Washington State Department of
Labor & Industries

Chapter 2: Information for All 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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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.

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.

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

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:

- 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?

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.

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.

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.

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.

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.