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:

- **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).

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.

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.

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,

- 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.

