

Note: To avoid duplicate payment of resource costs, these costs are excluded from the **RBRVS** rates for professional services in facility settings.

Anesthesia services paid using the RBRVS method

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

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

Links: For more information on payment calculations for Anesthesia services paid using the **RBRVS** method, see Chapter 12: Injections and Medication Administration.

Requirements for billing

Remember to include a valid 2-digit place of service code (POS) on your bill. Bills without a POS code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

Payment policy: Non-facility setting services paid at the RBRVS rate

Payment methods

When services are provided in non-facility settings, the professional provider typically bears the costs of:

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

These costs are included in the **RBRVS** rate for non-facility settings. Non-facilities are not eligible for separate facility reimbursement.

Professional services will be paid at the **RBRVS** rate for non-facility settings when the insurer doesn't make a separate payment to a facility.

Requirements for billing

Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

Link: Payment rates for each place of service (POS) code are available in Appendix C: Place of Service (POS) Codes.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for the conversion factor	Washington Administrative Code (WAC) 296-20-132 WAC 296-20-135
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services	Fee schedules on L&I's website
A list of the current RVUs used in calculating the insurer's conversion factor	RVUs on the CMS website

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Washington State Department of
Labor & Industries

Chapter 23: Surgery

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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Payment policy: All surgery services

General information

This policy includes general information about coverage and limitations for surgical procedures. For more information, see L&I's fee schedules, coverage decisions, and treatment guidelines and resources.

This chapter also contains separate policies related to bilateral surgeries, endoscopies, global surgery, pre-, intra-, and post-operative services, multiple surgeries, and unlisted procedures.

Registered Nurses (RN) as surgical assistants

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of their valid and current registered nurse license, *and*
- A letter granting onsite hospital privileges for each institution where surgical assistant services will be performed.

Surgical dressings

Primary surgical dressings are therapeutic or protective coverings directly applied to wounds or lesions on the skin or caused by an opening on the skin. These dressings include items such as:

- Telfa,
- Adhesive strips for wound closure, *and*
- Petroleum gauze.

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. These dressings include items such as:

- Adhesive tape,
- Roll gauze,
- Binders, *and*
- Disposable compression material.

Tobacco cessation treatment for surgical care

The department has published a coverage decision for Tobacco Cessation Treatment for Surgical Care.

CPT® codes **99406** and **99407** may be billed for tobacco cessation counseling.

Billing for each claim is limited to a maximum of 8 units of any combination of the 2 codes.

Angioscopy procedures

Angioscopy during therapeutic intervention (CPT® **35400**) is limited to only 1 unit based on its complete code description encompassing multiple vessels.

Note: The work involved with varying numbers of vessels is incorporated in the relative value units (RVUs).

Bone growth stimulators

These HCPCS (billing) codes for bone growth stimulators require prior authorization:

- **E0747** (Osteogenesis stimulator, electrical, noninvasive, other than spinal application), *and*
- **E0748** (Osteogenesis stimulator, electrical, noninvasive, spinal application), *and*
- **E0749** (Osteogenesis stimulator, electrical (surgically implanted)), *and*
- **E0760** (Osteogenesis stimulator, low intensity ultrasound, noninvasive).

The insurer, with prior authorization, pays for bone growth stimulators for specific conditions when medically necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, *and*
- Implanted electrical stimulators that supply a direct current to the bone.

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Bone morphogenic protein (BMP)

The insurer may cover the use of bone morphogenic protein 7 (rhBMP-7) as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. The insurer may also cover the use of rhBMP-2 for primary anterior open or laparoscopic lumbar fusion at one level between L4 and S1, or revision lumbar fusion on a compromised injured worker for whom autologous bone and bone marrow harvest aren't feasible or not expected to result in fusion.

All of the guidelines for bone morphogenic protein treatment must be met before the insurer will authorize the procedures. In addition, lumbar fusion guidelines must be met.

Bone morphogenic protein-2 (rhBMP-2) isn't covered for use in long bone nonunion fractures.

Bone morphogenic protein-7 (rhBMP-7) isn't covered for use in lumbar fusion.

BMP isn't covered for use in cervical spinal fusion or any other indication.

Chondral defects of the knee

Autologous chondrocyte implants (ACI) isn't covered by the insurer. For more information see, L&I's coverage decision.

Osteochondral Allograft/Autograft Transplantation (OAT) is covered by the insurer with prior authorization. For more information see, L&I's coverage decision.

Closures of enterostomy

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code **44139** will be denied if it is billed with CPT® code **44625** or **44626**.

Epidural adhesiolysis

Epidural adhesiolysis is covered under certain conditions. For details, see L&I's coverage decision.

Femoroacetabular impingement (FAI) syndrome

29914 and **29915** are covered when hip labral tear co-occurs with FAI syndrome. Utilization review is required. For details, see L&I's coverage decision.

Fractional ablative laser

Fractional ablative laser fenestration of burn and traumatic scars requires prior authorization.

0479T and **0480T** are covered for fractional ablative laser fenestration of burn and traumatic scars where deemed medically necessary by the insurer to treat scarring that impairs the worker's function. Authorization will be given only for treatment of scarring that resulted from the industrial injury, or treatment thereof.

Fractional ablative laser isn't covered for cosmetic purposes only.

0479T is limited to a max of 1 unit per day per claim.

0480T is limited to a max of 40 units per day per claim.

Lumbar Intervertebral Artificial Disc Replacement

Lumbar intervertebral artificial disc replacements aren't covered. For more information, see L&I's coverage decision.

Meniscal allograft transplantation

Meniscal allograft transplantation is covered under certain conditions. For more information, see L&I's coverage decision.

Skin Cell Substitutes

The insurer covers certain HCPCS codes for skin cell substitutes. For the current list of covered codes, see the Professional Services Fee Schedule.

Stem cell therapy for musculoskeletal conditions

Stem cell therapy for musculoskeletal conditions isn't covered. For details, see L&I's coverage decision.

Payment policy: Bilateral surgeries

Requirements for billing

Bilateral surgeries must be billed as 2 line items:

- Modifier **–50** must be applied to the second line item, *and*
- The second line item is paid at the lesser of the billed charge, or 50% of the fee schedule maximum.

Bilateral surgeries are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.

If a procedure is performed bilaterally, but isn't subject to the bilateral surgery rule, it must be billed on a single line with the appropriate number of units, based on the code description.

Link: To see if modifier **–50** is valid with the procedure performed, check the Professional Services Fee Schedule.

Example 1: Billing for bilateral surgeries

Line item	CPT® code (and modifier)	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	**64721**	**$827.12**	—	**$827.12**(1)
2	**64721-50**	**$827.12**	**$413.56**(2)	**$413.56**
			Total allowed amount in non-facility setting:	**$1,240.68**(3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

Example 2: Billing for bilateral surgeries and multiple procedures

Line item	CPT® code (and modifier)	Max payment (non-facility setting)	Bilateral policy applied	Multiple procedure policy applied	Allowed amount
1	63042	**$2,316.28**	—	—	**$2,316.28**
2	63042-50	**$2,316.28**	**$1,158.14** (1)	—	**$1,158.14**
				Subtotal:	**$3,474.42** (2,3)
3	22612-51	**$2,817.34**	—	**$1,408.67**(4)	**$1,408.67**
				Total allowed amount in non-facility setting:	**$4,883.09**(5)

(1) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier **–50** is paid at 50% of the value paid for the first line item.

(2) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.

(3) Allowed amount for the highest valued procedure is the fee schedule maximum.

(4) The third line item billed with modifier **–51** is paid at 50% of the maximum payment.

(5) Represents total allowable amount.

Payment policy: Endoscopy procedures

General information

For the purpose of this policy, endoscopy is used to refer to any invasive procedure performed with the use of a fiber optic scope or other similar instrument.

Endoscopy family groupings

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule.

How multiple endoscopy procedures pay

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- The endoscopy procedure with the highest dollar value is 100% of the fee schedule value, *then*
- For subsequent endoscopy procedures, payment is the difference between the family member and the base fee (see Example 1, below), *then*
- When the maximum fee for the family member is less than the maximum base fee, the payment is $0.00 for the family member (see Example 2, below), *then*
- No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group.

If more than 1 endoscopic group or other non-endoscopy procedure is billed for the same worker on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4, below).

Multiple endoscopies that aren't related (each is a separate and unrelated procedure) are priced as follows:

- 100% of fee schedule value for each unrelated procedure, *then*
- Apply the standard multiple surgery policy.

Payment limits

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless:

- A documented, separately identifiable service is provided, *and*
- Modifier **–25** is used.

Example 1: Billing for 2 endoscopy procedures in the same family

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Multiple procedure policy applied	Allowed amount
Base (1)	**29805**	**$867.95**	**$0.00** (2)		—
1	**29820-51**	**$982.28**	**$114.33** (4)	**$57.17** (5)	**$57.17** (6)
2	**29824**	**$1,241.85**	**$1,241.85** (3)		**$1,241.85** (6)
Total allowed amount in non-facility setting:					**$1,299.02** (7)

(1) Base code listed is reference only (not included on bill form).

(2) Payment isn't allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Multiple procedure policy applies to these services if the service is billed with another endoscopy in the same family. The first line item billed with modifier **–51** is paid at 50% of the maximum payment.

(6) Amount allowed.

(7) Represents total allowed amount after applying all applicable global surgery policies..

Example 2: Billing for endoscopy family member with fee less than base procedure

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	43235	**$524.39**	—	—
1	43241	**$250.82**	**$0.00** (3)	
2	43243	**$416.48**	**$416.48** (2)	**$416.48** (4)
			Total allowed amount in non-facility setting:	**$416.48** (5)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the endoscopy policy.

(5) Represents total allowed amount.

Example 3: Billing for 2 surgical procedures billed with an endoscopic group (highest fee)

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	11402	**$316.15**	—	**$158.08** (5)
2	11406	**$582.13**	—	**$291.07** (5)
Base (1)	29830	**$846.37**	—	—
3	29835	**$940.86**	**$94.49** (3)	**$47.25** (5)
4	29838	**$1,093.69**	**$1,093.69** (2)	**$1,093.69** (4)
Total allowed amount in non-facility setting:				**$1,590.09** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: Billing for 1 surgical procedure (highest fee) billed with an endoscopic group

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	23412	**$1,552.16**		**$1,552.16** (4)
Base (1)	29805	**$867.95**		
2	29820	**$982.28**	**$114.33** (3)	**$57.17** (5)
3	29824	**$1,241.85**	**$1,241.85** (2)	**$620.93** (5)
Total allowed amount in non-facility setting:				**$2,230.26** (6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100% of fee schedule value.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

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Payment policy: Global surgery

Global surgery follow up periods

Many surgeries have a follow up period during which charges for normal post-operative care are **bundled** into the global surgery fee.

The global surgery follow up period for each surgery is listed in the 'FOL UP' column in the Professional Services Fee Schedule.

A new post-operative period begins with the subsequent procedure.

What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless modifier **–24**, **–57** or **–FT** are appropriately used:

- E/M codes:
  - **99212**-**99215**,
  - **99231**-**99239**,
  - **99291**-**99292**,
  - **99304**-**99310**,
  - **99315**-**99316**,
  - **99347**-**99350**,
- Ophthalmological codes: **92012**-**92014**

Link: For information about these requirements, see the Separately billable services policy Chapter 9: Evaluation and Management (E/M), and Appendix B: Modifiers.

The following services and supplies **are included** in the global surgery follow up period and are considered **bundled** into the surgical fee:

- The operation itself, *and*
- Pre-operative visits, in or out of the hospital, beginning once the decision to operate is made and/or on the day before the surgery, *and*
- Services by the primary surgeon, in or out of the hospital, during the post-operative period, *and*
- The following services:
    - Dressing changes, *and*
    - Local incisional care and removal of operative packs, *and*
    - Removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, *and*
    - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric, and rectal tubes, *and*
    - Change and removal of tracheostomy tubes, *and*
    - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

What isn’t included in the follow up period

The following services and supplies aren’t included in the global surgery follow up period and may be separately payable:

- Casting materials, *and*
- The initial **consultation** or evaluation by the surgeon to determine the need for surgery, *and*
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care, *and*
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications, *and*
- Treatment for the underlying condition or an added course of treatment which isn’t part of the normal surgical recovery, *and*
- Diagnostic tests and procedures, including diagnostic radiological procedures, *and*
- Distinct surgical procedures during the post-operative period which aren’t reoperations or treatment for complications, *and*
- Treatment for post-operative complications which requires a return trip to the operating room, *and*
- Immunotherapy management for organ transplants, *and*
- Critical care services (CPT® **99291**, **99292**) unrelated to the surgery where a seriously injured or burned worker is critically ill and requires constant attendance of the provider, *and*
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

In many of these cases, the appropriate modifier must be appended to indicate the service isn’t included in the global surgery period. Refer to the relevant policy in this chapter, Appendix B: Modifiers, or the CPT® book for details.

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Who must perform these services to qualify for payment

The follow up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the worker; identified by modifiers **–54**, **–55**, and **–56**,),
- Assistant surgeon (identified by modifiers **–80**, **–81**, and **–82**),
- 2 surgeons (identified by modifier **–62**),
- Team surgeons (identified by modifier **–66**),
- Anesthesiologists and CRNAs.

Documentation requirements

Providers, including providers participating in multiple and team surgeries, must submit documentation in workers' individual operative reports to verify the level, type, and extent of surgical services. Surgeons using an assistant surgeon must document the name and actions of the assistant surgeon.

Payment limits

Professional inpatient services (CPT® codes **99221-99223**) are only payable during the global period if they are performed on an emergency basis. For example, they aren't payable for scheduled hospital admissions.

Codes that are considered **bundled** aren't payable during the global surgery follow up period.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of **DME** and won't be reimbursed as **DME**.

Pneumatic compression devices used during surgery and sent home with the worker are considered surgical supplies. The cost of the device is **bundled** into the surgical service fee and isn't separately payable, even to **DME** suppliers. For details on coverage of **pneumatic compression devices**, see Chapter 7: Durable Medical Equipment (DME) and Supplies.

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Payment policy: Microsurgery

Services that can be billed

CPT® code **69990** is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

Payment limits

CPT® code **69990** isn't payable when:

- Using magnifying loupes or other corrected vision devices, *or*
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), *or*
- Another code describes the same procedure being done with an operative microscope.

For example, CPT® code **69990** can't be billed with CPT® code **31536** because CPT® code **31536** describes the same procedure using an operating microscope.

Payment policy: Minor surgical procedures

General information

Minor surgical procedures are those that have a global period of 10 or less days. These services may be performed in a physician's office or in a facility setting, as appropriate.

Services that can be billed

For minor surgical procedures, the insurer only allows payment for an evaluation and management (E/M) office visit on the same day and/or during the global period when:

- A documented, significant, unrelated service is furnished during the post-operative period and modifier **–24** is used, or
- The provider who performs the procedure also reports a significant, separately identifiable service on the same date and modifier **–25** is used.

Link: For information about these requirements, see the Separately billable services policy Chapter 9: Evaluation and Management (E/M), and Appendix B: Modifiers.

Services that aren't covered

Modifier **–57**(decision for surgery) isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and an E/M or **consultation** visit isn't paid in addition to the procedure.

Services billed with modifier **–SU** when performed in physician's office aren't covered. Bill without the modifier.

Payment limits

Modifier **–57** is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

Procedures performed in a provider's office are paid at non-facility rates, which includes office expenses. The provider's office must meet ASC requirements to qualify for separate facility payments.

Link: For information about ASC requirements, see WAC 296-23B.

Payment policy: Pre, intra, or post-operative services

Services that can be billed

The insurer will allow separate payment when different providers perform the pre-operative, intra-operative, or post-operative components of the surgery.

Link: Pre and post operative evaluation and management (E/M) services are typically **bundled** in the procedure and aren't separately payable. For more information on when these services are covered outside the global surgical period, see Chapter 9: Evaluation and Management (E/M).

Requirements for billing

When different providers perform pre-operative, intra-operative, or post-operative components of the surgery, modifiers (**–54**, **–55**, or **–56**) must be used.

If different providers perform different components of the surgery (pre, intra, or post-operative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the worker to another provider for the post-operative care, the same global surgery policy, including the restrictions in the follow up day period, applies to both providers.

Link: For information on modifiers, see Appendix B: Modifiers.

Payment limits

When modifiers **–54**, **–55**, or **–56** are billed, the percent of the maximum allowable fee for each component of the global surgery is listed in the Professional Services Fee Schedule.

Payment policy: Standard multiple surgeries

How multiple surgeries pay

When multiple surgeries are performed on the same worker at the same operative session or on the same day, the total payment equals the sum of:

- 100% of the global fee schedule value for the procedure or procedure group with the highest value, according to the fee schedule, and
- 50% of the global fee schedule value for the second through fifth procedures with the next highest values, according to the fee schedule.

When different types of surgical procedures are performed on the worker on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures, *then*
- Other modifier policies, *then*
- Standard multiple surgery policy.

Requirements for billing

All surgical procedure codes subject to the standard multiple surgery policy must be billed as a separate line item.

For additional instructions on billing bilateral procedures, see the payment policy on bilateral procedures in this chapter.

Payment policy: Unlisted surgical procedures

General information

Some covered procedures don't have a specific code or payment level listed in the fee schedule. These services are billed using an unlisted CPT® code.

Requirements for billing

When reporting such a service, the appropriate unlisted procedure code must be billed.

Documentation requirements

Within the surgical report, supporting documentation must include:

- 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 an established procedure code(s).
- List the most similar procedure code(s) to the services performed, including units of service and appropriate modifiers.

No additional payment is made for the supporting documentation.

Services that aren't covered

Unlisted codes can't be billed when another code describes the service provided.

Unlisted codes aren't appropriate when a service for which a code exists was substantially more complex than typically required. When this occurs, the provider must bill the specific code with modifier **–22** to indicate an increased procedural service was performed. For more information on use of modifier **–22**, see Appendix B: Modifiers.

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Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for Ambulatory Surgery Center (ASC) payment	Washington Administrative Code (WAC) 296-23B
Ambulatory Surgery Center **Fee Schedule**	Fee schedules on L&I's website
Autologous chondrocyte implant (ACI)	Autologous chondrocyte implant coverage decision
Becoming an L&I Provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bone growth stimulators	Bone growth stimulators coverage decision
Bone morphogenic protein (BMP)	Bone morphogenic protein coverage decision
Condition and Treatment Index	Condition and treatment index on L&I's website
Epidural adhesiolysis	Epidural adhesiolysis coverage decision
Medical treatment guideline for Lumbar fusion arthrodesis	Lumbar fusion arthrodesis treatment guidelines
Meniscal allograft transplantation	Meniscal allograft transplantation coverage decision
Professional Services **Fee Schedules**	Fee schedules on L&I's website
Tobacco Cessation Treatment for Surgical Care	Tobacco cessation treatment for surgical care coverage decision

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of Labor & Industries

Chapter 24: Telehealth, Remote, and Mobile Services

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All telehealth services

General information

This payment policy applies to all services provided via telehealth, except:

- **Independent Medical Exams (IME).** Refer to the payment policy: **Telehealth** for independent medical exams (IME) in this chapter.
- **Vocational services.** Refer to the **Remote** services policy in Chapter 25: Vocational Services.
- **Interpretive services.** Refer to Chapter 14: Language Access Services for Spoken Language or the Sign language interpretation policy in Chapter 18: Other Services.

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 an in-person evaluation and intervention(s) in certain circumstances. See Services that must be performed in person in this policy and the service-specific policies in this chapter for additional details.

When scheduling the **telehealth** visit, the provider is responsible for ensuring **telehealth** is the appropriate method of service delivery to effectively conduct the services.

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

System requirements

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

Services provided without a video connection (audio-only) aren't considered **telehealth**. Audio-only evaluation and/or intervention isn't covered for most services. See the Audio-only services policy in this chapter for exceptions.

Note: L&I doesn't follow the Center for Medicare and Medicaid Services (CMS) definition of **telehealth** which includes audio-only.

Originating site requirements

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.

Links: For more information about billing **originating site** fee **Q3014**, see the Originating site fee for telehealth policy in this chapter.

Prior authorization

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

Services that must be performed in person

The provider is expected to make arrangements for in-person evaluation and/or intervention in certain circumstances.

In-person services are always required when:

- The provider has determined the worker isn't a candidate for **telehealth** either generally or for a specific service, *or*
- The worker doesn't want to participate via **telehealth**, *or*
- A worker files a reopening application, *or*
- A **consultation** is requested to determine if continued conservative care is appropriate (including but not limited to 60 and 120 day consults) or to satisfy the 6-month in person requirement for mental health, *or*
- When the service to be performed requires a hands-on component.

Except for mental health services, in-person services are also required when:

- It is the first visit of the claim, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of **attending provider**.

The insurer prefers that physical and occupational therapy services be provided in person.

Links: For information on in-person requirements for specific services, including mental health, see the supplemental policies in this chapter.

Services that can be billed

Telehealth is covered for most services that don't require a hands-on component, with exception of those listed in Services that must be performed in person.

Due to the medico-legal nature of workers compensation, only the following types of services may be covered via **telehealth**. This list includes links to service-specific supplemental **telehealth** policies in this chapter detailing additional or differing service requirements. Unless otherwise noted, the All telehealth services payment policy applies.

- Activity coaching (PGAP®),
- Brain Injury Rehabilitation Programs (BIRP),
- Chronic Pain Management (SIMP) services,
- Evaluation and Management (E/M) Services, including teleconsultations,
- Mental health services and Behavioral Health Interventions (BHI),
- Nurse Case Management (NCM),
- Obesity treatment, *and*
- Physical medicine services.

Originating site and store and forward fees are covered, when applicable. See the payment policies in this chapter for additional details.

Supervision via telehealth

Direct supervision of **students** may be provided via **telehealth**, but only when the service to the worker is allowed via **telehealth**, except for physical (PT) and occupational (OT) therapy **students**. When performing this type of direct supervision, the provider must bill the service using modifier **–FR** (supervisor present via **telehealth**), in addition to modifier **–GT**. Don't bill modifiers with local codes.

Certain services require in-person care. These services require in person direct supervision, in alignment with Department of Health (DOH) requirements for **student** and assistant licensures. PT/OT **students** must always have in person direct supervision, even if the service is provided via **telehealth**.

Links: For more information on **students** and **student** supervision, see Chapter 2: Information for All Providers and Chapter 20: Physical Medicine.

For information on **telehealth** vocational services, IMEs, and video **remote** interpretation, see the links at the beginning of this policy.

Services that aren't covered

Telehealth procedures and services that aren't covered include:

- An examination to complete a Report of Accident (ROA/PIR). 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.
- All re-opening examinations,
- The same services that aren't covered in the applicable service chapters,
- The services listed in Services that must be performed in person in this policy and the service-specific supplemental policies in this chapter,
- Services that require physical hands-on and/or attended treatment of a worker,
- Examinations to complete an Activity Prescription Form (APF) when the update will take the worker off work or the provider increases the worker's restrictions, except when completed by a mental health provider, *and*
- Home health monitoring.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment. Including but not limited to the purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems.

Evaluation and/or treatment via app-based services or texting isn't covered.

Links: Telephone calls (audio-only) aren't an appropriate replacement for most in-person and/or **telehealth** services. The insurer won't pay for audio-only evaluation and/or intervention (modifier **–93**), except for those listed in the audio-only services policy in this chapter.

For telephone calls related to but not used to render treatment (case management), see Chapter 5: Care Coordination.

Requirements for billing

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person, unless otherwise specified in the service-specific supplemental policies in this chapter.

The insurer doesn't recognize modifier **–95**. Bill using modifier **–GT** to indicate **telehealth**, except when billing L&I local codes.

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

The insurer reimburses **telehealth** based on where the worker is at the time of service. The insurer doesn't reduce payment for **telehealth** appointments.

Place of service **27** (outreach site/streets) isn't covered. When **telehealth** is provided to a worker that is not in a facility, POS **10** (home) should be used.

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 in each **telehealth** visit.

If evaluation and/or intervention is to continue via **telehealth**, evaluation reports must include a detailed plan for implementing **telehealth** as agreed upon in a collaborative manner between the provider and worker.

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

Payment limits

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

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Supplemental payment policy: Telehealth for activity coaching (PGAP®)

General information

In addition to the information within the all telehealth services policy, the following is applicable to activity coaching (PGAP®).

Services that can be billed

Activity coaching (PGAP®), including **1400W**-**1402W** and **1160M**, may be performed in person, via audio only, or **telehealth**.

Links: For more information about PGAP® services performed via an audio-only connection, see the Audio-only services payment policy in this chapter. For telephone calls related to but not used to render treatment, see Chapter 5: Care Coordination and Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Requirements for billing

The insurer doesn't recognize modifier **–95**. Do not bill using modifier **–GT** to indicate **telehealth** with local codes.

Supplemental payment policy: Telehealth for brain injury rehab programs (BIRP)

General information

In addition to the information within the all telehealth services policy, the following is applicable to brain injury rehab programs (BIRP).

Services that must be performed in person

Comprehensive brain injury evaluations (**8950H**, rev code **0014**) must be performed in person, even if the equivalent stand-alone service is allowed via **telehealth**.

Services that can be billed

Telehealth services that can be billed for BIRP include post-acute brain injury rehabilitation:

- Full day (**8951H**, rev code 0015), *and*
- Half-day (**8952H**, rev code 0016).

Requirements for billing

The insurer doesn't recognize modifier **–95**. Do not bill using modifier **–GT** to indicate **telehealth** with local codes.

Supplemental payment policy: Telehealth for chronic pain management (SIMP)

General information

In addition to the information within the all telehealth services policy, the following is applicable to chronic pain management (**SIMP**).

Services that must be performed in person

SIMP evaluation services (**2010M**) must be performed in person, even if the equivalent stand-alone service is allowed via **telehealth**.

Services that can be billed

Telehealth services that can be billed for **SIMP** include:

- **SIMP** treatment services (**2011M**), *and*
- **SIMP** follow up face-to-face services (**2014M**).

Requirements for billing

SIMP follow up that doesn't occur face-to-face (**2015M**) is covered via audio only under the regular local code, based on its description. It would not be appropriate to use this code for **SIMP** follow up via **telehealth**.

The insurer doesn't recognize modifier **–95**. Do not bill using modifier **–GT** to indicate **telehealth** with local codes.

Links: For more information about **SIMP** follow-up non-face-to-face services (**2015M**), see the chronic pain management policy in Chapter 27: Rehabilitation Facilities and Programs.

Payment limits

Physical medicine services including exercise and work rehabilitation activities conducted via **telehealth**, including as part of a chronic pain management program (**SIMP**), are limited to 2 hours per day per worker.

Supplemental payment policy: Telehealth for evaluation and management (E/M) services

General information

In addition to the information within the all telehealth services policy, the following is applicable to evaluation and management (E/M) services.

Services that can be billed

New & established outpatient office visits

The American Medical Association (AMA) made substantial changes to **new** and **established patient** evaluation and management (E/M) office visits provided via **telehealth**, effective January 1, 2025. The insurer has chosen to **not** adopt these changes, including CPT® codes (**98000**-**98007**).

Providers must continue to use in-person **new** and **established** outpatient CPT® codes (**99202**-**99215**) appended with modifier **–GT**, for these services provided via **telehealth**.

Teleconsultations

Teleconsultations are **consultations** requested by the **attending provider**, department, self-insurer, or authorized department representative that are performed via **telehealth**.

Only **attending providers** who have E/M in their scope of practice can report teleconsultations using E/M codes (**99242**-**99245**, **99252**-**99255**). Psychologists must use the mental health evaluation CPT® code **90791** to report these services.

The insurer covers teleconsultations in alignment with L&I's in-person **consultations** policies.

Team conferences

Team conferences (CPT® **99367**, **99366**, **99368**, or E/M code) may be performed via **telehealth**.

Links: Learn more about coverage and requirements for **consultation** services in Chapter 3: Attending Providers, WAC 296-20-045, WAC 296-20-051, and WAC 296-20-01002.

For more information on team conferences, see Chapter 5: Care Coordination.

For more information on audio-only services, see the Audio-only services policy in this chapter.

Services that aren't covered

Per WAC 296-20-01501, teleconsultations can't be performed by physician assistants (PA).

Per WAC 296-20-051, providers can't bill **consultation** codes for **established patients**.

New and **established** outpatient **telehealth** visits billed using synchronous audio-video CPT® codes (**98000**-**98007**) aren't covered.

Consultations performed by psychologists using E/M **consultation** codes (**99242**-**99245**, **99252**-**99255**) aren't covered. Psychologists must use the mental health evaluation CPT® code **90791** to report these services.

Documentation requirements

For teleconsultations, the **telehealth** provider must submit a written report that meets all in-person **consultation** and telehealth documentation requirements including the name of the referring provider, to the insurer and referring provider.

Links: For more information on **consultation** documentation requirements, see Chapter 3: Attending Providers. For more information on other E/M visits, see Chapter 9: Evaluation and Management (E/M).

Supplemental payment policy: Telehealth for mental health services and behavioral health interventions (BHI)

General information

In addition to the information within the all telehealth services policy, the following is applicable to mental health services and behavioral health interventions (BHI).

Services that must be performed in person

Mental health services

Mental health **consultations** performed via **telehealth** follow the same requirements as L&I's in-person policies. For complete details, see the **consultations** policy in Chapter 3: Attending Providers.

In-person visits aren't required for mental health when:

- It is the first visit of the claim, *or*
- The worker has an emergent issue such as re-injury, new injury, or worsening status*, or*
- Restrictions or changes are anticipated (the APF requires an update), *or*
- A worker requests a transfer of **attending provider**.

However, an **in-person visit is required once every 6 months for mental health services.** In-person mental health visits may occur with another mental health provider in place of the current treating provider. The evaluating mental health provider must:

- Document the referral from the treating provider for an in-person evaluation, *and*
- Submit documentation of the visit to the insurer as well as the treating provider.

Note: MLTs must refer to a psychologist, psychiatric ARNP, or psychiatrist for an in-person mental health evaluation to satisfy the 6-month in-person visit requirement to continue **telehealth**-based mental health care.

Services that can be billed

Behavioral Health Interventions (BHI)

Establishing BHI care and performing interventions via **telehealth** is covered.

Mental health services

Mental health examinations to complete an initial ROA or PIR filing and/or Activity Prescription Forms (even when restrictions or changes are anticipated) are covered when performed via **telehealth**.

Mental health teleconsultations and **telehealth** evaluations must be performed by a psychiatrist (MD or DO), psychiatric ARNP, or licensed clinical psychologist (PhD or PsyD) and in line with the payment policies in Chapter 17: Mental Health and Behavioral Health Interventions (BHI). MLTs can't perform mental health evaluations in person or via **telehealth**.

Neuropsychological (**96132**, **96133**) and psychological evaluation (**96130**, **96131**) may be performed via **telehealth**. The test administration and scoring (**96137**-**96139**, **96147**) must be completed in-person.

Neurobehavioral status examinations (**96116**, **96121**) may be performed via **telehealth**.

Links: Mental health services and BHI may be payable via audio-only in certain circumstances. For additional details, see the Audio-only payment policy in this chapter. Telephone calls related to but not used to render treatment, see Chapter 5: Care Coordination.

Services that aren't covered

Neuropsychological and psychological test administration and scoring (**96137**-**96139**, **96147**) isn't covered via **telehealth**. The evaluation (**96130**-**96133**) may be completed in-person or via **telehealth**.

All re-opening examinations must be completed in person.

App-based and texting therapy, such as Better Help, Talkiatry, Talkspace, and other similar services, isn't covered.

Supplemental payment policy: Telehealth for nurse case management (NCM)

General information

In addition to the information within the all telehealth services policy, the following is applicable to nurse case management (NCM).

Services that can be billed

NCM casework (**1297M**) may be performed in person, via audio only, or **telehealth**.

Requirements for billing

The insurer doesn't recognize modifier **–95**. Don't bill using modifier **–GT** to indicate **telehealth** with local codes.

Supplemental payment policy: Telehealth for obesity treatment

General information

In addition to the information within the all telehealth services policy, the following is applicable when providing obesity treatment .

Services that can be billed

Telehealth services that can be billed for obesity treatment include:

- Nutrition counseling – **initial visit** (**97802**), *and*
- Nutrition counseling – re-assessment (**97803**).

Supplemental payment policy: Telehealth for physical medicine services

General information

In addition to the information within the all telehealth services policy, the following is applicable to physical medicine services.

Speech (SLP), physical (PT), and occupational therapists (OT) as well as their assistants, athletic trainers, and **students** may conduct services via **telehealth**.

Direct supervision in accordance with **student** licensures must be provided in-person, even if the service is provided to the worker via **telehealth**.

Direct supervision of therapy assistants may occur via **telehealth** (modifier **–FR**) when the service to the worker is allowed via **telehealth**. Certain services require in-person care. These services require in-person direct supervision in alignment with DOH requirements for the assistant licensure.

Services that must be performed in person

Physical medicine services that must be performed in person also include:

- Work rehabilitation (**1001M**, **1023M**, **1024M**, **97545**, **97546**),
- Functional Capacity Evaluations (**1045M**, **1098M**)

Direct supervision of physical medicine **students** must occur in-person (Modifier **–FR** is not covered).

Payment limits

Physical medicine services conducted by **telehealth** are limited to 2 hours per day per worker, regardless of the service provided.

Payment policy: Audio-only services

General information

This payment policy applies to all evaluation and interventions provided via audio only, except for vocational and spoken interpretive services. See the separate policies for these services.

Audio-only shouldn't be used in place of telehealth or in-person services. The insurer won't pay for audio-only evaluation and/or interventions billed using modifier **–93** (audio-only), except for those listed in this policy and that meet specific requirements. The services covered in this policy are only allowed via-audio only when a documented attempt has been made to conduct the service via an audio-visual connection. Audio-only isn't covered for any service, except those noted in Services that can be billed, even when an audio-visual connection has been attempted or in any circumstance where the worker refuses to conduct the service using the video connection.

Links: Services that are customarily delivered by audio-only technology, such as case management telephone calls (**9919M**) and **SIMP** follow-up non-face-to-face services (**2015M**) aren't considered audio-only.

For telephone calls related to but not used to render treatment (case management telephone calls), see Chapter 5: Care Coordination.

For **SIMP** follow-up non-face-to-face services, see the chronic pain management policy in Chapter 27: Rehabilitation Facilities and Programs.

System requirements

Audio-only services involve delivery of treatment through use of audio-only technology that permits real-time connection between the worker and provider. Providers are responsible for ensuring complete confidentiality and protecting the privacy of the worker at all times.

Note: L&I doesn't follow the Centers for Medicare and Medicaid Services (CMS) definition of **telehealth** which includes audio-only.

Originating site requirements

Audio-only 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 audio-only services must be licensed in the state where the worker is receiving audio-only services. Only vocational rehabilitation counselors are exempt from this requirement.

Prior authorization

The insurer covers mental health interventions via audio only when prior authorization for mental health has been obtained, and only in specific circumstances.

For all other services, the prior authorization requirements listed in the applicable service chapters apply regardless of how the service is rendered to the worker, either in person or via audio only, or **telehealth**.

Services that must be performed in person

The provider is expected to make arrangements for in-person evaluation and/or intervention in certain circumstances. Audio-only services follow the same in-person requirements as **telehealth**.

Services that can be billed

Audio-only is covered for the following services, except for the circumstances linked above in Services that must be performed in person.

Activity coaching (PGAP®)

Activity coaching (PGAP®), including **1400W-1402W** and **1160M**, may be performed in person, via audio only, or **telehealth**.

Behavioral Health Interventions (BHI)

Behavioral health interventions (BHI) may be performed via audio-only, but only if **telehealth** isn't available for the worker.

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.

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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**).

Links: BHI doesn't include components of a diagnosed mental health condition and shouldn't be used in place of a mental health referral or intervention. For more information on how mental health and BHI may intersect, see Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

Mental Health Services

When mental health services are conducted via audio only, the provider is unable to perform a visual assessment of the worker. Therefore, the insurer has adopted a modified list of services that may occur via audio only.

The following CPT® codes are covered when performed via audio-only:

- Psychiatric diagnostic evaluation (**90791**),
- Psychotherapy, without an E/M (**90832**, **90834**, **90837**),
- Crisis psychotherapy (**90839**, **90840**),
- Family psychotherapy with worker (**90847**), *and*
- Group psychotherapy (**90853**).

In addition, CPT® **90785** (interactive complexity) may be billed if it is appropriate for the audio-only visit but only when billed with CPT® **90791**, **90832**, **90834**, **90837**, or **90853**. See CPT® for additional requirements when billing CPT® **90785**.

Nurse case management

NCM casework (**1297M**) may be performed in person, via audio only, or **telehealth**.

Services that aren't covered

Audio-only services that aren't covered include:

- Services that require visual intervention of a worker,
- Audio-only services done for the convenience of the provider or worker,
- Any service not listed in Services that can be billed above,

- Services listed in Services that must be performed in person, *and*
- Audio-only outpatient evaluation and management (E/M) services (**98008**-**98015** or in-person E/M codes with modifier **–93**).

Originating site fees (**Q3014**) aren't covered for audio-only services.

Requirements for billing

When billing audio-only delivery of...	Bill using...
PGAP® (**1400W**-**1402W** or **1160M**)	No modifier.
Behavioral Health Interventions (**9959M**)	No modifier.
Mental health evaluation (**90791**) or psychotherapy (**90832**, **90834**, **90837**, **90839**, **90840**, **90847**, **90853**, **90785**)	Modifier **–93**.

Providers billing for audio-only services must use place of service **02** to denote the audio-only visit when the worker isn't located in their home and will be reimbursed at the facility rate. Providers billing for audio only services must use place of service **10** to denote the audio-only visit when the worker is located in their home and will be reimbursed at the non-facility rate.

Documentation requirements

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

- The date of the call, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call, *and*
- All medical, vocational, or return to work decisions made, *and*
- A notation of the worker's **originating site**,
- Documentation of attempt made to conduct the service via an audio-visual connection, *and*
- Documentation of the worker's consent to participate in audio-only services.

Chart notes, including BHI assessment forms, must contain documentation that justifies the level, type and extent of services billed. See this chapter and other applicable MARFS chapter(s) for the **type of service** rendered and the documentation requirements.

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Payment limits

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

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

Payment policy: Mobile clinic services

General Information

Mobile clinics must obtain a group provider account using the location address on their business license for their application in ProviderOne. Each licensed provider rendering services via the mobile clinic must be individually credentialed under the mobile clinic's group provider account. Professional services must be billed under the individual provider's account who rendered the service with their usual and customary fees. Technicians of any kind are not eligible to be credentialed. Services provided by technicians, when appropriate, must be billed by the supervising provider.

The mobile clinic is considered to be the provider's usual and customary location. Providers who are traveling to provide services outside of their usual and customary location aren't considered to be providing service in a mobile clinic. **IME** providers can't provide services via a mobile clinic and must follow the policies outlined in Chapter 11: Impairment ratings and Independent Medical Exams (IMEs).

Filing of a Report of Accident/Provider's Initial Report (ROA/PIR) is required for occupational illness or injuries requiring treatment beyond basic first aid as defined in WAC 296-800-099.

Workers have the right to choose their healthcare providers and file a claim if they have reason to believe their injury or illness is work related, even if the provider or employer disagrees.

Link: For more information on provider accounts and billing instructions, see WAC 296-20-010, and WAC 296-20-125.

For more information on provider and worker responsibilities, see WAC 296-20-065, WAC 296-20-025, Chapter 2: Information for All Providers, and our website.

Prior authorization

Prior authorization may be required for services provided. See the applicable MARFS chapters for details.

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

Services that can be billed

Providers rendering services out of a mobile clinic may bill for services within their scope of practice and that adhere to the department's rules and policies.

Mobile clinics qualify as an appropriate **originating site** for **telehealth** coverage.

Note: For more information on specific service requirements and limitations, see the appropriate MARFS chapter.

Services that aren't covered

Services provided via a mobile clinic are subject to the coverage requirements for the service being provided.

The mobile clinic or it's providers can't charge the worker or the insurer for:

- Appointment hold fees,
- Mileage (including **1046M**),
- Transportation and set up of radiology services (**R0070**, **R0075**, **R0076**, or **Q0092**). For additional information on portable x-rays, see the Portable radiology services policy in this chapter,
- Diagnostic ultrasound performed on the same day as an Evaluation and Management (E/M) office visit as it is considered **bundled** into the E/M CPT® code, *or*
- Basic first aid as defined by WAC 296-800-099.

Providers may bill workers for missed appointments, only if their established policy equally applies to all patients per WAC 296-20-010(6). For additional information on missed appointments, see Chapter 2: Information for All Providers.

Requirements for billing

Services provided via a mobile clinic are subject to the billing requirements for the service being provided.

When scheduling a mobile clinic visit, the provider is responsible for ensuring it is an appropriate environment to effectively conduct the services. The services must be rendered in a private space within the mobile clinic to allow for confidentiality.

In order to bill for rapid testing or other labs, the mobile clinic is required to obtain a Medical Test Site (MTS) license through the Department of Health.

Place of Service

When services are furnished in a mobile clinic, they are often provided to serve an entity for which another Place of Service (POS) exists. The following describes how to identify the appropriate POS code and associated requirements for billing.

- The appropriate POS code is based on the capacity in which the mobile clinic is serving. See the table below for more details.

- Services will be paid at the facility or non-facility rate based on the appropriate POS code. For a complete list of payment rates for each POS code, see Chapter 2: Information for All Providers.
- All services must be appropriate to render in the location of the applicable POS code and must be safe to perform in a mobile environment. Surgeries and procedures required to be performed at certain types of facilities aren't covered when performed in a mobile clinic, even if the appropriate facility POS code is used.

When the mobile clinic is…	Use POS Code…	Additional information:
Serving an entity for which another POS exists. Example: A mobile clinic is sent to a physician's office and is serving that entity.	Applicable POS for entity mobile clinic is serving. Example: The appropriate POS code is 11 (office) and would be reimbursed at the non-facility rate.	Reimbursement based on the payment rate for the POS code billed.
Not serving an entity for which another POS exists. Example: A mobile clinic providing urgent care in a grocery store parking lot.	POS 15 (mobile clinic).	POS 15 is reimbursed at the non-facility rate.
Acting as a **distant site** for a **telehealth** provider.	POS 02 (**telehealth** – worker is not at home) POS 10 (**telehealth** – worker is at home)	For more details on **telehealth** requirements, see the appropriate MARFS chapter for the services being provided.

Link: For a complete list of POS codes and their full descriptions, see CMS Place of Service Code Set.

Documentation requirements

In addition to the documentation requirements for the service being provided, providers rendering services via a mobile clinic also must document:

- A notation that the visit is being rendered via a mobile clinic,
- The entity in which the mobile clinic is servicing, if applicable, *and*
- The address of the location where the visit takes place.

Payment Limits

Services provided via a mobile clinic are subject to the payment limits for the service provided.

Drive-through clinics using POS 15 are limited to the lowest level E/M CPT® code **99211**. Higher-level E/M codes billed with POS 15 aren't covered.

Payment policy: Originating site fee for telehealth

General information

The insurer may 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.

Services can be billed

Originating site fees (**Q3014**) include only the use of the provider's **telehealth** equipment. The **distant site** provider conducting the services via **telehealth** must bill for the professional services rendered.

Q3014 is payable when the **originating site** provider (clinic or facility payee) owns the **distant site** where the provider is conducting the **telehealth** service. In this case, it may be appropriate for the **distant site** provider to bill for **Q3014**.

Q3014 is only payable to independent medical examiners in certain circumstances. See Telehealth for independent medical exams (IME) for details.

Services that aren't covered

Q3014 isn't covered when:

- The **originating site** provider performs any service to the worker 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.

Requirements for billing

To bill for the **originating site** fee, use HCPCS code **Q3014**.

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

Q3014 Billing Example

A worker attends an in-person Evaluation and Management (E/M) appointment at their **attending provider**'s office. The **attending provider** documents all necessary information

as part of this visit and bills for the E/M service. The **originating site** (**attending provider**'s office) also arranges a secure and private space for the worker to participate in a **consultation** with their cardiologist at another location (**distant site** provider). The **originating site** provider separately documents the use of their space as part of their bill for **Q3014**.

How to bill for this scenario

The **originating site** provider may bill the insurer **Q3014** for allowing the worker to use their space for their **telehealth** visit with the **distant site** provider. The **distant site** provider bills for the services they provide; they can't bill **Q3014**.

For this **telehealth** visit:

- The **distant site** provider would bill the appropriate CPT® E/M code with modifier **–GT**.
- The **originating site** provider would bill **Q3014**.

Note: For more information on E/M service requirements, refer to Chapter 9: Evaluation and Management (E&M).

Documentation requirements

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 (distinctly separate visit) to a worker, separate documentation is required for both the in-person visit and the **Q3014** service.

Documentation by the **originating site** provider for **Q3014** must include:

- The location of the **originating site**,
- A notation of who the **distant site** provider is, *and*
- That the service is separate from any in-person visits that occurred on the same day, if applicable.

Payment limits

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.

Payment policy: Portable radiology services

General information

This policy applies only to the transportation and set up of portable radiology equipment, not the radiology services provided. For information regarding radiology services and their requirements, see Chapter 8: Electrodiagnostics and Radiology.

Services that can be billed

Portable X-ray services (transportation and set up of equipment) are only payable when the worker can't access or otherwise be examined on fixed conventional X-ray equipment and the X-ray service is furnished in the worker's place of residence, which includes:

- The workers' home,
- Assisted living, adult family, or boarding home, *and*
- Skilled Nursing Facilities.

All tests must be performed under the general supervision of a physician and are limited to:

- Skeletal films involving extremities, pelvis, vertebral column, *or* skull,
- Chest or abdominal films that don't involve the use of contrast media, *and*
- Diagnostic mammograms.

Code	Description	Modifier (if applicable)	**Maximum fee**
R0070	Transportation of portable x-ray equipment to a worker's residence, per trip; 1 patient served		**$202.47**
R0075	Transportation of portable x-ray equipment to a worker's residence, per trip, 2 patient served	**–UN**	**$101.24**
	3 patients served	**–UP**	**$67.50**
	4 patients served	**–UQ**	**$50.60**
	5 patients served	**–UR**	**$40.49**
	6 patients served	**–US**	**$33.75**
Q0092	Set-up of portable x-ray equipment, each procedure		**$50.16**

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Services that aren't covered

R0070, **R0075** or **Q0092** for portable X-ray services aren't covered when:

- Performed in a location other than the workers' place of residence,
- The equipment was stored in the location the service was performed (such as a mobile clinic or stored at the worker's place of residence).

Transportation of portable EKGs (**R0076**) to any location is **bundled** into the EKG procedure and isn't separately payable.

There are no codes for transportation of portable ultrasound equipment. This is not a covered benefit.

Documentation requirements

Portable radiology services documentation must include:

- Date of service,
- Worker name and L&I claim number,
- Location and address where the portable radiology service was performed,
- Number of patients served during the visit to the location,
- Description of radiology service performed, *and*
- Reasoning why the worker wasn't able to access or otherwise be examined on fixed conventional X-ray equipment.

Separate documentation is required by the performing provider to support the radiology service provided.

Link: For more information on service and documentation requirements for the X-ray service, see Chapter 8: Electrodiagnostics and Radiology.

Payment limits

R0075 will pay based on the number of patients served and the modifier billed.

HCPCS codes for transportation of portable X-ray equipment **R0070** (1 patient) or **R0075** (multiple patients), and set up of portable X-ray equipment **Q0092**, if appropriate, may be paid in addition to the appropriate X-ray CPT® code(s). The X-ray service is payable as long as the service and documentation requirements are met, regardless of whether portable radiology service codes are payable.

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Split billing

Only a single transportation charge (**R0070** or **R0075**) is allowed for each trip the portable X-ray supplier makes to a location. When more than one worker is served, the charge must be split equally among all patients, even if the other patient(s) isn't a worker with an open L&I claim.

Set up of the X-ray equipment (**Q0092**) is separately billable for each radiological procedure performed on each patient. Bill the appropriate number of units of **Q0092** under each claim separately.

Link: For more information on split billing procedures and requirements, see the Split billing – treating multiple separate conditions payment policy in Chapter 2: Information for All Providers.

Payment policy: Remote monitoring

Services that aren't covered

The following **remote** monitoring services aren't a covered benefit:

- **Remote** therapeutic monitoring (RTM) to support monitoring of the respiratory system, musculoskeletal system, or cognitive behavioral therapy (CPT® **98975**-**98978**),
- **Remote** physiologic monitoring (RPM) such as weight, blood pressure, pulse oximetry, and respiratory flow rate (CPT® **99453**-**99454**) and treatment management services (CPT® **99457**-**99458**), *and*
- Self-Measured Blood Pressure (SMBP) (CPT® **99473**-**99474**).

Phone, computer, or other digital applications, such as phone applications, for **remote** monitoring aren't covered.

Payment Limits

Collection and interpretation of physiologic data, such as ECG and glucose monitoring (CPT® **99091**) is **bundled** and not separately payable.

Payment policy: Store and forward fees

General information

The insurer may pay a store and forward fee to a provider for **remote** assessment of recorded video and/or images submitted by an **established patient** to determine if a visit is required.

This service doesn't include recording reviews requested by the insurer. See **1066M** in Chapter 21: Reports and Forms.

Services that can be billed

Store and forward fees include interpretation and worker follow up. **G2010** or **G2250** is only payable when the following service requirements are met:

- The service is initiated by an **established patient**,
- The service being provided is not PGAP®, BIRP, **SIMP**, mental health, BHI, or obesity treatment,
- Follow up with the worker (phone, **telehealth**, or in person) occurs within 24 business hours of receiving the images and/or video recordings,
- The **remote** assessment of video and/or images isn't part of another service already performed in the prior 7 days, *and*
- The provider's evaluation of the image or video recording doesn't lead to a visit within the next 24 hours or soonest available appointment.

Code	Description
G2010	Worker-initiated **remote** assessment of video and/or images by provider who has Evaluation and Management (E/M) services in their scope of practice.
G2250	Worker-initiated **remote** assessment of video and/or images by a non-physician provider who can't independently bill for Evaluation and Management (E/M) services; however, the service must be consistent with their scope of practice.

Services that aren't covered

These services are not covered for providers rendering:

- Activity coaching (PGAP®),
- Behavioral health interventions (BHI),
- Brain injury rehab program (BIRP) services,
- Chronic pain management (**SIMP**) services,
- Mental health services, *or*
- Obesity treatment.

Documentation requirements

Store and forward documentation must include:

- Permanent storage (electronic or hard paper copy) of the images and/or recordings,
- The patient verbally consented to the service,
- The service was medically necessary,
- Follow-up communication with the patient occurred within 24 business hours, including the nature, method (phone, **telehealth** or in person), and total time of the discussion,
- The patient initiated use of the **remote** evaluation of the video or images, *and*
- The clinical decision making that occurred as a result of the **remote** evaluation, including the provider's interpretation of the images and/or recording.

Payment Limits

G2010 and **G2250** are limited to 1 unit per day per provider.

Follow up isn't separately payable.

Payment policy: Telehealth for independent medical exams (IME)

General information

The insurer reimburses **telehealth** at parity with in-person **Independent Medical Exam** (**IME**) 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 examination in certain circumstances. See Services that must be performed in person in this policy.

When scheduling the **telehealth** visit, the provider is responsible for ensuring **telehealth** is the appropriate method of service delivery to effectively conduct the **IME**.

The worker must be present at the time of the **telehealth** service and the evaluation of the worker must be under the control of the **telehealth** provider. Per WAC 296-23-358, when an **IME** provider isn't in a reasonably convenient location for the worker, the insurer may make alternative arrangements for the examination, including using **telehealth** where appropriate.

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.

Services provided without a video connection (audio-only) aren't considered **telehealth**. Audio-only IMEs aren't covered.

Note: L&I doesn't follow the Center for Medicare and Medicaid Services (CMS) definition of **telehealth** which includes audio-only.

Originating site requirements

IME telehealth services must occur from an appropriate **originating site**. **IME telehealth** services may not be delivered from the employer's worksite, any location owned or controlled by the employer, or any other medical or vocational site.

An appropriate **origination site** for an **IME** must be:

- The worker's home, *or*
- An **IME** firm's location.

The provider performing **telehealth** services must be licensed in the state where the worker is receiving **telehealth** services.

Prior authorization

The prior authorization requirements listed in Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) applies regardless of how the service is rendered to the worker, either in person or via **telehealth**.

Services that must be performed in person

The provider is expected to make arrangements for in-person examination in certain circumstances.

In-person examinations IMEs 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 has an emergent issue such as re-injury, new injury, or worsening status*, or*
- When the service to be performed requires a hands-on component.

Services that can be billed

Telehealth is covered for most services that don't require a hands-on component, with exception of those listed in Services that must be performed in person. The following IMEs may be conducted via **telehealth**:

- Mental health,
- Dermatology,
- Speech, when there is no documented hearing loss,
- Kidney function,
- Hematopoietic system, *and*
- Endocrine.

Per WAC 296-23-359, additional **IME** specialties not on this list may be approved on a case-by-case basis, upon request to the insurer and with agreement of the worker.

Originating site fee (Q3014)

The insurer may pay an **originating site** fee to an **IME** firm when they allow the worker to use their telecommunications equipment for a **telehealth** service with a provider at another location. **Originating site** fees (**Q3014**) include only the use of the provider's **telehealth** equipment. The **distant site** provider conducting the **IME** via **telehealth** must bill for the professional services rendered. **Q3014** is only payable to **IME** providers when:

- The worker is in Washington State and the **telehealth IME** provider is in another state, *and*
- The worker has an in-person exam at the **originating site** that happens the same day as an **IME telehealth** exam at the **distant site**, *and*
- The worker requires the use of the firm's space for the **telehealth** visit with an approved **IME** provider for an exam, *and*
- The firm isn't using that space for another worker, *and*
- No other in-person service is being provided to the worker concurrently during the **telehealth** exam.

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.

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 (distinctly separate visit) to a worker, separate documentation is required for both the in-person visit and the **Q3014** service. Documentation by the **originating site** provider for **Q3014** must include:

- The location of the **originating site**,
- A notation of who the **distant site** provider is, *and*

That the service is separate from any in-person visits that occurred on the same day, if applicable.

Services that aren't covered

Audio-only telemedicine can't be used in place of telehealth or in-person IME services. The insurer won't pay for audio-only **IME** billed using modifier **–93** (audio-only), even when an audio-visual connection has been attempted or if the worker refuses to conduct the service using a video connection.

Telehealth procedures and services that aren't covered for IMEs include:

- The services listed under Services that must be performed in person in this policy,

- The following services,
    - **1104M**, **IME** addendum report,
    - **1105M**, **IME** Physical Capacities Estimate,
    - **1124M**, **IME**, other, **by report**,
    - **1125M**, physician travel per mile,
    - **1129M**, **IME**, extensive file review by examiner,
    - **1147M**, Correctional facility **IME**,
- Completion and filing of any form that requires a hands-on physical examination, *and*
- Store and forward fees (**G2010** or **G2250**).

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **telehealth** appointment, including but not limited to the purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems.

Requirements for billing

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

Do not bill using modifier **–GT**. The insurer doesn't recognize modifier **–95**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home.

Place of service **27** (outreach site/streets) isn't covered. When **telehealth** is provided to a worker that is not in a facility, POS **10** (home) should be used.

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, *and*
- Documented consent from the insurer regarding the appropriateness of the **IME** to be conducted via **telehealth**.

IME reports must contain documentation that justifies the level, type, and extent of services billed. See this policy and Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) for the **type of service** rendered and the documentation requirements.

Payment limits

The same limits noted in Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs) apply regardless of how the service is rendered to the worker.

Payment policy: Virtual reality services and devices

General information

Virtual reality involves a computer-generated simulation that immerses the worker in a virtual world for therapy.

Virtual reality devices may be used as a delivery mechanism for a covered therapeutic service, such as physical therapy exercises delivered with virtual reality tasks or cognitive behavioral therapy with virtual reality exposure therapy.

Services that aren’t covered

Providers can’t charge an additional fee for the use of virtual reality devices to deliver the service.

Purchase or rental of virtual reality **DME** isn’t covered for clinical or home use.

Payment limits

The cost of virtual reality as a modality for treatment in a clinical setting is **bundled** into the cost of therapy services and isn’t separately payable.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for basic first aid	Washington Administrative Code (WAC) 296-800-099
Administrative rules for billing instructions	WAC 296-20-125
Administrative rules for consultation requirements	WAC 296-20-045 WAC 296-20-051 WAC 296-20-01002 WAC 296-20-01501
Administrative rules for prior authorization	WAC 296-20-030(1) WAC 296-20-03001
Administrative rules for provider accounts and missed appointments	WAC 296-20-010
Administrative rules for provider and worker responsibilities	WAC 296-20-065 WAC 296-20-025 Chapter 2: Information for All Providers L&I's website
Administrative rules for transfer of providers	WAC 296-20-065
Interpretive Services	Chapter 14: Language Access Services for Spoken Language Chapter 18: Other Services
Payment policy for attending providers	Chapter 3: Attending Providers

If you're looking for more information about…	Then see…
Payment policy for evaluation and management (E/M) services	Chapter 9: Evaluation and Management (E/M)
Payment policy for impairment ratings and IMEs	Chapter 11: Impairment Ratings and Independent Medical Exams (IMEs)
Payment policy for mental health and behavioral health interventions (BHI)	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Payment policy for rehabilitation facilities	Chapter 27: Rehabilitation Facilities and Programs
Payment policy for remote vocational services	Chapter 25: Vocational Services
Payment policy for student supervision, split billing, and other information for all providers	Chapter 2: Information for All Providers
Payment policy for telephone calls	Chapter 5: Care Coordination
Place of service	Appendix C: Place of Service (POS) Codes CMS Place of Service Code Set
Updates and corrections to payment policies and fee schedules	Updates and corrections tab of the L&I website

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 25: Vocational Services

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Billing by referral type

Prior authorization

All vocational services require prior authorization.

Vocational services are authorized by referral type. The State Fund uses 6 referral types:

- Vocational recovery,
- Assessment,
- Plan development,
- Plan implementation,
- Forensic, *and*
- Stand-alone **job analysis**.

Each referral is a separate authorization for services.

Option 2 vocational counseling and job placement services are authorized when the department accepts a worker's Option 2 election. For more information on Option 2 services, see Option 2 Vocational Services.

How insurers will pay

Insurers will pay:

- Interns at 85% of the vocational rehabilitation counselor (VRC) professional rate, *and*
- Forensic evaluators at 120% of the VRC professional rate.

All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. For more information, see the payment policy for Fee caps later in this chapter.

Note: The firm must assign a VRC upon referral in order to receive payment for services.

Link: For more detailed information on billing, consult the Statement for Miscellaneous Services (F245-072-000). For a list, see Appendix C: Place of Service (POS).

Services that can be billed

The following several tables show billing codes by referral type.

Vocational recovery

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0800V	Vocational recovery services (VRC)	**$10.65**
0801V	Vocational recovery services (intern)	**$9.08**
0802V	Vocational recovery services exception (VRC)	**$10.65**
0803V	Vocational recovery services exception (intern)	**$9.08**

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0810V	Assessment services (VRC)	**$10.65**
0811V	Assessment services (Intern)	**$9.08**
0812V	Assessment services exception (VRC)	**$10.65**
0813V	Assessment services exception (intern)	**$9.08**

Vocational evaluation, pre-job and job modification consultation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0821V	Vocational evaluation (VRC)	**$10.65**
0823V	Pre-job or job modification **consultation** (VRC)	**$10.65**
0824V	Pre-job or job modification **consultation** (Intern)	**$9.08**

Plan development

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0830V	Plan development services (VRC)	**$10.65**
0831V	Plan development services (Intern)	**$9.08**

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Plan implementation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0840V	Plan implementation services (VRC)	**$10.65**
0841V	Plan implementation services (Intern)	**$9.08**
0842V	Plan implementation services exception (VRC)	**$10.65**
0843V	Plan implementation services exception (intern)	**$9.08**

Forensic services

The VRC assigned to a forensic referral must directly perform **all the services** needed to resolve the vocational issues and make a supportable recommendation.

Exception: Vocational evaluation services may be billed by a third party if authorized by the insurer.

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0881V	Forensic services (Forensic VRC)	**$12.75**

Stand-alone job analysis

The codes in the following table are used for **stand-alone and provisional job analyses**. (Also see Payment limits, below.)

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0808V	Stand-alone **job analysis** (VRC)	**$10.65**
0809V	Stand-alone **job analysis** (intern)	**$9.08**
0378R	Stand-alone **job analysis** (non-VRC)	**$10.55**

Vocational evaluation and related codes for non-vocational providers

Certain non-vocational providers may deliver the above services with the following codes:

Code	Description	Maximum fee
0389R	Pre-job or job modification **consultation**, 1 unit = 6 minutes	**$12.84** per 6 minutes

Code	Description	Maximum fee
0390R	Vocational evaluation, 1 unit = 6 minutes	**$10.55** per 6 minutes

Payment limits

When a worker has 2 or more open claims requiring time-loss compensation and vocational services, the insurer may make a separate but concurrent vocational referral for each claim. In such cases, vocational evaluators are expected to split the billing equally amongst the referrals. When providing vocational evaluation on multiple referrals and/or claims, follow these instructions:

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims.
- If there are 3 (or more) claims, the vocational evaluation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received.

Stand-alone job analysis

For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager.

Bills for dates of service beyond the 15th day won't be paid.

Payment policy: Fee caps for vocational services

Fee cap policy for referrals

Vocational services are subject to fee caps. Travel, **wait time**, and mileage charges aren't included in the fee cap for any referral type.

If the **description** of the fee cap referral is…	Then the **applicable codes** are:	And the **maximum fee** is:
Vocational recovery referral cap, per referral	**0800V**, **0801V**	**$7,496.18**
Assessment referral cap, per referral	**0810V**, **0811V**	**$7,496.18**
Plan development referral cap, per referral	**0830V**, **0831V**	**$7,167.50**
Plan implementation referral cap, per referral	**0840V**, **0841V**	**$8,125.85**
Stand-alone **job analysis** referral cap, per referral	**0808V**, **0809V**, **0378R**	**$546.64**

Fee cap policy for vocational evaluation services

The fee cap for vocational evaluation services applies to multiple referral types and is allowed once per claim.

For example, if **$698.00** of vocational evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment of a subsequent evaluation under another referral type.

If the **description** of the service is…	Then the **applicable codes** are:	And the **maximum fee** per claim is:
Vocational evaluation services	**0821V**, **0390R**	**$1,568.44**

Fee cap exceptions for vocational recovery, able to work assessment, and plan implementation referrals

When nearing the fee cap, the vocational provider may request a fee cap exception if services are still needed. Once approved, the vocational provider may bill the exception codes(s) up to the additional fee cap.

Exception codes must be used to authorize an extra number of billable hours.

Any use of these exception codes requires prior authorization by the vocational services specialist (VSS) for State Fund claims, or for self-insured claims, by the self-insured employer or its third-party administrator (if applicable).

Vocational recovery referrals

For vocational recovery referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$1,044.86.**

Code	Description	Maximum fee
0802V	Vocational recovery services exception (VRC)	**$10.65** per 6 minutes
0803V	Vocational recovery services exception (intern)	**$9.08** per 6 minutes

AWA referrals

For AWA referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$1,044.86**

Code	Description	Maximum fee
0812V	Assessment services exception (VRC)	**$10.65** per 6 minutes
0813V	Assessment services exception (intern)	**$9.08** per 6 minutes

Plan implementation referrals

For plan implementation referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$2,414.93**

Code	Description	Maximum fee
0842V	Plan implementation services exception (VRC)	**$10.65** per 6 minutes
0843V	Plan implementation services exception (intern)	**$9.08** per 6 minutes

New referral under the same referral type (ADMX)

The vocational provider may request a new referral if additional services are needed when nearing the fee cap (plan development) or fee cap exception (vocational recovery, AWA, plan implementation). The decision to approve the ADMX will be made on a case-by-case basis.

If approved:

- L&I will close the original referral using the outcome code ADMX and create a new referral.
- Providers won't be able to enter a fee cap reached closure outcome with their closing report. Only L&I can enter this closure code.
- The vocational provider may bill the new referral codes up to the fee cap.

If not approved:

- Submit a closing report.

Flat rate policy for 30-day progress reports

There is a **$50** flat rate for each 30-day progress report. Progress report fees don't count toward professional hour fee caps.

Code	Description	Flat rate
0910V	30-day progress report (VRC)	**$50.00** per 30-day progress report
0910V	30-day progress report (intern)	**$50.00** per 30-day progress report

How to submit bills

You can only bill 1 progress report per referral every 30 days.

To bill for more than 1 progress report for the same referral on the same invoice, use separate line items of 1 unit and $50 each for each date of service. If you bill for more than 1 report on the same line, all but 1 will be denied.

If the worker has multiple claims with open referrals, you should bill the progress report under the most recent claim. If time-loss is only involved in 1 claim, progress reports should be billed under that claim.

Link: For more information, see WAC 296-19A.

Payment policy: Job Modification and Pre-Job Accommodation

Prior authorization

Prior authorization is required for services provided by an occupational therapist (OT), physical therapist (PT) and ergonomic specialist.

- The need for a job modification or pre-job accommodation must be identified and documented by L&I, the attending health-care provider, treating occupational or physical therapist, employer, worker, or assigned vocational rehabilitation counselor.
- **Consultations** for a specific job modification or pre-job accommodation must be preauthorized after the need has been identified.

Who must perform these services to qualify for payment

Consultations

The provider of a job modification or pre-job accommodation **consultation** must be a:

- Licensed occupational therapist or physical therapist, *or*
- Vocational rehabilitation provider, vocational rehabilitation provider intern, *or*
- Ergonomic specialist.

Telehealth

When the **consultant** is unable to go onto the worksite, **telehealth** may be used as an alternative method to complete the **consultation**. Qualified PT or OT providers may have to be licensed in the state where the worker is receiving **telehealth** services, per that state's licensing requirements.

Services that can be billed

In some cases, the department may reimburse for **consultation** services.

Code	Description	Activities	Maximum fee
0823V	**Pre-job or job modification consultation** Vocational Rehabilitation Provider	Discussing/consulting about modifications to a job. This may include: • Exploring ways a job may be modified within the individual's abilities and the needs of the employer. This may include modifying time, duties, environment, and/or use of alternative equipment. • Discussing available L&I benefits to include stay at work, preferred worker, and job modification with the employer, worker, and/or **attending provider**. • Communication with others about modifying a job to include the worker, employer, health-care providers, vocational provider, insurer, and/or vendor. • Documenting findings and recommendations, • Instruction in work practices (such as body mechanics, ergonomic principles), • Obtaining bids, • Completing and submitting the Job Modification/Pre-job Assistance Application and any associated follow up, and • Assisting an employer with accessing return to work incentives.	**$10.65** per 6 minutes

Code	Description	Activities	Maximum fee
0824V	**Pre-job or job modification consultation** Vocational Rehabilitation Provider Intern	Same as above	**$9.08** per 6 minutes
0389R	**Pre-job or job modification consultation, analysis of physical demands** OT, PT, Ergonomic Specialist	Same as above Analyzing job physical demands to assist a VRC in completing a **job analysis** (qualified PT or OT only).	**$12.84** per 6 minutes
0391R	**Travel/wait time** (non-VRC)	Traveling to work/training site or to an equipment vendor to meet with the worker as part of direct **consultation** services.	**$5.81** per 6 minutes
0392R	**Mileage** (non-VRC), per mile.	Mileage to work/training site or to an equipment vendor to meet with the worker as part of direct **consultation** services. 1 unit=1 mile	**State rate**
0393R	**Ferry charges** (non-VRC).	Ferry travel if required to travel to work/training site as part of direct **consultation** services.	**State rate**

Authorized equipment vendors

The following codes can be billed by equipment vendors:

Code	Description	Activities	Maximum fee
0380R	**Job modification**	Equipment/tools: • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work area modification or reconfiguration.	Maximum allowable for **0380R** is **$10,000.00** per job or job site.
0385R	**Pre-job accommodation**	Equipment/tools: • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work/training area modification or reconfiguration.	Maximum allowable for **0385R** is **$10,000.00** per claim. Combined costs of **0380R** and **0385R** for the same return to work goal can't exceed **$10,000.00.**

Obtaining equipment from consultants

Consultants may supply the equipment/tools only if:

- Custom design and fabrication of unique equipment or tool modification is required, *and*
- Prior authorization is obtained, *and*
- Proper justification and cost estimates are provided, *and*
- They agree to send insurer a PDF picture of the final product.

Services that aren't covered

- Performing services as described in WAC 296-19A-340.
- Services prior to any communication with those directly involved in claim.

Payment limits

The combined costs of both codes **0380R** and **0385R** for same return to work goal can't exceed **$10,000.00**.

For self-insured claims, pre-job accommodations can't be approved. However, self-insured employers may pay any pre-job accommodation expenses for injured workers who no longer work for them.

Links: Additional information regarding Job Modifications and Pre-Job Accommodations is available online.

Payment policy: Option 2 vocational services

The insurer may pay for authorized Option 2 vocational counseling and/or job placement services if the worker's training plan was approved on or after July 31, 2015.

Option 2 vocational counseling services include, but aren't limited to:

- Help in accessing available community services to assist the worker with reentering the workforce
- Assistance in developing a training plan
- Coaching and guidance as requested by the worker
- Interests and skills assessment, if the worker requests or agrees such is needed to reach the worker's training or employment goals
- Other services directly related to vocational counseling, such as job readiness and interview practice

Option 2 job placement services may include, but aren't limited to:

- Help in developing an action plan for return to work
- Job development, including contacting potential employers on the worker's behalf
- Job search assistance
- Job application assistance
- Help in obtaining employment as a preferred worker, if certified, up to and including educating the employer on preferred worker incentives
- Other services directly related to job placement, such as targeted resume development and referral to community resources such as WorkSource

Link: More information on Option 2 vocational services is available online.

Limits

Interns can't provide Option 2 vocational services.

Option 2 vocational services must be provided within 5 years following the date of the department's order confirming the worker's Option 2 election.

Total of all payments for all Option 2 vocational services for a worker won't exceed 10 percent of the worker's maximum Option 2 training fund, nor will the total exceed the remaining balance of the worker's Option 2 training fund at the time payment is made.

Option 2 travel and **wait time** aren't payable; other services that aren't payable are listed in WAC 296-19A-340.

Reports

To receive payment for Option 2 vocational services, the VRC must provide the insurer with a copy of a summary of services, signed by the worker and VRC, with each billing. State Fund claims require form F280-063-000 and self-insured claims require form F280-064-000.

Billing

The VRC can't bill the worker directly for Option 2 vocational services.

For self-insured claims, contact the self-insured employer or its third-party administrator for billing instructions.

For State Fund billing, use referral number **9999999** and the billing codes below:

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
R0399	Option 2 vocational counseling (VRC)	**$10.65**
R0398	Option 2 job placement services (VRC)	**$10.65**

Note: The VRC can't bill the insurer for completing the Option 2 vocational services summary form.

Payment policy: Quality Assurance

General information

Quality assurance activities: For the State Fund, vocational firms must perform quality assurance (QA) activities to comply with WAC 296-19A-210.

Services that can be billed

Payment is allowed for QA activities regarding claims listed on the department-provided, randomized list of claims. QA activities include, but aren't limited to:

- Following the department's validation guidance and reporting requirements while completing department-provided validation template(s).
- Discussing validation results with the vocational rehabilitation counselor assigned to the claim to reinforce quality work and to support continued improvement.

Limits

A vocational firm's everyday business operations aren't considered quality assurance activities. The activities outlined in WAC 296-19A-340 are considered overhead and the department won't pay for these services.

Aggregate data collection and reporting aren't payable. For the purposes of this policy, data in this context refers to numbers. Specific examples include QA elements published by the department such as the number of:

- Open vocational recovery referrals.
- Engagement activities for a worker.
- Meetings with identified claim parties.

Payment policy: Remote vocational services

General information

Remote services may be appropriate where vocational services can be completed effectively via audio only or a two-way audio-visual platform (**telehealth**).

The insurer reimburses **remote** services at parity with in-person vocational appointments.

The worker must be present at the time of the **remote** service and the services provided to the worker must be under the control of the **remote** vocational services provider.

System requirements

Remote vocational services require either:

- An interactive telecommunication system consisting of special two-way audio and video equipment that permits real-time **consultation** between the worker and provider, *or*
- An audio-only connection 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.

Services that must be performed in person

In alignment with the worker-centric model, **remote** services are an option, but may not be possible or preferred by the worker. In-person services must be provided when:

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

In-person services should have priority for in-person meetings when possible:

- Job analyses,
- Plan development rights and responsibilities, *and*
- Initial meetings with the worker.

Services that aren't covered

Remote services that aren't covered include:

- The same services that aren't covered in Chapter 24: Vocational Services, *or*
- The services listed under "Services that must be performed in person" in this policy.

No payment will be made to the worker or provider for obtaining or maintaining equipment for a **remote** appointment. Including but not limited to the purchase, rental, installation, transmission, or maintenance of telecommunication equipment or systems.

Requirements for billing

For **remote** vocational services, bill the applicable codes as if delivering care in person.

Don't bill using modifier **–GT**. The insurer doesn't recognize modifier **–95**.

Distant site providers must use place of service **02** to denote the **telehealth** visit when the worker isn't located in their home. **Distant site** providers must use place of service **10** to denote the **telehealth** visit when the worker is located in their home.

Link: For a list of place of service, see Appendix C: Place of Service (POS).

Documentation requirements

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

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

Note: When participating in case management telephone call services, follow the documentation requirements in Chapter 5: Care Coordination.

Payment limits

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

Payment policy: School billing, cancellation, and refunds

General information

Schools and training programs are L&I-approved training providers that equip **workers** with the knowledge, skills, and abilities they need to be successful in the workforce. Approved providers are either accredited, licensed, or otherwise meet L&I provider requirements.

A training provider must have an L&I provider account to be paid for services. Resources for billing are available on the insurer's website.

For the purposes of this policy:

- A registration fee is any fee charged by a school to process **student** applications and establish a **student** record system.
- The terms worker and **student** are used interchangeably and mean an individual who has an L&I claim number and qualifies for training.

Prior authorization

Prior authorization is required to bill for **student** application fees and/or placement tests (code **0388R**).

Training must be approved by L&I. This will include allowed dollar limits, date spans, and billing codes for each vendor. The authorized expenses must be on an encumbrance form (F245-454-000 for an Option 1 training plan), on an authorization letter (for an Option 2 plan), or a Skill Enhancement Training Application (F280-086-000). See Resources for Training Providers.

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Who must perform these services to qualify for payment

To be paid for services, a training provider must have an L&I provider account and prior authorization from L&I.

To maintain status as an approved training provider, schools must:

- Have an admission policy allowing all qualified members of the general population to be candidates for admission, *and*
- Maintain documentation on **student** completion and placement rates, *and*
- Maintain credentials. Accredited or licensed training providers must maintain their accreditation or licensure status per WAC 296-19A-590. Non-accredited or unlicensed training providers must reapply every two years per WAC 296-19A-550. Failure to maintain credentials may result in termination of the provider number (WAC 296-19A), *and*
- Comply with all federal, state, and local regulations, and other requirements governing their education and business operations, *and*
- Ensure services provided are respectful, equitable, and responsive to diverse cultural beliefs, practices, preferred languages, and communication needs, *and*
- Ensure access to spoken and sign language according to Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA). Interpretation services for an injured worker or a crime victim are covered by L&I and don't require prior authorization. For further details, see Chapter 2: Information for All Providers.

For additional guidance, see Schools and Training Programs (wa.gov).

Note: To become an approved L&I training provider, schools must submit an application and be accredited, licensed, or otherwise meet L&I provider requirements. To apply for an L&I provider account, see Become a Training Provider.

Changes to a billing address, tax ID, etc. could require a different L&I provider number and could cause bills to be delayed or denied. Contact SchoolOversightProgram@Lni.Wa.Gov for assistance.

Services that can be billed

With documentation and prior authorization, the insurer covers the following codes:

- Fees for **student** applications and placement tests (**0388R**). This code can be authorized before training has been approved.

Under approved training, the insurer may cover the following codes:

- Tuition and fees (training, exams, licensing) (**R0310**)
- Books, supplies, and equipment (**R0312**)
- Skill enhancement training (**1307W**).

Note: Childcare providers must be licensed.

How to bill the insurer

Billing must fall within the date spans and allowed amounts as listed in the approved training plan (either the Encumbrance form, the Option 2 Authorization Letter, or Skill Enhancement Training Application). Otherwise, it may cause payment delays or denials.

Tuition must be billed by quarter or semester.

For schools without quarters or semesters, billing can't exceed 90-day increments.

For additional billing guidance, see Resources for Training Providers.

Note: Self-insured employers pay schools directly for these costs.

Refund requirements

At a minimum, schools must use the refund and cancellation policies outlined below unless the school is governed by a higher statutory authority. For example, community and technical colleges are governed by different laws and also defer to federal laws regarding financial aid. The insurer may approve refund policies whose terms are more favorable to **students** than the following established minimums.

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The process

Refunds must be calculated using the official date of withdrawal or termination.

The withdrawal or termination date is the earliest of any of the following dates:

- The date the school recorded the **student**'s last day of attendance, or
- The date a **student** is terminated for violation of published school policy, or
- The date a **student** is terminated for not meeting performance requirements, or
- The date the **student** notifies the school in writing that they will withdraw.

Refunds require the L&I claim number, the billing codes, dates of service, the original bill ICN, and the refund amount. For details, see Getting a Payment Adjusted and complete the Refunding Money form (F245-043-000).

Refunds are only payable for bills submitted to the insurer.

Refunds must be submitted within thirty calendar days of the **student's** official date of withdrawal or termination. See RCW 51.48.260 and WAC 296-19A-390.

If training ends before a student begins classes

If the applicant isn't accepted, the school may keep money billed for applications and placement tests under code **0388R**. The school must refund all money billed under codes **R0310** (tuition and fees) and **R0312** (books and equipment, and supplies), and **1307W** (skill enhancement training).

If the school cancels a class before it starts, the school must refund all money billed for the class under codes **R0310, R0312, and 1307W**.

If a training is terminated after signing the enrollment contract and before the **student** begins classes, the school may retain an established registration fee equal to 10% of the total tuition cost, or $100, whichever is less.

If training ends after the student begins classes

The school may retain the registration fee, plus a percentage of the total tuition as described in the table below.

The percentage will be applied within the date span that includes the official date of withdrawal or termination. Authorized dates are listed on the Encumbrance Form, Authorization Letter, or Skill Enhancement Training Application.

For example, if a **student** completes 4 weeks within a 10-week date span (40% of the scheduled training), the school may bill no more than 50% of the tuition for that date span.

When the **student completes this amount of training**…	Then the school may **retain no more than this percentage of tuition**:
1 week or up to 10%, whichever is less	10%
More than 1 week but less than 25%	25%
25% up to 50%	50%
More than 50%	100%

Services that aren't covered

The following services aren't covered:

- Subscription training services, *or*
- Membership fees, *or*
- Tutoring billed by the hours. Total hours and costs must be pre-approved.

Requirements for billing

The insurer will only pay bills that fall within the dollar limits and date spans identified in the approved training documents. For further assistance, see Resources for Training Providers.

All charges for tuition must be submitted to the insurer.

Schools can't charge workers or vocational rehabilitation counselors (VRCs) for tuition. Bills must be submitted to the insurer.

Documentation

L&I may request records regarding the worker's training. Records may include a course catalog with prices and policies, signed enrollment agreement, documentation of a **student's** attendance dates, or other information needed to evaluate the **student's** progress or attendance.

Upon request, schools are required to submit records or information on the **student's** progress to L&I or vocational counselors at no cost.

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Payment limits

Schools must bill the insurer based on their usual and customary fees.

Schools can't:

- Bill the worker more than any other **student** for the same program, *or*
- Charge workers or VRCs directly for tuition, *or*
- Bill the worker or VRC for amounts above the approved training plan cost. See RCW 51.04.030(2) and WAC 296-20-020.

Licensed schools in Washington must maintain a current catalog with costs on file with the school's credentialing body. This catalog must include total cost of the program including tuition, fees, supplies, etc. When questions arise about the cost of training, L&I will base decisions on the relavent catalog on file when the training was approved.

Payment Policy: Skill enhancement training

General information

For the purposes of this payment policy, a worker is an individual who has an L&I claim number and qualifies for workers' compensation. The terms "worker" and "**student**" are used interchangeably.

Skill enhancement training helps workers maintain and build job readiness skills while receiving vocational services. Workers who qualify may choose to use this incentive when they are in a qualifying vocational referral and have an assigned vocational rehabilitation counselor (VRC).

Approved providers must be accredited, licensed, or otherwise meet L&I provider requirements in order to provide training. A training provider must have an L&I provider account to be paid for services. Resources for providers are available on the insurer's website.

As of January 1, 2025, skill enhancement funding may cover the following:

- English language training,
- General education development or high school equivalent training,
- Adult basic education, *or*
- Technology or software needed to participate effectively in skill enhancement training.

The insurer may cover basic computer literacy for the purpose of supporting other training noted above.

See RCW 51.32.095 for further details.

Any equipment, technology, or software requested that are required to engage effectively in skill enhancement training may be covered by the insurer (please see **Prior authorization** and **Payment limits** sections below). Funding is available once per claim. Use of these funds doesn't reduce funds available for a formal retraining plan.

Prior authorization

Prior authorization is required to bill for skill enhancement training (code **1307W**). This authorization may be granted only to workers who have an open vocational referral in vocational recovery, ability to work assessment, or plan development.

Pre-approval is contingent upon the submission of F280-086-000 by the vocational counselor.

Authorization is required prior to any class. Sequential classes can't be authorized in advance.

Who must perform these services to qualify for payment

The following providers may be paid for services if they have an active L&I provider account:

- Schools,
- Training programs,
- Vocational firms, *and*
- Equipment vendors.

Services that can be billed

With documentation and prior authorization, the insurer covers skill enhancement training (**1307W**).

- This code can be authorized for the length of each approved skill enhancement class.
- Tuition must be billed by quarter or semester. For schools without quarters or semesters, billing must not exceed 90-day increments.

How to bill the insurer

Billing must fall within the date spans and allowed amounts as listed in the approved training application form.

Billing dates must be within the approved training dates. If not, it may cause payment delays or denials.

For additional billing guidance, see Resources for Training Providers.

Note: Self-insured employers pay schools and vendors directly for these costs.

Services that aren't covered

The following services aren't covered:

- Schools using a monthly subscription service, *or*
- Training and services paid for by the worker, such as internet access (Wi-Fi) or individual home office or school set up, *or*
- Travel and accommodation expenses.

Funding isn't allowed beyond the end of the vocational referral or claim closure.

When workers are unable to complete the paid skill enhancement training, see Refund requirements for details on the school billing, cancellation, and refund policies.

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Classes that have started but not yet been approved by the insurer will not be retroactively authorized.

Vocational firms can't be training providers for skill enhancement training.

0388R isn't covered for skill enhancement training.

Requirements for billing

The insurer will only pay bills that fall within the dollar limits and date spans identified on the skill enhancement training application form.

All charges must be submitted to the insurer.

Schools or vendors must not charge workers or VRCs for registration, equipment, or tuition.

Vocational firms who provide equipment to workers participating in skill enhancement training must:

- Have an L&I approved vendor provider number separate to their Vocational Firm provider number (provider type 97) for billing, *and*
- Provide proof of purchase using the receipt for the equipment, *and*
- Request prior authorization from the insurer prior to purchasing equipment for the worker using the skill enhancement training request form.
- Bill using the statement for miscellaneous services.

Link: For list of place of service, see Appendix C: Place of Service (POS).

Documentation requirements

Upon request, schools are required to submit records or information on the **student**'s progress to L&I or vocational counselors at no cost.

Vocational firms must provide documentation of the purchase of any equipment they acquire on behalf of the worker.

Payment limits

Schools and vendors must bill the insurer based on their usual and customary fees. The insurer can't pre-pay for skill enhancement training. Funding is available once per claim equal to 25% of the maximum funding available for vocational retraining.

When questions arise about the cost of training (such as tuition, fees, supplies, etc.), the insurer will base decisions on the most recent catalog at time of approval. This catalog must include total cost of the program including tuition, fees, supplies, etc. Licensed schools must maintain a current catalog with prices on file with the school's credentialing body.

Schools and vendors can't:

- Bill the insurer more than any other **student** for the same program, *or*
- Charge workers or VRCs directly for registration, equipment, tuition, *or*
- Bill the worker or VRC for costs associated with the approved skill enhancement training. See RCW 51.04.030(2) and WAC 296-20-020.

Additionally, vocational firms with a separate vendor provider number (provider type 97):

- Can't charge above the purchase price to the insurer for equipment, technology or software they purchase, *and*
- Must attempt to use an existing L&I vendor prior to purchasing equipment, technology or software, and only purchase equipment from third-party vendors (e.g., vendors that aren't associated with a vocational firm).

Note: It is strongly encouraged equipment purchased by a vocational firm won't require customer service, returns, or repairs.

Schools, vendors, and vocational firms assume the risk of recoupment if there is a claim action, such as a decision that requires repayment of the funds used to procure equipment, technology or software for the worker.

Payment policy: Special services, non-vocational providers

Prior authorization

Code **0388R** (for special services provided during vocational recovery, AWA, plan development, and plan implementation) requires prior authorization.

For State Fund claims, VRCs must contact the VSS or claim manager (CM) to arrange for prior authorization. For self-insured claims, contact the self-insured employer or its third-party administrator (if applicable) for prior authorization.

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

Who must perform these services to qualify for payment

A non-vocational provider can use the R codes. A vocational provider delivering services for a referral assigned to a different payee provider may also use the R codes.

Services that can be billed

L&I established procedure local billing code **0388R** to be used for special services provided during AWA, plan development and plan implementation, such as:

- Commercial driver's license (CDL),
- Pre-employment physical examinations,
- Background checks,
- Driving abstracts,
- Fingerprinting,
- College placement testing and enrollment fees.

College placement testing and enrollment fees may be authorized during a vocational recovery referral in order to pursue skill enhancement training.

Code **0388R** has a description of "Plan, providers," and pays **by report**.

Requirements for billing

Code **0388R** must be billed by a medical or a miscellaneous non-physician provider on a **Statement for Miscellaneous Services** billing form (F245-072-000). The referral ID and referring vocational provider account number must be included on the bill.

As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you):

- You can't bill as a vocational provider (provider type **68 vocational**), *and*
    - You must either use another provider account number that is authorized to bill the ancillary services codes (type **34-physical therapist**, **52-physical therapy clinic**, or **55-occupational therapist**), *or*
    - Obtain a miscellaneous services provider account number (type **97 miscellaneous payee**) and bill the appropriate codes for those services.

These providers use the **Statement for Miscellaneous Services** billing form but must include the following specific information to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, *and*
- The vocational provider's L&I provider account number for the assigned vocational provider in the Name of physician or other referring source box at the top of the form, *and*
- The non-vocational provider's own provider account numbers at the bottom of the form.

Link: For list of place of service, see Appendix C: Place of Service (POS).

Payment limits

For code **0388R**, there is a limit of 1 unit per day, per claim.

Payment policy: Travel, wait time, and mileage

General information

L&I supports in-person meetings to encourage effective engagement, collaborative problem solving, and delivery of quality vocational services. Travel, **wait time**, and mileage charges aren't included in the fee cap for any referral type.

The vocational provider may bill mileage, round trip, from their primary branch office to their in-state or border city destination for that referral. The primary branch office is designated by the vocational provider on their Vocational Provider and Firm Application (F252-088-000),

When submitting bills, the vocational provider should:

- Round to the nearest number if necessary.
- Bill all services for the same worker, for the same date of service, on 1 bill form.

For example:

VRC travels from primary branch office to **attending provider**'s (AP) office to meet with the worker and the AP. VRC will bill the round trip time and miles from their primary branch office to the AP's office.

Splitting travel when there is more than 1 claim

If traveling for more than 1 claim (per worker or for multiple workers), the vocational provider can bill a round trip from their primary branch to include their destinations for the multiple referrals.

- Split charges equally between all claims, rounding to the nearest number if necessary.
- For 2 claims, bill half to each claim.
- For 3 or more claims split the charges accordingly (3 claims = by thirds, 4 claims = by fourths)

For example:

VRC travels from their primary branch office to a meeting with worker on Referral A, then to onsite **job analysis** meeting on Referral B, then to a meeting at AP's office on Referral C, and then back to their primary branch office. VRC will bill a third of the total time and mileage under each referral.

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Prior authorization

Reimbursement for lodging and airfare requires prior authorization from L&I. The VRC is responsible for obtaining authorization from the Vocational Services Specialist (VSS) for their travel in advance.

Extension of stay

If the stay is extended for the VRC referral needs, L&I will reimburse for the additional lodging provided prior authorization has been obtained. It is the VRC's responsibility to contact the VSS to request authorization to extend the stay.

Services that can be billed

Code	Description	Maximum fee
0891V	Travel/**wait time** (VRC or forensic VRC) 1 unit = 6 minutes Includes time spent driving, waiting for appointments, or other similar circumstances.	**$5.34** per 6 minutes
0892V	Travel/**wait time** (intern) 1 unit = 6 minutes Includes time spent driving, waiting for appointments, or other similar circumstances.	**$5.34** per 6 minutes
0893V	Professional mileage (VRC) 1 unit = 1 mile	**State rate**
0894V	Professional mileage (intern) 1 unit = 1 mile	**State rate**
0895V	Air travel (VRC, Intern, or forensic VRC)	**By report**
0896V	Ferry charges (VRC, intern or forensic VRC) Requires documentation with a receipt in case file.	**By report**
0897V	Hotel charges (VRC, intern or forensic VRC)	**State rate**

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Vocational evaluation and related codes for non-vocational providers

Certain non-vocational providers may deliver the above services with the following codes:

Code	Description	Maximum fee
0391R	Travel/wait (non-VRC), 1 unit = 6 minutes	**$5.81** per 6 minutes
0392R	Mileage (non-VRC), 1 unit = 1 mile	**State rate**
0393R	Ferry charges (non-VRC) Requires documentation with a receipt in case file.	**State rate**

Services that aren't covered

L&I won't reimburse for the following:

- **Meals**, *or*
- Incidental fees, *or*
- Additional cleaning fees for damage to the room, *or*
- Cancellations made by the lodging provider, *or*
- Lodging and/or fees outside the authorized period.

Documentation requirements

Documentation must be submitted separately from bills. Please include the phrase "**index: VOC"** in the bottom right corner of each page to ensure documentation is entered properly in L&I's systems.

Please submit a copy of the hotel invoice and airfare receipt for documentation. L&I will reimburse up to the US General Services Administration rates for out of state travel, and up to the Office of Financial Management travel reimbursement for in-state travel.

Documentation must contain:

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

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Payment policy: Additional requirements for all vocational services providers

Documentation requirements

For bills submitted to the department, see WAC 296-19A-360 for documentation requirements.

Inappropriate referral: ADMA billing

Vocational firms must assign a referral to a vocational counselor within 24 hours. After the assignment is made, the counselor may have reason to decline. The use of the ADMA outcome, *firm declines referral*, should be rare and determined as quickly as possible within 14 days of the referral assignment.

Examples of when a firm may need to use the ADMA outcome code include:

- Conflict of interest, or
- Higher level of specialization is necessary.

A maximum of 3 professional hours may be billed for reviewing the file and preparing a brief rationale after the referral is assigned to a counselor. The counselor assignment is critical to avoiding delays in payment

Prior to entering an ADMA outcome, the firm needs to call the unit vocational services specialist to discuss the reasons for declining the referral. If the ADMA code is still appropriate, the firm must enter the outcome code and send the rationale using an EVOC message.

The ADMA outcome code shouldn't be used by firms to selectively decline referrals in favor of less complicated cases or to manage capacity. Firms must be proactive in managing counselor caseload and notify L&I if the volume of referrals needs to be adjusted.

Preferred worker certification for workers who choose Option 2

Vocational providers must consider assisting a worker covered by the State Fund in obtaining preferred worker certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining preferred worker certification for up to 14 days after an Option 2 selection has been granted by legal order.

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Insurer Activity Prescription Form (APF), 1073M

For State Fund claims, healthcare providers won't be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

Employers can obtain physical capacity information by:

- Using completed APFs available on the department's Claim and Account Center, *or*
- Requesting an APF through the claim manager when updated physical capacity information is needed.

Other VRC requests to attending providers for return to work information

Attending providers may respond to requests regarding return to work issues. Examples include:

- Return to work decisions based on a functional capacity evaluation (FCE),
- Request for worker to participate in FCE,
- Job modification or pre-job accommodation reviews,
- Proposed work rehabilitation program,
- Plan for graduated, transitional, return to work.

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Resume Services (State Fund claims only)

A resume isn't only an important job-seeking tool; it's also an opportunity to engage the worker in thinking about return to work. L&I encourages vocational providers to develop a resume with workers who are in an open vocational referral, within the following parameters:

- Participation of the worker is voluntary.
- The VRC assigned to the referral meets in-person with the worker to develop the resume. If that isn't possible, the assigned VRC may provide resume services telephonically, by **telehealth**, or by email. The VRC:
    - Ensures the resume accurately reflects the workers work experience and education and includes volunteer experience, other relevant information, and/or hobbies, if applicable.
    - Gives the worker copies of the resume in format(s) that meet the worker's needs such as paper and/or digital copies.
    - Coordinates a referral to L&I WorkSource partnership staff and encourages the worker to take the resume to WorkSource and register for assistance in finding a job. The VRC may accompany the worker to WorkSource if the worker prefers.
    - Sends the resume to the claim file with the Resume Cover Sheet (F242-418-000) and documents the resume service activities in the next vocational report.
- A cover letter may be developed as part of these services.
- The service is available once per referral.
- For each referral, L&I pays a maximum of **$345.98** for VRC and/or intern time.

Code	Description	Maximum fee
0844V	Resume services (VRC)	**$10.65** per 6 minutes
0845V	Resume services (intern)	**$9.08** per 6 minutes

Services that can't be billed

Billable services don't include performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals (except for activities noted in WAC 296-19A-340). Activities associated with reports (other than composing or dictating complete draft of the report) that aren't billable include:

- Editing, revising, or typing,
- Filing,
- Distributing or mailing.

Time spent on any administrative and clerical activity also isn't billable including:

- Typing,
- Copying,
- Faxing, mailing, or distributing,
- Filing,
- Payroll,
- Recordkeeping,
- Delivering or picking up mail.

Vocational evaluation

Vocational evaluations are payable during Ability to Work Assessment and Plan Development.

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing,
- Interest testing,
- Work samples,
- Academic achievement testing,
- Situational assessment,
- Specific and general aptitude and skill testing.

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A provider (vocational or non-vocational) who administers and/or interprets and reports on vocational evaluation and evaluation results must ensure that he or she is qualified to administer and/or interpret and report on the evaluations in regard to the specific instrument(s) being used.

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation, and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational evaluation isn't covered during a vocational recovery referral.

Test administration billing

When billing for testing services on multiple referrals and/or claims, test administration time must be split equally in whole units, charging the same dollar amount on each claim/referral. For example, if a provider performs 4.5 hours of appropriate group testing for 3 workers, then billing for each worker shouldn't exceed 1.5 hours.

Vocational providers

Vocational providers (provider type **68**) must use procedure code **0821V** to bill for vocational evaluation services. Use code **0821V** for:

- The formal testing itself, *or*
- A meeting that is directly related to explaining the purposes or findings of testing.

Non-vocational providers

Non-vocational providers must use procedure code **0390R**. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, *and*
- The vocational provider's L&I provider number for the assigned vocational provider in the Name of the physician or other referring source box at the top, *and*
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form,
- Obtain the vocational referral ID number from the VRC and place on the billing form,
- Obtain the VRC's L&I provider number and place in the Name of the physician or other referring source box at the top, *and*
- Place the school's provider account number at the bottom of the form.

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Link: For list of place of service, see Appendix C: Place of Service (POS).

Retraining plans that exceed statutory benefit limit

The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit. Additional vocational assistance can only be considered following previous retraining attempts that depleted available money and/or time.

The VSS won't approve an initial plan on a claim with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers shouldn't develop or submit such a plan.

How to bill when multiple providers work on a single referral

Multiple providers may deliver services on a single referral if they have the same payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where a provider covers the caseload of another provider.

When more than 1 provider works on a referral, each provider must bill separately for services delivered on the referral, and each provider must use:

- His/her individual provider account number, *and*
- The payee provider account number, *and*
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral.

Split billing across multiple referrals

When a worker has 2 or more open time loss claims, the insurer may make a separate referral for each claim. In cases where the insurer makes 2 (or more) concurrent referrals for vocational services, vocational providers are expected to split the billing. When providing vocational services on multiple referrals and/or claims, follow these instructions:

- To accurately capture the work done without overbilling, combine billable hours over a larger interval of work (up to the entire billing period) rather than bill for each single activity.

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Examples:

- A provider has 2 open referrals for the same worker and the provider bills once per week. They provided a total of 90 minutes during this billing period. They would bill 8 units under each claim.
- A provider has 2 open referrals for the same worker and the provider bills daily. They provided a total of 40 minutes during this billing period. They would bill 4 units under each claim.

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims as directed above.
- If there are 3 (or more) claims requiring time loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received. These requirements also apply when billing for testing services. For example, if provider performs 4.5 hours of testing for a worker with more than 1 claim and referral, the billing must be split equally among the claims.

Note: Vocational providers must document multiple referrals and split billing for audit purposes.

Appropriate timing of outcome recommendations for State Fund claims

State Fund has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral. The VRC must complete the report before a *VocLink Connect* outcome recommendation is made to State Fund. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which isn't complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include VRC no longer available and VRC or firm declines referral.

In all other cases, the paper report must be submitted to the claim file when the recommendation is submitted. The VRC should confirm the report was received in the claim file for billing and payment.

Submitting a vocational assessment or retraining plan for self-insured claims

Answers to the following common questions can be found in various WACs:

- What is the Self-Insurance Vocational Reporting Form? (WAC 296-15-4302)
- What must the self-insurer do when an assessment report is received? (WAC 296-15-4304)
- When must a self-insurer submit a vocational rehabilitation plan to the department? (WAC 296-15-4306)
- What must the vocational rehabilitation plan include? (WAC 296-15-4308)
- What must the self-insurer do when the department denies the vocational rehabilitation plan? (WAC 296-15-4310)
- What must the self-insurer do when the vocational rehabilitation plan is successfully completed? (WAC 296-15-4312)
- What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? (WAC 296-15-4314)

Change in status: Responsibilities of service providers and firms

The insurer must be notified immediately by both the firm and the L&I provider number (VRC or intern) when there is a change in status. Changes in status includes:

- VRC or intern ends their association with a firm, *or*
- VRC assigned to a referral is no longer available to provide services on the referral(s), *or*
- Firm closes.

Change in status responsibilities apply to both State Fund and Self-Insurance vocational providers. Forms for reporting change in status are available on L&I's website.

Link: For more information, see WAC 296-19A-270.

Failure to report change in status

A firm or service provider that fails to notify L&I of changes in status may be in violation of WAC and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in WAC 296-19A-270.

Approved plan services that occur prior to plan start date

The insurer may cover these are services/fees prior to a plan start date:

- Tuition and fees (training, exams, licensing) (billing code **R0310**), *and*
- Books, equipment, supplies, other (billing code **R0312**), *and*
- Rent, food, utilities, and furniture rental. Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, **0301R**, isn't payable prior to a plan start date. Travel that occurs prior to a plan start date is generally:

- To a jobsite to evaluate whether a particular job goal is reasonable, *or*
- To a school to pay for registration, books or look over the campus.

These types of trips aren't part of a retraining plan and should be billed by the worker under **V0028**. Travel to appointments with the VRC is also billed under **V0028**.

Selected plan procedure code definitions

L&I has defined the following retraining codes:

- **R0312**, Retraining books, equipment, and supplies are consumable goods such as:
    - Books,
    - Paper,
    - Pens,
    - CDs,
    - Disposable gloves,
    - Calculator,
    - Software,
    - Survey equipment,
    - Computers,
    - Welding gloves & hood,
    - Professional uniforms, including shoes,
    - Bicycle repair kits,
    - Mechanics tools.
- **R0390**, Retraining childcare. Providers must be licensed. If a worker is unable to attend training without the use of training funds to pay child care, all anticipated childcare needs must be identified by the VRC in the proposed retraining plan. The total cost of the identified childcare, in addition to other allowable costs, must fit within the statutory retraining benefit limit.

The insurer doesn't have the authority to purchase:

- Glasses,
- Hearing aids,
- Dental work,
- Clothes for interviews,
- Other items as a way to remove barriers during retraining.

Reimbursement for food

The insurer may reimburse for food including grocery and restaurant purchases made while the worker is participating in an approved plan with authorized board and lodging.

Food charges combined in weekly or monthly date spans aren't allowed.

Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable.

Note: The provider and/or the worker should also retain a copy of receipts.

The vocational provider must review billed food charges:

- To remove inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.), *and*
- To ensure each date of purchase is itemized on the bill.

The worker won't be reimbursed over the monthly allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker doesn't exceed their monthly allotment for food.

The vocational provider will:

- Review the receipts, *and*
- Deduct personal and other non-covered items, *and*
- Sign the Statement for Retraining and Job Modification Services form (F245-030-000).

Once the vocational provider signs the **Statement for Retraining and Job Modification Services** form, the insurer will assume the provider has:

- Reviewed the bill and receipts, *and*
- Removed inappropriate charges, *and*
- Verified the charges are within the workers per diem allotment for that month.

Mileage on Plan Time/Cost/Travel Encumbrance

The insurer reimburses mileage only in whole miles.

Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Plan Time/Cost/Travel Encumbrance form (F245-454-000) should be referred to the VSS.

Link: For more information, see WAC 296-19A.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for corrective action for failure to notify about changes in status	Washington Administrative Code (WAC) 296-19A-270
Administrative rules for vocational services	WAC 296-19A
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare and vocational services	Fee schedules on L&I's website
Job modifications and pre-job accommodations policies	Job modifications on L&I's website Pre-job accommodations on L&I's website
L&I's Claim and Account Center	Claim and Account Center
Quality assurance by vocational firms	Vocational Firm Quality Assurance Plan
Statement for Miscellaneous Services	F245-072-000 on L&I's website
Option 2 Vocational Services	WAC 296-19A-631, 633, 635, 637 Option 2 details on L&I's website Self-Insured Option 2 Vocational Services Summary State Fund Option 2 Vocational Services Summary

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If you're looking for more information about…	Then see…
Services that aren't covered	WAC 296-19A-340
Statement for Retraining and Job Modification Services form	F245-030-000 on L&I's website
Notify L&I of changes in status	Email Private Sector Rehab Services PSRS@LNI.WA.GOV
Vocational Provider and Firm Application	F252-088-000 on L&I's website

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs)

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

Payment policy: All Ambulatory Surgical Centers (ASC) services

Prior authorization

Procedures not on L&I's ASC fee schedule require prior authorization. Specifically:

- Under certain conditions, the director, the director's designee, or self-insurer, at their sole discretion, may determine that a procedure not listed on L&I's ASC fee schedule may be authorized in an ASC.
    - For example, this may occur when a procedure could be harmful to a particular worker unless performed in an ASC.
- The healthcare provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. Requests for coverage under these special circumstances require prior authorization. The written request must contain:
    - A description of the proposed procedure with associated CPT® or HCPCS procedure codes, *and*
    - The reason for the request, *and*
    - The potential risks and expected benefits, *and*
    - The estimated cost of the procedure.
- The healthcare provider must provide any additional information about the procedure requested by the insurer.

Who must perform these services to qualify for payment

To qualify for payment for ASC services, an ASC must:

- Be licensed by the state(s) in which it operates, unless that state doesn't require licensure, *or*
- Have at least 1 of the following credentials:
    - Medicare (CMS) Certification as an ASC, *or*
    - Accreditation as an ASC by a nationally recognized agency acknowledged by CMS, and
- Have an active ASC provider account with L&I.

Services that can be billed

L&I uses the CMS list of procedure codes covered in an ASC, plus additional procedures determined to be appropriate.

L&I's rates for ASC procedures are based on a modified version of the current system developed by CMS for ASC services. L&I expanded the CMS list by adding some procedures CMS identified as excluded procedures.

Link: All procedures covered in an ASC are listed online in the fee schedule.

Services that aren't covered

Procedure codes not listed in L&I's ASC fee schedule aren't covered by the insurer for ASC facilities.

Additional information: Who to contact to become accredited or Medicare certified as an ASC

For national accreditation, contact:

- Accreditation Association for Ambulatory Health Care
- American Osteopathic Association
- Commission on Accreditation of Rehabilitation Facilities
- The Joint Commission
- QUAD A

For Medicare certification, contact:

Department of Health, **Office of Health Care Survey**
Facilities and Services Licensing
PO BOX 47874
Olympia, WA 98504-7874
360-236-4983

Payment policy: All hospitals

Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a patient admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via a Percent of Allowed Charges (POAC) rate. For information about POAC rates for outpatient hospital visits, see the State Fund payment methods section for outpatient hospitals later in this chapter.

L&I follows CMS in regards to hospital admissions in the course of an encounter at another site for E/M services. Refer to Chapter 9: Evaluation and Management (E&M) "Services that can be billed" for more information.

Payment limits

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury.

For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance.

No copayments or deductibles from workers are required or allowed.

Payments won't exceed allowed billed charges.

Links: Hospital payment policies established by L&I are reflected in the Hospital Billing Instructions (email L&I's Provider Hotline at PHL@Lni.wa.gov for a current copy) and in WAC 296-20, WAC 296-21, WAC 296-23, and WAC 296-23A.

Acquisition costs

Items covered under hospital **acquisition costs** will be paid using a hospital-specific POAC rate.

Nonhospital facilities will be paid a statewide average POAC rate.

Payment policy: Inpatient hospital acute care

Self-insured employer payment methods

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital-specific POAC rates for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program payment methods

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using hospital-specific POAC rates for all hospitals (see WAC 296-30-090).

State Fund provider network coverage requirements

Services from both network and non-network providers can be covered:

- If done in an emergency room at an acute care hospital, or
- If done prior to discharge for a patient who was directly hospitalized from an initial emergency room visit.

Links: For more information about the network, see WAC 296-20-01010(3).

For information on who may treat, see WAC 296-20-015(1).

State Fund payment methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

- An All Patient Refined Diagnosis Related Group (APR DRG) system. L&I currently uses APR DRG Grouper version 38. For exclusions and exceptions, see WAC 296-23A-0470, *or*
- A statewide per diem rate for those APR DRGs that have low volume, *or*
- A POAC rate for hospitals excluded from the APR DRG system.

Link: The current APR DRG Assignment List is available online.

Payment methods for hospital types or locations

If the **hospital type** or **location** is…	Then the **payment method** for inpatient hospital acute care services is:
Hospitals not in Washington State, including psychiatric facilities and HMOs	Paid by an out of state POAC rate. The POAC rates are 66.14% for hospitals within the United States and 100% for hospitals outside the United States.
Hospitals in Washington State that are excluded: • Children's hospitals, • Health Maintenance Organizations (HMOs), • Military hospitals, • Veterans Administration facilities, • State psychiatric facilities, • Tribal-owned facilities located on tribal land.	Paid 100% of allowed charges.
Hospitals not in Washington State that are excluded: • Children's hospitals, • Military hospitals, • Veterans Administration facilities	Paid 100% of allowed charges.

If the **hospital type** or **location** is…	Then the **payment method** for inpatient hospital acute care services is:
Hospitals in Washington State that are major teaching hospitals: • Harborview Medical Center, • University of Washington Medical Center. *OR* All other Washington hospitals	Paid on a per case basis for admissions falling within designated APR DRGs. For low volume APR DRGs, Washington hospitals are paid using the statewide per diem rates for the designated APR DRG categories below: • Chemical dependency, • Psychiatric, • Rehabilitation, • Medical, • Surgical.

Hospital inpatient acute care rates

The APR DRG Assignment List with APR DRG codes, descriptions, relative weights for each severity of illness category and average length of stay can be viewed on L&I's fee schedule page.

For information on how specific rates are determined see WAC 296-23A.

APR DRG base rates

If the **hospital** is…	Then the **base rate** is:
Harborview Medical Center	**$13,545.20**
University of Washington Medical Center	**$11,994.52**
All other Washington hospitals	**$11,209.50**

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APR DRG per diem rates

If the **payment category** is…	Then the **rate** is…	And the **definition** is:
Psychiatric APR DRG per diem	**$1,215.03** multiplied by the number of days allowed by L&I.	APR DRGs identified as Psych
Chemical dependency APR DRG per diem	**$1,004.69** multiplied by the number of days allowed by L&I.	APR DRGs identified as Chem Dep
Rehabilitation APR DRG per diem	**$1,783.82** multiplied by the number of days allowed by L&I.	APR DRGs identified as Rehab
Medical APR DRG per diem	**$2,558.29** multiplied by the number of days allowed by L&I.	APR DRGs identified as Medical
Surgical APR DRG per diem	**$5,367.77** multiplied by the number of days allowed by L&I.	APR DRGs identified as Surgical

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Additional inpatient acute care hospital rates

If the **payment category** is…	Then the **rate** is…	And the **definition** is:
Transfer-out cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the APR DRGs average length of stay. If the worker's stay is less than the average length of stay, a per-day rate is established by dividing the APR DRG payment amount by the average length of stay for the APR DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the worker's stay is equal to or greater than the average length of stay, the APR DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low outlier cases (costs are less than the threshold)	Hospital-Specific POAC rate multiplied by allowed billed charges.	Cases where the cost (see note below table) of the stay is less than 10% of the statewide APR DRG rate or a statutory amount inflated to current dollars, whichever is greater.
High outlier cases (costs are greater than the threshold)	APR DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (see note below table) of the stay exceeds a statutory amount inflated to current dollars or 2 standard deviations above the statewide average cost for each DRG and SOI combination, whichever is greater.

How costs are determined

Costs are determined by multiplying allowed billed charges by the hospital-specific POAC rate. Hospitals outside of the United States will be paid at a POAC rate of 100% of allowed charges. High and low outlier amounts are listed on the APR-DRG Assignment sheet on L&I's fee schedule page.

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Payment policy: Outpatient hospitals

Self-insured employer payment methods

Services for hospital outpatient care provided to workers covered by self-insurers are paid using hospital-specific POAC rates or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program payment methods

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using hospital-specific POAC rates or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund payment methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

- Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system.
- An amount established through L&I's Professional Services Fee Schedule for covered services not processed using the APC system.
- A POAC rate for covered hospital outpatient services not processed using either the APC system or with an amount from the Professional Services Fee Schedule.

Note: Under the APC payment model, some line items may be packaged into the payment of other services on the bill and do not receive individual payment. The outpatient code editor (OCE) that Centers for Medicare & Medicaid Services created and maintains is utilized to determine which lines get packaged and which do not.

Links: For a description of L&I's OPPS system, see WAC 296-23A (Part 4), WAC 296-23A-0220, and WAC 296-23A-0700 through WAC 296-23A-0780.

How the above payment methods are applied

Hospital types or locations…	Then the **payment method** for hospital outpatient services is:
Hospitals not in Washington State, including psychiatric facilities and HMOs	Paid by out of state POAC rates. The rates are 66.14% for hospitals within the United States and 100% for hospitals outside the United States.
Hospitals in Washington State that are excluded: • Children's hospitals, • Military hospitals, • Veterans Administration facilities, • State psychiatric facilities, • Tribal-owned facilities located on tribal land.	Paid 100% of allowed charges
Hospitals not in Washington State that are excluded: • Children's hospitals, • Military hospitals, • Veterans Administration facilities	Paid 100% of allowed charges
Rehabilitation hospitals, Cancer hospitals, Critical access hospitals, Private psychiatric facilities	Paid a facility-specific POAC rate or a fee schedule amount depending on procedure
All other hospitals in Washington State	Paid on an APC basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC rate.

Additional payment details

When ER visits develop into inpatient stays, hospitals should bill all charges on an inpatient bill. Use the inpatient admission date as the first covered date.

Military hospitals may bill HCPCS code **T1015** for all outpatient clinic services.

Hospitals will be sent their individual POAC and APC rates each year.

Hospitals outside the United States will be paid at a POAC rate of 100%.

Pass-through devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device hasn't already been incorporated into an APC.

Hospitals will be paid by fee schedule or if no fee schedule exists, a hospital-specific POAC rate for new or current pass-through devices.

New or current drug or biological pass-through items will be paid by fee schedule or a POAC rate (if no fee schedule exists).

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Hospital OPPS payment process

Question:	If the **answer** is…	Then the **payment method** is:
1. Does L&I cover the service?	No	Don't pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Don't pay
	Yes	Go to question 3
3. Are the service codes listed on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC rate
4. Is the service packaged?	No	Go to question 5
	Yes	Don't pay. Go to question 7
5. Is there a valid APC for the service?	No	Go to question 6
	Yes	Pay the APC amount and total the APC payment(s) for outlier consideration. Go to question 7
6. Are the service codes listed in a fee schedule?	No	Pay POAC rate
	Yes	Pay the facility amount for the service
7. Does the service qualify for outlier?	No	No outlier payment
	Yes	Pay outlier amount

Additional payment details

If only 1 line item on the bill is an inpatient (IP) code, the entire bill will be paid at POAC rate.

Outlier amounts are in addition to regular APC payments.

OPPS relative weights and payment rates

The relative weights published by CMS are used for the OPPS program.

Each hospital's blended APC rate was determined using a combination of the average hospital-specific APC rate and the statewide average APC rate.

Links: Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720.

Hospitals will receive notification of their blended APC rates via separate letter from L&I or by accessing the Hospital Rates link in the fee schedule.

OPPS outlier payments

L&I uses a modified version of the CMS outlier payment policy.

Payment policy: Post-exposure prophylaxis (PEP) drugs for HIV

General information

The insurer will cover up to a 28-day supply of post-exposure prophylaxis (PEP) drugs for HIV when dispensed directly from a Washington State hospital emergency department for proper and necessary treatment of an injured worker or crime victim.

Link: For PEP HIV drugs dispensed through a pharmacy, see Chapter 19: Pharmacy.

Services that can be billed

Local rev code	Description and notes	Max fee
0017	Post-exposure prophylaxis (PEP) drugs for HIV	**Hospital-specific POAC rate**

Note: Don't include a CPT®/HCPCS code on the line billed with local rev code 0017.

Documentation requirements

Documentation of the PEP HIV drug(s) dispensed must include:

- Drug name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity

Payment policy: Swing beds for sub-acute care

Payment methods

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

Prior authorization

You must contact an ONC for approval. To obtain information about contacting an ONC, email L&I's Provider Hotline at PHL@Lni.wa.gov.

Requirements for billing

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

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

Does this policy apply to self-insured employers?

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

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for ASC payment policies	Washington Administrative Code (WAC) 296-23B
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
Administrative rules for hospital payment policies	Washington Administrative Code (WAC) 296-20 WAC 296-21 WAC 296-23 WAC 296-23A WAC 296-30-090
Administrative rules for the State Fund provider network and Who may treat	WAC 296-20-01010 WAC 296-20-015
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms **Adjustments, Refunds, Protests & Appeals**	Chapter 2: Information for All Providers
Evaluation and management services	Chapter 9: Evaluation and Management Services
Fee schedules for all healthcare facility services	Fee schedules on L&I's website
Minimum Data Set (MDS) Basic	Medicare's (CMS's) website

If you're looking for more information about…	Then see…
Assessment Tracking Form	
Payment policies for **durable medical equipment (DME)**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Residential treatment facilities for mental health	Chapter 26: Rehabilitation Facilities and Programs
Statement for Miscellaneous Services form	Statement for Miscellaneous Services form on L&I's website
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100 RCW 51.36.110

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

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Washington State Department of
Labor & Industries

Chapter 27: Rehabilitation Facilities and Programs

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

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How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: Brain injury rehabilitation programs (BIRPs) and services

Prior authorization

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment.

State Fund claims

To determine whether or not to authorize post-acute brain injury rehabilitation for a claim, both an occupational nurse consultant (ONC) and L&I claim manager will review the claim separately. (See Approval criteria, below.)

The Provider Hotline can't authorize brain injury treatment; however, the Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

Self-insured claims

Contact the SIE or TPA for authorization (see Approval criteria, below).

Link: Contact information for the SIE or TPA is available via L&I's self-insured lookup tool.

Approval criteria

Before a worker can receive treatment, all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim,
- The brain injury is related to the industrial injury or is retarding recovery,
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program,
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury, *and*
- The screening evaluation report by the program identifies specific goals to help the worker improve function or compensate for lost function.

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Who must perform these services to qualify for payment

Only providers approved by the department can provide post-acute brain injury rehabilitation services for workers.

Providers must maintain CARF accreditation in Outpatient Medical Rehabilitation Program – Interdisciplinary with Brain Injury Specialty designation and provide the Department of Labor and Industries (L&I) with documentation of satisfactory recertification including the latest CARF Accreditation Report. This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account may be inactivated if CARF accreditation expires or this information is not received from the provider. It is the provider's responsibility to notify L&I when an accreditation visit is delayed.

Additional provider requirements include:

- Provide L&I with the program organization structure annually.
- Notify L&I in writing of key organization changes within 30 days.
- New programs must provide L&I contact information with the provider application and be available to provide additional information, as needed.
- For applicable programs, L&I must be notified of substantial material changes to the program description in writing within 30 days.

Providers must send this information to Jason.Fodeman@Lni.Wa.Gov.

Qualifying programs

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation,
- Treatment, *and*
- Follow up.

When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to:

Department of Labor and Industries

Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Specific L&I provider account number required

Providers will be issued a provider-specific ID number (separate from any provider ID they may already have with L&I) which will enable payment via the brain injury program billing codes.

Providers may request a provider application or find out if they have a qualifying provider account number by emailing PHL@Lni.wa.gov.

Services that can be billed

Nonhospital based programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs:

Local code	Description	Maximum fee
8950H	Comprehensive brain injury evaluation	**$5,170.34**
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,172.86**
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$816.87**

Hospital based programs

The following revenue codes and payment amounts for hospital-based outpatient post-acute brain injury rehabilitation treatment programs:

Local rev code	Description	Maximum fee
0014	Comprehensive brain injury evaluation	**$5,170.34**
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,172.86**
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$816.87**

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Meals

L&I will reimburse the brain injury provider for 1 **meal** per day provided there is an onsite **meal** offered to the worker, and the worker is participating in more than 4 hours of treatment that day. Don't bill L&I for **meals** not provided to or paid by the worker.

Code	Description	1 unit of service equals…	Maximum fee per unit
5934M	Outpatient Day Program - Lunch	1 **meal** per authorized person	**State Rate** (includes taxes & gratuity)

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

The brain injury provider should bill L&I their usual and customary charges for the **meal** provided. Reimbursement will be at your usual and customary charge or the **State Rate**, whichever is less.

Services that aren't covered

Brain injury rehabilitation program services performed in the worker's home aren't covered.

Requirements for billing

For State Fund claims billing, providers participating in the Brain Injury Program must bill for brain rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. (See who must perform these services to qualify for payment, above.)

Billing for partial days for the treatment phase

If a worker receives less than the 4 hour minimum per day of treatment under code **8952H**, the clinic can bill only for the percentage of the 4 hours that treatment has been provided.

Example:

- The worker has an unforeseen emergency and has to leave the clinic after 2 hours (50% of the half-day treatment). The clinic would bill **8952H** at the reduced fee of **$816.87** x 50% = **$408.44**

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Comprehensive brain injury evaluation requirements

A comprehensive brain injury evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in depth analysis of the worker's cognitive, psychological, emotional, social, physical status and functioning. It must also include review of the workers' **medical records**, assessment of any important associated conditions that may hinder recovery, identification of the worker's family and support resources, and identification of factors that may affect participation. The evaluation must be provided by a multidisciplinary team that includes all of the following:

- Medical physician,
- Psychologist,
- Neuropsychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist, and
- Speech language pathologist

Additional medical **consultations** are referred through the program's physician. For State Fund claims, each **consultation** may be billed under the provider account number of the consulting physician. Services must be preauthorized by an L&I claim manager or the self-insured employer / third party administrator.

Documentation requirements

The following documentation is required of providers when billing for evaluation and/or treatment services within the post-acute brain injury rehabilitation program:

- All daily chart notes including a daily record of a workers' attendance, activities, treatments and progress,
- All test results and scoring,
- Documentation of team meetings and/or care conferences, including participants,
- Documentation of interviews with family, *and*
- Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program.

Progress reports must be sent to the insurer regularly, including all preadmission and discharge reports.

Payment limits

Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation, may be performed in any combination depending on the worker's condition and related needs, and **can't be billed separately**:

- Neuropsychological diagnostic interview(s), evaluation, testing, scoring, and interpretation of results,
- Psychological diagnostic interview(s), evaluation, testing, scoring, and interpretation of results,
- Initial **consultation** and exam with the program's physician,
- Occupational and Physical Therapy evaluations,
- Vocational Rehabilitation evaluation,
- Speech and language evaluation, *and*
- Comprehensive report.

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is **considered part of the provider's administrative overhead**. It includes but isn't limited to:

- Obtaining and reviewing the workers' historical **medical records**,
- Interviewing family members, if applicable,
- Phone contact and letters to other providers or community support services,
- Writing the final report, *and*
- Office supplies and materials required for service(s) delivery.

Treatment

These therapies, treatments, and/or services are included in the Brain Injury Program maximum fee schedule amount for the full day or half-day brain injury rehabilitation treatment and **can't be billed separately**:

- Psychotherapy,
- Behavioral modification,
- Behavioral Health Interventions, see Chapter 17: Mental Health and Behavioral Health Interventions for more details,
- Individual or group therapy,
- Physical therapy and occupational therapy,
- Speech and language therapy,
- Nursing and health education and pharmacology management,
- Activities of daily living management,
- Recreational therapy (including group outings),
- Vocational counseling, *and*
- Follow up interviews with the worker or family.

Ancillary work, materials, and preparation that may be necessary to carry out Brain Injury Program functions and services are considered part of the provider's administrative overhead and **aren't payable separately**. These include, but aren't limited to:

- Daily charting of patient progress and attendance,
- Report preparation,
- Case management services,
- Coordination of care,
- Team conferences and interdisciplinary staffing, *or*
- Educational materials (for example, workbooks and tapes).

Follow up care is included in the cost of the full day or half-day program. This includes, but isn't limited to:

- Telephone calls, *and*
- Therapy assessments.

Payment policy: Mental health residential treatment facilities

General information

Residential treatment facilities for mental health provide high-level care to workers with long-term or severe mental health disorders, or workers with substance-related disorders requiring detoxification and treatment, with 24-hour medical and nursing services. Residential treatment facilities for mental health typically provide less intensive medical monitoring than subacute hospitalization care. Treatment includes a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential treatment facilities for mental health include training in the basic skills of living as determined necessary for each worker. Treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance use disorders are included in this level of care. Adult family homes, skilled nursing facilities, or boarding homes aren't included in this definition.

This policy applies to workers who require admission to a residential treatment facility for mental health services. Workers covered under this policy are either filing the initial claim, or have an open and allowed claim. This includes those who:

- Have an accepted mental health condition, such as occupational posttraumatic stress disorder (PTSD), *or*
- Have mental health treatment authorized, which may include the need for treatment of substance use disorder.

For information on which insurer to bill, see Chapter 2: Information for All Providers.

For additional inpatient or outpatient facility information, see Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs).

For mental health services and authorization requirements, see the information in this chapter. Supplemental information is defined in WAC 296-21-270.

Requirements for PTSD are defined in RCW 51.08.165. For occupational disease requirements, see RCW 51.08.142 and RCW 51.32.185 (presumptive coverage).

Claim filing

The filing of the initial L&I Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) does not require prior authorization. The insurer covers the **initial visit** and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. See Chapter 2: Information for All Providers for additional details on **initial visits**.

For workers where the facility is filing the L&I Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) **and the worker requires treatment**, the following must be submitted to the insurer:

- The ROA or PIR, *and*
- Initial evaluation of the worker, including DSM-5 diagnosis with supporting documentation to support the diagnosis and pre-screening intake, if conducted, *and*
- Request for authorization for ongoing treatment.

The recommended treatment plan and all treatment records must be submitted to the insurer for authorization of ongoing treatment.

Note: Each facility may require their own release of record form, however, the insurer's ROA/PIR requires a signature by the worker to release relevant **medical records**. The insurer determines 'relevant.' The ROA/PIR may be used in lieu of the facility's release of records form.

Claim status

The following are example claim statuses of workers who seek treatment at a residential treatment facility for mental health services:

1. Initial claim filing, evaluation **without** treatment. In this case, the worker may seek initial evaluation from a facility without prior authorization, but may not receive a mental health diagnosis per DSM-5 or require ongoing treatment. The insurer covers the **initial visit** and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility are submitted within 1 year from date of service. See Chapter 2: Information for All Providers for additional details on **initial visits**.
2. Initial claim filing, evaluation **with** treatment. In this case, the worker may seek treatment from a facility and may require ongoing treatment of a DSM-5 diagnosis. The insurer covers the **initial visit** and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. Prior authorization is required before initiating treatment. See the Mental Health Services webpage, this chapter, and the prior authorization requirements below for additional details.
3. Established claim. In these cases, an L&I worker's compensation claim is open and allowed and requires prior authorization for treatment. See prior authorization requirements below for additional details.

In order to assist the worker and their providers, the insurer requires timely documentation. See documentation requirements below for additional details.

Treatment beyond the first visit and evaluation won't be paid when a claim is rejected.

Treatment

A referral from either the **attending provider (AP)** or a mental health provider (psychiatrist, psychiatric ARNP, psychologist) is required prior to admission for open and allowed claims.

Prior authorization

Mental health prior authorization treatment requirements apply to claims filed through a residential treatment facility for mental health services. Contact the insurer for prior authorization.

For workers with an open and allowed claim for accepted mental health conditions and treatment has been authorized, the following is required:

Inpatient/Residential treatment:

- An evaluation by the facility, including a treatment plan, must be sent to the insurer for authorization **prior** to initiating treatment. The start date for treatment must be submitted as part of the evaluation.
- Initial authorization is up to 6 weeks. For treatment lasting longer than 6 weeks additional authorization is required. Contact the insurer for prior authorization. An updated treatment plan is required for additional authorization.

Ongoing outpatient treatment:

- Continuation of mental health treatment by the facility in an outpatient setting requires authorization. The facility must submit an updated treatment plan as part of the authorization request. Facilities aren't required to develop an updated treatment plan once the worker has transferred care to an AP.

Discharge:

- Upon discharge, the facility must coordinate and transfer the worker's care back to the AP and/or referring provider. If the worker does not have an AP prior to admission, the facility must help the worker identify an AP prior to discharge and then coordinate and transfer the worker's care to the identified AP. The AP is responsible for managing the overall care of the worker after discharge from a residential treatment facility for mental health services. The worker has the right to choose their AP.

Payment methods

Bill the insurer usual and customary fees.

Washington state facilities will be paid POAC, DRG, or fee schedule amounts. See Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs) for details.

Out of state facilities will be paid at the out-of-state POAC rate. See Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs) for details.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a worker admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via POAC rate.

Who must perform these services to qualify for payment

Washington State residential treatment facilities for mental health services must be certified and licensed by the Washington State Department of Health.

Out of state residential treatment facilities for mental health services must be licensed by the state the facility is located in, and accredited by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or any other state-approved accrediting organization.

See All mental health services for additional details on who can provide mental health services.

Services that can be billed

The insurer covers the following codes with prior authorization:

- **H0035**
- **H0047-H0050**
- **H2035**
- **H2036**
- **S9480**

This is in addition to the codes found in L&I's professional provider fee schedule.

Services that aren't covered

In addition to the codes not covered on the fee schedule, the following services aren't covered:

- **H0031-H0032**
- **H0036-H0040**
- **H0046**
- **H2001**
- **H2010-H2034**
- **H2037-H2038**

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Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Documentation requirements

Per Chapter 2: Information for All Providers, chart notes and any treatment plan updates, must be submitted to the insurer.

In addition to the requirements noted in Chapter 2: Information for All Providers and this chapter, all facilities must provide the insurer with the following documentation:

- Causality statement for the industrial injury or occupational disease (DSM-5 diagnosis) for initial claim filing, *and*
- The initial evaluation from a provider at the facility when the worker is admitted, *and*
- A recommended course of action for the worker, *and*
- Treatment that was provided, *and*
- Progress reports on a bi-weekly basis, *and*
- Discharge summary, including but not limited to, ongoing treatment plan for the worker when they return to their AP and/or mental health provider; assessment of worker's psychological status especially as related to reintegration in the workplace, home and community; and communication with the AP, referring provider, claim manager, assigned vocational counselor or family to support the worker's continued management of mental health condition, *and*
- The worker's full name, *and*
- L&I claim number, *and*
- Time as required per CPT® or HCPC coding, *and*
- Treating provider name, address and telephone number.

Don't fax the treatment plans or chart notes with bills. See Chapter 2: Information for All Providers for details on submitting chart notes and treatment plans to the insurer.

Additional information

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

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Payment policy: Structured, intensive, multidisciplinary program (SIMP)

General information

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP (structured intensive multidisciplinary program).**

For purposes of this policy, a **SIMP** means a chronic pain management program with the following 4 components:

- **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
- **Intensive** means the Treatment Phase is delivered on a daily basis, 6 to 8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
- **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare professionals with expertise in pain management in at least the areas of medicine, psychology, and physical therapy or occupational therapy. The **SIMP** may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits, *and*
- **Program** means an interdisciplinary pain rehabilitation program that provides outcome focused, coordinated, goal oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Prior authorization is required for all workers to participate in a **SIMP** for functional recovery from chronic pain. See details about prior authorization requirements later in this Payment policy section.

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

For the purposes of this policy, a treatment plan means an individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and

addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

For the purposes of this policy, validated tests and instruments are those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

Program design: Phases of an approved SIMP

An approved **SIMP** has 3 phases:

- Evaluation Phase,
- Treatment Phase, and
- Follow up Phase.

See below for details about each of these 3 phases.

1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes treatment plan development and a report. Only 1 evaluation is allowed per authorization but it can be conducted over 1 to 2 consecutive business days. The evaluation is a comprehensive evaluation and must be performed in person by the interdisciplinary team of physician, psychologist, and physical or occupational therapist and may include other specialties as appropriate.

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants (PA-C) can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*
- Review of **medical records** and reports, including diagnostic tests and previous efforts at pain management, *and*
- Assessment of any important associated medical or psychological conditions (often referred to as co-morbid conditions) that may hinder functional recovery from pain, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease, *and*
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs. This must include checking the Prescription Monitoring Program Database *and*
- Psychological and bio-psycho-social assessment by a licensed clinical psychologist using validated tests and instruments for use with individuals with chronic pain, *and*
- Identification of the worker's family and support resources and perceived social support, *and*

- Identification of the worker's reasons and motivation for participation and improvement, and goals from the program *and*
- Identification of factors that may affect participation in the program, *and*
- Assessment of pain and function using validated tests and instruments; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
    - Activities of Daily Living (ADLs),
    - Range of Motion (ROM),
    - Strength,
    - Stamina, *and*
    - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the **SIMP** vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for **SIMP** workers section of this chapter), *and*
- A summary report of the evaluation and a preliminary recommended treatment plan. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6 to 8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical and/or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities or daily activites guided by a physical and/or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the **attending provider**, claim manager, family, employer, vocational rehabilitation counselor and community resources as needed to accomplish the goals set forth in the treatment plan, *and*

- **Education and skill development** on the factors that contribute to pain, responses to pain, and effective pain management, *and*
- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using validated tests and instruments consistent with those at evaluation, *and*
- **Ongoing assessment** of important associated conditions, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment. This must include checking the Prescription Monitoring Program Database, *and*
- **Performance** of real or simulated work or daily functional tasks, *and*
- **SIMP vocational services**: these may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and* a discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase.
- At time of discharge, the **SIMP** physician must call the **attending provider** to discuss the worker's treatment in the program, progress, barriers, and discharge plan. *and*
- **A summary report** at the conclusion of the Treatment Phase that addresses all the following questions:
  - To what extent did the worker meet their treatment goals?
  - What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?
  - What changes if any, have occurred in the worker's pain level and functional capacity as measured by validated tests and instruments (consistent with the tools used during evaluation)?
  - What changes if any, have occurred in the worker's ability to self-manage pain?
  - What is the status of the worker's readiness to return to work or daily activities?
  - What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
  - How much and what kind of follow up care does the worker need?

3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into their job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), or
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

- Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.
- Non face-to-face services are when the **SIMP** provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in their community, activity levels, and support systems,
- What was done during the Follow up Phase,

- What resulted from the follow up care, and
- Measures of pain and function using validated tests and instruments (consistent with the tools used during the **SIMP** program)

This summary report must be submitted at the 1, 3, and 6 month marks; if applicable.

Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with validated tests and instruments, *and*
- Evaluating whether the worker is adherent to their home and work program that was developed at the conclusion of the Treatment Phase, *and*
- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing important associated conditions and psychological status especially as related to reintegration in the workplace, home, and community, *and*
- Assessing level and type of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical and/or occupational therapist, *and*
- Adjusting the worker's home and work program for self-management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*
- Teaching new techniques or skills that weren't part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the **attending provider**, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued self-management of chronic pain, *and*
- Making recommendations for assistance or accommodations in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in their community to learn about the worker's current status and needs and help them find the needed resources, *and*
- Holding case conferences with the:
- Interdisciplinary team of clinicians, *and/or*
- Worker's **attending provider**, *and/or*
- Other individuals closely involved with the worker's care and functional recovery.

Follow up Phase special considerations

When determining what follow up services the worker needs, **SIMP** providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a **SIMP** provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the **SIMP** provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*
- If a **SIMP** provider wishes to coordinate the delivery of physical and/or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

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Link: More information about Helping Workers Get Back to Work is available online.

Prior authorization

General referral and prior authorization requirements

All **SIMP** services require prior authorization by the claim manager and a referral from the worker's **attending provider**. An occupational nurse **consultant**, claim manager, or insurer-assigned vocational counselor may recommend a **SIMP** evaluation for the worker, but only the **attending provider** can make a referral.

Note: Only the **attending provider** can refer a worker for a **SIMP** evaluation.

SIMP referral

SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the **attending provider** refers a worker to a **SIMP**, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the **SIMP** provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the **SIMP** provider recommends the worker move on to the Treatment Phase, the **SIMP** provider must provide the insurer with a report and treatment plan as described under the Evaluation Phase, *or*

- **Doesn't meet the requirements**, the **SIMP** provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*
  - The goals the worker must meet before they can return and participate in the program, *also*
  - If the worker is found to have important associated conditions during the Evaluation Phase that prevent them from participating in the Treatment Phase, the **SIMP** provider must either treat the worker or recommend to the worker's **attending provider** and the claim manager what type of treatment the worker needs.

Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

SIMP provider requirements

To provide functional restoration / chronic pain management program services to eligible workers, **SIMP** service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see General information section earlier in this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, *and*
- Ensure care is coordinated regularly amongst the interdisciplinary team, *and*
- Communicate and coordinate with providers claim managers, family, employer and vocational counselor, who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's **attending provider**, *and*
- Inform the claim manager if the worker:
  - Stops services prematurely,
  - Has unexpected adverse occurrences, or
  - Doesn't meet the worker requirements (see Worker requirements section below)
- Communicate with the worker during treatment to ensure they understand and follow the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*

- Provide the insurer with the required documentation in a timely manner (Evaluation Summary Report, all daily chart notes, Treatment Phase Summary Report including the discharge care plan, Follow up visit notes, and Follow Up Summary Report).
  - Documentation of team meetings and/or care conferences must include participants
- Coordinate the worker's transition and reintegration back to their home, community, and/or employment.
- Provide the Department with the **SIMP** organization structure annually.
- Notify the Department in writing of key organization changes within 30 days.
- New programs must provide the Department contact information with the provider application and be available to provide additional information, as needed.

  For applicable programs, the Department must be notified of substantial material changes to the program description in writing within 30 days. Providers must maintain CARF accreditation and provide the Department with documentation of satisfactory recertification including the latest CARF Accreditation Report. This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account will be inactivated if CARF accreditation expires or this information isn't received from the provider. It is the provider's responsibility to notify the Department when an accreditation visit is delayed.

  For any existing **SIMP** provider wanting to add a new site to the **SIMP** program, they must provide the L&I's Provider Accounts and Credentialing unit with a copy of the completed *CARF OCForm_Relocation_Expansion_Elimination* to be added to your provider account file. Additionally, **SIMP** provider must provide the Department with contact information for the new site and be available to provide additional information, as needed.

Worker requirements

A worker must make a good faith effort to participate and adhere to the treatment plan prescribed for them by the **SIMP** provider. To complete a **SIMP** successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of their treatment plan, *and*
- Be psychologically stable enough to understand and follow instructions and to fully engage in treatment, including between session work, and work toward the goals that are part of their treatment plan, *and*
- Agree to be evaluated and adhere to treatment prescribed for any important associated conditions that may hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and/or other unmanaged chronic disease), *and*
- Attend each day and each session that is part of their treatment plan. Sessions may be made up if, in the opinion of the provider, it wouldn't interfere with the worker's progress toward treatment plan goals, *and*
- Cooperate and adhere to their treatment plan, *and*
- Not pose a threat or risk to themself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help their transition back to home, community, and/or workplace.

Services that can be billed

SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table. The fee schedule applies to workers only in an outpatient program:

Description	Local code	Duration / limits	Units of service	Maximum fee
SIMP Evaluation Services	**2010M**	1 evaluation per authorization, which may be conducted over 1 to 2 consecutive business days.	Bill only 1 unit for evaluation even if conducted over 2 days	**$1,343.26**
SIMP Treatment Services, each 6-8 hour day	**2011M**	Not to exceed 20 treatment days (6-8 hours per day).	1 day equals 1 unit of service	**$860.39** per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community	**2014M**	Not to exceed 4 hours per day and not to exceed 24 hours total (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.81** per minute (**$108.60** per hour)
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community	**2015M**	Not to exceed 40 hours (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.41** per minute (**$84.60** per hour)

Description	Local code	Duration / limits	Units of service	Maximum fee
Outpatient Day Program - Lunch for **meal** reimbursement	**5934M**	Worker must be onsite for treatment of more than 4 hours. Prior authorization required. Don't bill for **meals** not provided to or paid for by the worker.	1 **meal** per authorized person	**State Rate** (includes taxes & gratuity)
Mileage for traveling to and from the worker's community	**0392R**	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

Requirements for billing

Outpatient functional restoration / chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form (F245-127-000).

Billing for partial days for the treatment phase

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the worker was scheduled for less than 8 hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill **$860.39** x 25% = **$215.10**

Payment limits

SIMP evaluation services

Only 1 evaluation per authorization is allowed, which may be conducted over the course of 1 to 2 days consecutive business days. If the evaluation is conducted over a 2 day period, bill only 1 unit and span the dates.

SIMP treatment services

These services can't exceed 20 treatment days (6-8 hours per day).

SIMP follow up services

Face-to-face services (local code **2014M**) can't:

- Exceed 4 hours per day, *and*
- 24 hours total.

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Note: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit.

Payment policy: Vocational services for SIMP workers

General information

This policy is for workers participating in **SIMP**-related vocational services.

For non-**SIMP** vocational services, see Chapter 25: Vocational Services.

Prior authorization

Prior to authorizing participation in a **SIMP**, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

- Is working, *or*
- Is scheduled to return to work, *or*
- Has been found employable or not likely to benefit from vocational services.

Requirements for a Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with **SIMP** treatment and the claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the **outcomes** listed in the Return to Work Action Plan **must be included** with the Treatment Phase summary report.

If a vocational counselor is assigned, the **SIMP** will coordinate with vocational counselor as needed to agree upon a Return to Work Action Plan with a return to work goal.

Note: Don't forget to include the outcomes from the Return to Work Action Plan in your Treatment Phase Summary Report.

Return to Work Action Plan roles and responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the **SIMP** vocational counselor, the **attending provider**, and the worker are involved.

The specific roles and responsibilities of each are as follows:

The SIMP vocational counselor will:

- Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
- Present the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the **SIMP** recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.

The insurer assigned vocational counselor will:

- Co-develop the Return to Work Action Plan with the **SIMP** vocational counselor, *and*
- Attend the functional restoration / chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
- Negotiate with the **attending provider** when the initial Return to Work Action Plan isn't approved in order to resolve the **attending providers** concerns, *and*
- Obtain the worker's signature on the Return to Work Action Plan, *and*
- Communicate with the **SIMP** vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
- Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

The attending provider will:

- Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
- Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.

The worker will:

- Participate in the selection of a return to work goal, *and*
- Review and sign the final Return to Work Action Plan, *and*
- Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

Link: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Crime Victims Compensation Program contact information	**Phone**: 1-800-762-3716 (toll free) **Fax**: 1-360-902-5333 Crime Victims on L&I's website
Fee schedules for all healthcare services	Fee schedules on L&I's website
Return to work: "Helping Workers Return to Work"	Helping Workers Return to Work on L&I's website
Self-insured claims authorization from the self-insured employer (SIE) or their third party administrator (TPA)	Contact list of SIE/TPAs on L&I's website
Worker refuses to cooperate with care plan: Legal issues defined in Washington state laws	Revised Code of Washington (RCW) 51.32.110

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

Washington State Department of Labor & Industries

Chapter 28: Skilled Nursing, Home Health, and Residential Care

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Table of Contents Page

Payment policy: All residential care services

General requirements

The insurer covers:

- Proper and necessary residential care services that require **24 hour institutional care** to meet the worker's needs, abilities, and safety, *and*
- Medically necessary hospice care, comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Services must be:

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

Prior authorization and reauthorization requirements

Initial admission

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

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

Link: For authorization procedures on a self-insured claim, contact the self-insurer.

When care needs change

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

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

Who must perform these services to qualify for payment

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

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

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

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

Services that aren't covered

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

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

Pharmaceuticals and durable medical equipment (DME)

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

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

Requirements for billing

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this chapter. All residential care services should be billed on form F245-072-000 (Statement for Miscellaneous Services).

Link: The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125.

Additional information: Residential services review, periodic independent nursing evaluations

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

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

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

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

Payment policy: Assisted living facilities, adult family homes, and boarding homes

Requirements for the Residential Care Assessment Tool

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

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

The insurer will determine the appropriate L&I payment grouping based on the nursing assessment of the worker's **personal care** needs. Services must be proper and necessary and related to the worker's industrial injury or covered under a department medical treatment order. Facilities shouldn't submit bills for the assessment; the nurse who completes the form will bill the Department for their services.

Link: If you are a Nurse Case Manager performing an annual care assessment requested by the department, see Chapter 5: Care Coordination.

Services that can be billed

The insurer will advise the facility of which billing code to use. The 3 levels of care will be applied to all nonskilled nursing facility types. The payment rates are daily payment rates (see table below).

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

If the **assessment determines the level of care is**…	Then the appropriate **billing code** is…	And the **daily payment rate** is…
Basic level care	**8893H**	**$192.49**
Intermediate level care	**8894H**	**$233.78**
Advanced/Special level care	**8895H**	**$275.03**

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

Services that can't be billed

L&I won't pay adult family homes or other residential care when the injured worker isn't present, such as when hospitalized or on vacation.

L&I won't pay bed hold fees, admission fees, or any services not defined by the fee schedule.

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Payment policy: Attendant home care services

General information

Attendant home care services are proper and necessary **personal care** services provided to maintain the injured worker in his or her residence.

Attendant services support **personal care** or assist with activities of daily living of a medically stable worker with physical or cognitive impairments. Attendant home care services are provided in the workers' home.

Link: See WAC 296-23-246 for details about attendant services.

Prior authorization

All attendant care services require prior authorization.

The insurer will determine maximum hours and type of authorized attendant care based on a nursing assessment of the worker's **personal care** needs.

Services must be proper and necessary and related to the worker's industrial injury or covered under a department medical treatment order.

Attendant care services may be **terminated or not authorized if**:

- Behavior of worker or others at the place of residence is threatening or abusive,
- Worker is engaged in criminal or illegal activities,
- Worker doesn't have the cognitive ability to direct the care provided by the attendant and there isn't an adult family member or guardian available to supervise the attendant,
- Residence is unsafe or unsanitary and places the attendant or worker at risk, *or*
- Worker is left unattended during approved service hours by the approved provider.

The insurer will notify the provider in writing when current approved hours are modified or changed.

Attendant care agency requirements

Attendant care services may be provided by a *home health licensed agency* or a *home care licensed agency*. The agency providing services must be able to provide the type of care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

Attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services.

The agency can bill workers for hours that aren't approved by the insurer if the worker is notified in advance that they are responsible for payment.

Home Health Agencies

Home health agencies provide skilled nursing and therapy related services. Home health agencies must have RN supervision of caregivers providing care to a worker.

Examples of services include nursing and home health aide.

Home Care Agencies

Home care agencies provide non-medical services to people with functional limitations.

Examples of non-medical services include: Activities of daily living, such as assistance with ambulation, transferring, bathing, dressing, eating, toileting, and personal hygiene to facilitate self-care.

Attendant care provider requirements

Caregivers and services provided are dependent on the type of agency license providing the services and the needs of the worker.

Payment limits

Reimbursement for attendant care services includes supervision and training and isn't billed separately (this doesn't include nurse delegation).

Attendant care providers can't bill for services the attendant performs in the home while the worker is away from the home.

The insurer won't pay services for more than 12 hours per day for any 1 caregiver, unless specifically authorized.

The insurer won't pay for care during the time the caregiver is sleeping.

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Services that can be billed

HCPCS code	Description	Max fee
S9122	Attendant in the home provided by a certified home care aide or certified nurse assistant per hour	**$43.43**
S9123	Attendant in the home provided by a registered nurse per hour	**$87.29**
S9124	Attendant in the home provided by licensed practical nurse per hour	**$63.06**

Link: To see which codes require prior authorization, see the HCPCS fee schedule.

Documentation requirements

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift,
- Printed name of caregiver, initials, signature and title of each caregiver, and
- Specific care provided and who provided the care.

Chore services

Chore services (housecleaning, laundry, shopping, menu planning and preparation, transportation of the injured worker, errands for the injured worker, recreational activities, yard work, and child care) and other services that are only needed to meet the worker's environmental needs aren't covered.

Link: Chore services aren't a covered benefit. See WAC 296-23-246.

Attendant care services in hospitals or nursing facilities

Attendant care services won't be covered when a worker is in the hospital or a nursing facility unless:

- The worker's industrial injury causes a special need that the hospital or nursing facility can't provide, and
- Attendant care is authorized specifically to be provided in the hospital or nursing facility.

Independent nurse evaluation reports

All RN evaluation reports must be submitted to the insurer:

- Within 15 days of the initial evaluation, *and then*
    - Annually, *or*
    - When requested, *or*
    - When the worker's condition changes and necessitates a new evaluation.

If a current nursing assessment is unavailable, a nursing evaluation will be conducted to determine the level of care and the maximum hours of **personal care** needs the worker requires.

An independent nurse evaluation requested by the insurer may be billed by a Nurse Case Manager or Home Health Agency RN. Home Health Agency RNs bill code **G0162**, 1 unit per 15 minutes. Nurse Case Managers, see Chapter 5: Care Coordination for additional details.

Wound care

When attendant care agencies are providing care to a worker with an infectious wound, prior authorization and prescription from the treating physician are required.

In addition to prior authorization, when caregivers are providing wound care a prescription from the treating provider is required to bill for infection control supplies (HCPCS code **S8301**).

An invoice for the supplies must be submitted with the bill.

Worker travel

Workers who qualify for attendant care and are planning a long-distance trip must inform the insurer of their plans and request specific authorization for coverage during the trip.

The insurer won't cover travel expenses of the attendant or authorize additional care hours.

Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

The worker must coordinate the trip with the appropriate attendant care agencies.

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Temporary or respite care

If in-home attendant care can't be provided by an agency, the insurer can approve a temporary stay in a residential care facility or skilled nursing facility.

Temporary or respite care requires prior authorization. The agency providing respite care must meet L&I criteria as a provider of home care services.

The insurer can approve home care services to provide respite (relief) for a spouse or family member who provides either paid or unpaid attendant care.

Note: Spouses won't be paid for respite care.

Spouse attendant care

Spouses may continue to bill for spouse attendant care if they:

- Aren't employed by an agency, *and*
- Provided insurer approved attendant services to the worker prior to October 1, 2001, *and*
- Met criteria in the year 2002.

Link: For more information on laws about spouse attendant care, see WAC 296-23-246.

Spouse attendants may bill up to 70 hours per week. Also:

- Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation, which must be performed yearly, *and*
- If the worker requires more than 70 hours per week of attendant care the insurer can approve a qualified agency to provide the additional hours of care, *and*
- The insurer will determine the maximum amount of additional care based on an RN evaluation.
- Spouse attendants won't be paid during sleeping time.

Services that can be billed

HCPCS code	Description	Max fee
8901H	Spouse attendant in the home per hour	**$16.66**

Documentation requirements

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of caregiver's shift,
- Printed name of caregiver, initials, signature of caregiver, *and*
- Specific care provided.

Payment policy: Home health services

General information

When services become proper and necessary to treat a worker's accepted condition, the insurer will pay for aide, registered nurse (RN)/licensed practical nurse (LPN), physical therapy (PT), occupational therapy (OT), and (ST) speech therapy services provided by a licensed home health agency.

Home health services are multidisciplinary (RN, LPN, nursing aide, PT, OT, speech) assessments and interventions for short-term rehabilitative therapy, home assessments for equipment and safety and long term nursing supervision for wound care, bowel and bladder management.

Most home health services provided are interventions to improve function and safety between hospital care and outpatient care and therapy. These services aren't intended for attendant care delivered in the home. The expectation of home health services is to enable the worker to receive outpatient, rehabilitative or medical services.

The following types of need are examples of when home health therapies may be approved:

- Post injury or post-surgical activity restrictions, restrictions on the ability to use 2 or more extremities, bilateral non-weight bearing restriction, or post-operative infection requiring IV antibiotics;
- Inability to ambulate or inability to maneuver a wheelchair;
- Inability to transfer in or out of a vehicle with or without assistance;
- Inability to safely negotiate ingress or egress of residence;
- Unable to sit (supported or unsupported) or alternate between sitting and standing for up to 2 hours;
- Inability to bathe or dress themselves if they live alone.
- No available transportation service exists due to rural setting; *or*
- No outpatient facilities are available to provide medically necessary care.

Links: For additional information on **home health services**, see WAC 296-20-03001(8) and WAC 296-23-246.

Link: For home infusion services, see Chapter 12: Injections and Medication Administration.

Prior authorization

All home health services require prior authorization.

The insurer will determine maximum hours and type of authorized home health care based on a nursing assessment of the worker's **personal care** needs that are proper and necessary and related to the worker's industrial injury.

All home health services must be requested by a physician. The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

Home health services may be terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

Who must perform these services to qualify for payment

Home health agencies provide skilled nursing and therapy related services. They must be licensed as a home health agency.

Services for which home health agencies may bill include:

- Nursing
- Home health aide
- Physical therapy
- Occupational therapy
- Speech therapy

Providers who perform services for home health agencies must be one of the following: Aide, RN, LPN, PT, OT, or ST.

Services that can be billed

HCPCS code	Description and notes	Max fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day	**$45.83**
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day	**$47.53**
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day	**$47.53**
G0159	Plan of care established by Physical Therapist in the home, 15 min units	**$47.53**
G0160	Plan of care established by Occupational Therapist in the home, 15 min units	**$47.53**
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units	**$47.53**
G0299	Services of skilled nurse RN in the home. 15 min units	**$47.53**
G0300	Services of skilled nurse LPN in the home. 15 min units	**$42.75**
8970H	Home Health Aide Service up to 2 hours	**$86.86**
8971H	Home Health Aide Services each additional 15 minutes	**$10.86**

Payment limits

Home Health Aide Service codes **8970H** and **8971H** can only be billed when there is RN oversight.

Base Rate Code **8970H** is billable once per day and covers up to 2 hours.

Add-on Code **8971H** is only billable with Base Rate Code **8970H**. Each unit of **8971H** equals 15 minutes. Up to 8 units per day are billable.

For **8970H** and **8971H** the insurer follows the timed code policies established by CMS in section 20.2 (reporting of service units with HCPCS), chapter 5 of the Medicare Claims Processing Manual (Internet-Only Manual 100-04).

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Documentation requirements

The following documentation is required to be submitted by the home health care provider within 15 days of beginning the services:

- **Attending provider**'s treatment plan and/or orders by the **attending provider**,
- An initial evaluation by the RN or PT/OT (bill using **G0159**, **G0160**, and **G0162** see table above), *and*
- A treatment plan.

Updated plans must be submitted every 30 days thereafter for authorization periods greater than 30 days.

Providers must submit documentation to the insurer to support each day billed that includes:

- Begin and end time of each caregiver's shift,
- Name, initials, and title of each caregiver, *and*
- Specific care provided and who provided the care.

Authorization for continued treatment requires:

- Documentation of the worker's needs and progress, *and*
- Renewed authorization at the end of an approved treatment period.

Durable medical equipment (DME)

Durable medical equipment may require specific authorization prior to purchase or rental. Codes that require prior authorization are noted with a Y in the "PRIOR AUTH" column.

Link: To see which codes require prior authorization, see the HCPCS fee schedule.

Worker responsibilities

The worker is expected to be present and ready for scheduled home health nurse or therapist treatment. The insurer may terminate services if the work isn't present, refuses treatment or assessment.

Payment policy: Hospice care

Requirements for billing

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

Hospice programs must bill the following HCPCS codes:

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

Payment limits

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

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

Payment policy: In-home hospice services

Prior authorization

In-home hospice services must be prior authorized and may include chore services. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Services that can be billed

HCPCS code	Description and notes	Max fee
Q5001	Hospice care, in the home, per diem. Applies to in-home hospice care.	**By report**

Payment policy: Skilled nursing facilities

Requirements for the Minimum Data Set Basic Assessment Tracking Form

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

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

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

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Payment policy: Skilled nursing facility and transitional care unit beds

Payment methods

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

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

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

Payment limits

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

Prior authorization requirements

A HIPPS code must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code. For a listing of HIPPS and local code combinations as well as maximum fees, see L&I's fee schedule.

Services that can't be billed

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

L&I won't pay bed hold fees, admission fees, or any services not defined by the fee schedule.

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Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
Administrative rules for home health services	Washington Administrative Code (WAC) 296-20-03001(8) WAC 296-20-1102 WAC 296-23-246
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services and professional services	Fee schedules on L&I's website
Minimum Data Set (MDS) Basic Assessment Tracking Form	Medicare's (CMS's) website
Payment policies for **durable medical equipment (DME)**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Payment policies for **physical therapy and occupational therapy**	Chapter 20: Physical Medicine
Payment policies for **supplies**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Statement for Miscellaneous Services form	Statement for Miscellaneous Services form on L&I's website
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100 RCW 51.36.110

Need more help?

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Washington State Department of
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Appendix A: Definitions

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

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The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For explanations of modifiers referenced throughout the payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS) Codes.

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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General information

The following terms are used throughout the payment policy chapters. Terms are listed in **blue text** to make it clear that they have a special definition. The definition applies anywhere the term appears in MARFS.

Definitions are listed alphabetically. Some letters don't have any terms that start with that letter, but are listed regardless to make it clear that no terms were accidentally omitted.

A

Acquisition cost

Acquisition cost equals:

- Wholesale cost of the item, and
- Shipping and handling if applicable, and
- Sales tax.

Attending Provider

A person licensed to practice one or more of the following professions: Medicine and surgery (MD); osteopathic medicine and surgery (DO); chiropractic (DC); naturopathic physician (ND); podiatry (DPM); dentistry (DDS, DMD); optometry (OD); clinical psychologist (PhD, PsyD); physician assistant (PA, PA-C); and advanced registered nurse practitioner (ARNP).

Attending Providers refer to the type of providers listed above, which are eligible to be the AP on a claim. Typically, this is the provider who directs the worker's treatment, much like a primary care provider. The worker may elect to change their attending provider and select another attending provider of their choosing at any time during their treatment. All other providers treating the worker are considered concurrent care providers, even if they are an attending provider type. References throughout MARFS, unless otherwise noted, apply to Attending Provider types and not solely the AP 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. Additional resources for **APs** are available in the Attending Provider Resource Center on L&I's website.

B

Bundled codes

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

Pharmacy and DME providers can bill HCPCS codes listed as Bundled on the fee schedules because, for these provider types, there isn't an office visit or a procedure into which supplies and/or equipment can be bundled.

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

By Report

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

C

Complementary and preparatory services

Interventions used to prepare for treatment and/or evaluation. For example, the application of heat or cold is considered a complementary and preparatory service.

Consultant

A consultant is a provider who has not agreed to accept transfer of care, whether as an **AP** or concurrent care provider, before an initial evaluation. The only attending providers who are eligible to be consultants are a(n) MD, DO, DPM, DDS, DMD, OD, ARNP, PhD, PsyD, or DCs enrolled in the Chiropractic Consultant Program. PAs and NDs can't be consultants.

Note: This definition of consultant doesn't include Occupational Nurse Consultants (ONCs), who are employees of L&I.

Consultation

A type of evaluation and management service provided at the request of an attending provider, the department, self-insurer, or authorized department representative to recommend care for a specific condition or problem. See WAC 296-20-045.

L&I doesn't use the CPT® definitions for consultation services with respect to who can request a consultation service, when a consultation can be requested, and requirements for when to bill a consultation vs. established or new patient codes. See the consultations policy in Chapter 3: Attending Providers for more information.

D

Distant site

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

Durable medical equipment (DME)

Equipment that:

- Can withstand repeated use, *and*
- Is primarily and customarily used to serve a medical purpose, *and*
- Generally isn't useful to a person in the absence of illness or injury, *and*
- Is appropriate for use in the worker's place of residence.

Supplies used during or immediately after surgery and not sent home with the worker don't meet the definition of DME and won't be reimbursed as DME.

E

Established patient

A patient who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past 3 years.

When advance registered nurse practitioners (ARNP) are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician. Physician assistants (PA) are considered as working in the same exact same specialty and exact same subspecialties as their supervising or collaborating physician.

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

F

G

H

I

Independent medical examination (IME)

An objective medical legal examination requested by the department or self-insurer to establish medical facts about a worker's physical condition. Only department-approved examiners may conduct these exams.

Link: For more information, see WAC 296-23-302.

Initial visit

The first visit to a healthcare provider during which the Report of Accident (Workplace Injury, Accident or Occupational Disease) is completed and the worker files a claim for workers' compensation. L&I's definition differs from the CPT® definition of an initial visit, and doesn't require billing a new patient code.

J

Job analysis (JA)

A detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Job description

An employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

Job offer

Based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis.

Link: For more information about Job offers, see RCW 51.32.090(4).

K

L

M

Meals

Breakfast, lunch and dinner. Meals may include non-alcoholic beverages only.

Medical records

All documentation to support 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.

N

New patient

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

When advance registered nurse practitioners (ARNP) are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician. Physician assistants (PA) are considered as working in the same exact same specialty and exact same subspecialties as their supervising or collaborating physician.

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

O

Originating site

The place where the worker is located when receiving telehealth. The worker's home is an eligible originating site.

P

Personal care

Activities related to the care of a worker. These may include, but aren't limited to: administration of medication, bathing, personal hygiene and skin care, bowel and bladder incontinence, ostomy care, feeding assistance, mobility assistance, turning and positioning, range of motion exercises, transfers or walking, and supervision due to cognitive impairment, behavior, or blindness.

Pneumatic compression devices

Pneumatic compression devices, specifically vasopneumatic devices, are comprised of inflatable garments for the arms or legs and an electrical pneumatic pump that fills the garments with compressed air. The garments intermittently inflate and deflate with cycle times and pressures that vary. The Food and Drug Administration (FDA) classifies these devices as Cardiovascular Therapeutic Devices, Compressible limb sleeve.

Preferred drug

A drug selected by the appointing authority for inclusion in the Washington preferred drug list and designated for coverage by applicable state agencies or a drug selected for coverage by applicable state agencies.

Preferred drug list (PDL)

The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state-purchased healthcare programs.

Q

R

Remote

Vocational services provided by a qualified vocational rehabilitation counselor via audio only or face-to-face through a real-time, two-way, audio video connection. This definition doesn't include remote monitoring services. For the definition of those services, refer to the CPT® book.

Resource based relative value scale (RBRVS)

RBRVS is a payment method used by many healthcare insurers to develop fee schedules for services and procedures provided by healthcare professionals. Each fee is based on the relative value of resources required to deliver a service or procedure. Services priced using RBRVS have a fee schedule indicator (FSI) of R in L&I's Professional Services Fee Schedule.

S

SIMP (Structured Intensive Multidisciplinary Program)

A chronic pain management program. See Chapter 27: Rehabilitation Facilities and Programs for more details.

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.

Student

This term may apply differently depending on the circumstances. Student means:

- A person who, as part of their clinical training, is enrolled and participating in an accredited educational program, or
- An interim permitted provider who has already completed their training but isn't yet licensed, or
- A worker who is participating in a skill enhancement training program or other vocational service.

See Chapter 2: Information for All Providers, Chapter 20: Physical Medicine, and Chapter 25: Vocational Services for details.

T

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

Codes used when billing to indicate the kind of provider who performed the service. 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

U

V

W

Wait time

The time between the scheduled start time and the actual start time of an appointment. No other covered services are performed during this time.

X

Y

Z

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Appendix B: Modifiers

Payment Policies for Healthcare Services

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Effective July 1, 2025

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General information

Modifiers are used to report a service that has been altered by some specific circumstance, but that circumstance has not changed the service definition or code.

CPT® (HCPCS Level I) code modifiers are developed, updated, and copyrighted by the American Medical Association (AMA). HCPCS Level II modifiers are maintained and updated by Centers for Medicare and Medicaid Services (CMS).

CPT® and HCPCS modifiers aren't used with CDT® (dental) codes.

This appendix is not a comprehensive list of all modifiers. Refer to the CPT® book for a complete list of current modifiers and their definitions.

The modifiers in this appendix are used throughout the payment policy chapters and are shown in **blue text**. This information applies anywhere the modifier appears in MARFS. Modifiers are listed numerically, followed by alphabetically, and are categorized by type. L&I local code modifiers are listed alphanumerically. Description of use and payment information are included with each modifier.

Note: Many factors contribute to the resulting allowed amount for a service. 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 on service and documentation requirements.

CPT® Modifiers

Use	Payment Information
–22 (Increased Procedural Services)	
Use this modifier to indicate the work to provide the service was substantially greater than typically required. Documentation in the chart note must include an explanation of the increased complexity for each service the modifier is appended to and why it was required for proper treatment. **Note**: This modifier can't be used with E/M or other leveled services.	Procedures with this modifier are reviewed and priced on an individual basis (**by report**). If allowed, payment is made at a maximum of **125%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–24 (Unrelated evaluation and management (E/M) service by the same physician during a postoperative period)	
Use this modifier to indicate when an E/M service is performed during a postoperative period that was unrelated to the surgical procedure. **Note**: This modifier can only be used with E/M services.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier can only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.

Use	Payment Information
–47 (Anesthesia by surgeon)	
Use this modifier with surgery CPT® codes to indicate when regional or general anesthesia was administered directly by the surgeon. **Note**: This modifier shouldn't be used with anesthesia CPT® codes or for services with local anesthesia.	The insurer won't pay separately for the anesthesia when this modifier is used. When the same physician performs anesthesia and surgery, the anesthesia is considered inclusive with the surgery.
–50 (Bilateral surgery)	
Use this modifier to indicate when a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each side of the body the procedure was performed. Apply the modifier to the second line.	The total payment is made at **150%** of the global surgery fee schedule amount for the procedure as follows: • **100%** of the global surgery fee for the procedure on the first line. • **50%** of the global surgery fee for the procedure on the second line.
–51 (Multiple surgeries)	
Use this modifier to indicate when multiple procedures were performed at the same operative session by the same individual. Providers must bill using separate line items for each procedure performed. Apply the modifier to all line items but the primary procedure. If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.	The total payment equals the sum of: • **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, *plus* • **50%** of the maximum allowable fee for the subsequent procedure(s) with the next highest values according to the fee schedule.

Use	Payment Information
–52 (Reduced services)	
Use this modifier to indicate when a service is reduced. Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. **Note**: Don't use this modifier for ASC services that require anesthesia. Instead, refer to modifiers **–73** and **–74**.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.
–57 (Decision for surgery)	
Use this modifier to indicate that an Evaluation and Management (E/M) service resulted in the initial decision to perform the surgery. **Note**: This modifier can only be used with E/M services.	This modifier doesn't affect payment but is necessary to describe the service performed.
–58 (Staged or related procedure or service by the same physician during the postoperative period)	
Use this modifier to indicate when a surgical procedure was planned or anticipated (staged), more extensive than the original procedure, or for therapy following a surgical procedure, and is performed during the global period.	This modifier allows payment for the staged or related procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–62 (Two surgeons)	
Use this modifier to indicate when 2 primary surgeons (usually with different specialties) performed distinct part(s) of the same procedure. Both surgeons must submit separate operative reports describing their specific roles.	Payment is made for each surgeon at **62.5%** of the global surgical fee or billed charge, whichever is less. No payment is made for an assistant in these cases.

Use	Payment Information
–66 (Team surgery)	
Use this modifier to indicate when a highly complex procedure is carried out by a surgical team. This requires the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Each surgeon must submit separate operative reports describing their specific roles.	Procedures with this modifier are reviewed and priced on an individual basis (**by report**).
–76 (Repeat procedure or service by same provider)	
Use this modifier to indicate when a procedure or service was repeated by the same provider subsequent to the original procedure or service. Documentation must include an explanation of why the procedure or service required repeating for proper treatment. **Note:** This modifier can't be appended to an E/M service.	This modifier allows payment for the repeat procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–77 (Repeat procedure or service by another provider)	
Use this modifier to indicate when a procedure or service was repeated by another provider subsequent to the original procedure or service. **Note:** This modifier can't be appended to an E/M service.	This modifier allows payment for the repeat procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–78 (Return to the operating room for a related procedure during the postoperative period)	
Use this modifier to indicate when another procedure was performed during the postoperative period of and is related to the initial procedure. The return to the operating room is for an unplanned procedure.	This modifier allows payment for the related procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–79 (Unrelated procedure or service by the same physician during the postoperative period)	
Use this modifier to indicate when another procedure was performed during the postoperative period of another procedure but isn't associated with the original surgery.	This modifier allows payment for the unrelated procedure. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–91 (Repeat clinical diagnostic laboratory test)	
Use this modifier to indicate when repeat tests are performed on the same day, by the same provider. Specifically to obtain reportable test values with separate specimens, taken at different times, when it was necessary to obtain multiple results during the course of treatment.	This modifier allows payment for the repeat procedure. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.
–99 (Multiple modifiers)	
Use this modifier to indicate when more than 2 modifiers affect payment. For billing purposes only, include only this modifier with the service(s) performed on the billing form, along with any modifiers not affecting payment. In the remarks section of the billing form, include the individual descriptive modifiers that affect payment.	This modifier doesn't affect payment but is necessary to accommodate all modifiers billed. Payment is based on the policy associated with each individual modifier that describes the actual services performed.

Surgical package modifiers

When providing less than the global surgical package, providers should use modifiers **–54**, **–55**, or **–56**. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period.

These modifiers allow direct payment to the provider for each portion of the global surgery service.

Use	Payment Information
–54 (Surgical care only)	
Use this modifier to indicate when the physician performs a surgical procedure but another physician provides preoperative and/or postoperative management.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–54** column of the Professional Services Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–55 (Postoperative care only)	
Use this modifier to indicate when the physician performs the postoperative management but another physician has performed the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–55** column of the Professional Services Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–56 (Preoperative care only)	
Use this modifier to indicate when the physician performs the preoperative care and evaluation but another physician performs the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–56** column of the Professional Services Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.

Assistant surgeon modifiers

Physicians who assist the primary physician in surgery should use modifiers **–80**, **–81**, or **–82**, depending on the medical necessity. The insurer doesn't recognize modifier **–AS**.

Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable. If the fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in the surgeon's report to receive payment.

Use	Payment Information
–80 (Assistant surgeon)	
Use this modifier to indicate when the physician assisted on a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–81 (Minimum assistant surgeon)	
Use this modifier to indicate when the physician only assisted on part of a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–82 (Assistant surgeon (when qualified resident surgeon not available))	
Use this modifier to indicate when the physician assisted on a surgery when a qualified resident surgeon was not available to assist the primary surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.

Ambulatory Surgery Center (ASC) hospital outpatient only modifiers

The following modifiers are only for use in an ASC and hospital outpatient setting. Refer to the CPT® book for a complete list of modifiers for use by ASC and other hospital outpatient facilities.

Use	Payment Information
–73 (Discontinued procedures prior to the administration of anesthesia)	
Use this modifier to indicate when a physician cancels a surgical procedure due to the onset of medical complications or extenuating circumstances subsequent to the worker's preparation (including sedation), but prior to the administration of anesthesia (local, regional block(s) or general). **Note:** For use in ASC and outpatient hospital only; not physician reporting.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.
–74 (Discontinued procedures after administration of anesthesia)	
Use this modifier to indicate when a physician terminates a surgical procedure due to the onset of medical complications or extenuating circumstances after the administration of anesthesia (local, regional block(s) or general) or after the procedure was started. **Note:** For use in ASC and outpatient hospital only; not physician reporting.	Payment is made at **60%** of the fee schedule level or billed charge, whichever is less.

HCPCS modifiers

Use	Payment Information
–FT (Unrelated critical care evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.)	
Use this modifier to indicate when a critical care E/M visit is furnished within the postoperative period but is unrelated to the surgery.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–FR (Direct supervision via telehealth)	
Use this modifier to indicate when direct supervision of a student is provided via telehealth. **Note:** Direct supervision for physical therapy (PT) or occupational therapy (OT) students must be performed in person. Modifier **–FR** is not allowed.	This service is only payable when the service provided to the worker is allowed via **telehealth**. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–GT (Service performed via telehealth)	
Use this modifier to indicate when a service was performed via telehealth. This modifier can't be used if the CPT® code includes audio-visual (telehealth) as part of the service description. **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.
–GM (Multiple workers, one ambulance trip)	
Use this modifier to indicate when multiple workers are being transported in the same ambulance trip.	This modifier doesn't affect payment but is necessary to describe the service.

Use	Payment Information
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–NU (New purchased DME)	
Use this modifier to indicate when the DME dispensed is being purchased and doesn't need to be returned to the supplier. **Note**: DME codes that are applicable to purchasing are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–NU** rate for each specific DME provided or billed charge, whichever is less.
–RR (Rented DME)	
Use this modifier to indicate when the DME dispensed will be rented and returned to the supplier. **Note**: DME codes that are applicable to rental are listed in the L&I Professional Services Fee Schedules	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–RR** rate for each specific DME provided or billed charge, whichever is less.
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–SU (Procedure performed in physician's office)	
This modifier isn't recognized by the insurer.	Facility fees are not payable for procedures performed in a physician's office. Services with this modifier will be **denied**.

Use	Payment Information
–TC (Technical component)	
Use this modifier to indicate when only the technical component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's technical component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the technical component (**–TC**) rate for each specific radiology service performed or billed charge, whichever is less.
–UN (2 workers served – portable radiology)	
Use this modifier to indicate when 2 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UP (3 workers served – portable radiology)	
Use this modifier to indicate when 3 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UQ (4 workers served – portable radiology)	
Use this modifier to indicate when 4 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UR (5 workers served – portable radiology)	
Use this modifier to indicate when 5 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–US (6 or more workers served – portable radiology)	
Use this modifier to indicate when 6 or more workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.

Anesthesia modifiers

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs should use the following modifiers.

Note: Except for modifier **–99**, the following modifiers aren't valid for anesthesia services paid based on maximum provider fee schedule.

Use	Payment Information
–AA (Anesthesia services performed personally by anesthesiologist)	
Use this modifier to indicate when anesthesia services were performed personally by the anesthesiologist.	This modifier doesn't affect payment but is necessary to describe the service.
–QK (Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals)	
Use this modifier to indicate when a physician has provided medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals. **Note:** This modifier is for physician use only.	See Team care payment policy for payment information.
–QX (CRNA service: with medical direction by a physician)	
Use this modifier to indicate when a Certified Registered Nurse Anesthetist (CRNA) provides anesthesia services with medical direction by a physician.	See Team care payment policy for payment information.
–QY (Medical direction of 1 certified registered nurse anesthetist (CRNA) by an anesthesiologist)	
Use this modifier to indicate when a physician has provided medical direction of 1 Certified Registered Nurse Anesthetist (CRNA) for a single anesthesia procedure. **Note:** This modifier is for physician use only.	See Team care payment policy for payment information.

Use	Payment Information
–QZ (CRNA service: without medical direction by a physician)	
Use this modifier to indicate when a Certified Registered Nurse Anesthetist (CRNA) has provided anesthesia services without medical direction by a physician.	Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.

L&I 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.

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Washington State Department of
Labor & Industries

Appendix C: Place of Service (POS) Codes

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout the payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout the payment policies, see Appendix B: Modifiers.

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).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

Table of Contents Page

General information

Place of service (POS) codes are two-digit codes that describe the location where the service(s) were rendered.

These codes must be included on professional bills. Bills without a POS code will be processed at the **RBRVS** rate for facility settings, which could result in lower payment.

This appendix is not a comprehensive list of all POS codes. For the most updated list of POS codes and their full descriptions, see CMS Place of Service Code Set.

POS codes in this appendix are listed numerically by code number. Description and payment rate are included with each code.

Place of Service codes

Professional services billed with the following place of service (POS) codes will be paid at either the facility or non-facility rate based on the table below.

Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
01 - Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed or otherwise provided directly to patients	Non-facility
02 - Telehealth provided other than in patient's home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.	Facility
03 - School	A facility whose primary purpose is education.	Non-facility
04 - Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters.)	Non-facility
05 - Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.	Facility
06 - Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.	Facility

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Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
07 - Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services to tribal members who do not require hospitalization.	Facility
08 - Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical) and rehabilitation services to tribal members admitted as inpatients or outpatients.	Facility
09 - Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center or any other similar facility maintained by either federal, state or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.	Non-facility
10 - Telehealth provided in patient's home	The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.	Non-facility
11 - Office	Location, other than a hospital, Skilled Nursing Facility (SNon-facility), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	Non-facility

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Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
12 - Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.	Non-facility
13 - Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.	Non-facility
14 - Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	Non-facility
15 - Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic and/or treatment services. The appropriate POS code for services provided in a mobile unit varies. For details, see Chapter 23: Telehealth, Remote, and Mobile Services.	Non-facility
16 - Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.	Non-facility
17 - Walk-in Retail Health Clinic	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	Non-facility

Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
19 - Outpatient Hospital - Off Campus	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	Facility
20 - Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	Non-facility
21 - Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under the supervision of, physicians to patients admitted for a variety of medical conditions.	Facility
22 - Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	Facility
23 - Emergency Room-Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	Facility
24 - Ambulatory Surgery Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	Facility
25 - Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care as well as immediate care of newborn infants.	Facility

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Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
26 - Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	Facility
31 - Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital.	Facility
32 - Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.	Non-facility
33 - Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	Non-facility
34 - Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	Facility
41 - Ambulance-Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	Facility
42 - Ambulance-Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	Facility

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Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
49 - Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative or palliative services to outpatients only.	Non-facility
50 - Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	Non-facility
51 - Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	Facility
52 - Psychiatric Facility- Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	Facility
53 - Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.	Non-facility

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Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
54 - Intermediate Care Facility/Individuals with intellectual disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.	Non-facility
55 - Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	Non-facility
56 - Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	Facility
57 - Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	Non-facility
60 - Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	Non-facility

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Bill using this 2-digit place of service code...	If the place of service description is…	And the payment rate will be...
61 - Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	Facility
62 - Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	Facility
65 - End Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	Non-facility
71 - State or Local Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.	Non-facility
72 - Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	Non-facility
81 - Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	Non-facility
99 - Other Place of Service	Other place of service not identified above.	Facility

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