Washington State Department of
Labor & Industries

Chapter 3: Attending Providers

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

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

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

Links to appendices

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

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

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

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

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

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Payment policy: All Attending Provider (AP) types

General information

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

Provider type vs primary provider on a claim

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

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

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

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

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

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

Provider eligibility

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

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

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

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

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

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

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

AP on the claim restrictions

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

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

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

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

AP responsibilities

Attending providers are a key resource for workers.

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

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

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

Services that can be billed

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

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

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

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

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

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

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

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

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

Fees appear in the Professional Services Fee Schedule.

Services that aren't covered

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

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

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

Supplemental payment policy: Advanced Registered Nurse Practitioners (ARNP)

General information

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

Additional credentialing requirements

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

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

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

Services that can be billed

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

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

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

Supplemental payment policy: Chiropractors (DC)

General information

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

Services that can be billed

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

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

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

Supplemental payment policy: Dentists (DDS/DMD)

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

Services that can be billed

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

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

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

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

Supplemental payment policy: Naturopaths (ND)

General information

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

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

Services that can be billed

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

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

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

Services that aren't covered

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

Supplemental payment policy: Optometrists (OD)

General information

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

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

Services that can be billed

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

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

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

Supplemental payment policy: Osteopaths (DO)

General information

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

Additional credentialing requirements

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

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

Services that can be billed

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

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

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

Supplemental payment policy: Physician (MD)

General information

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

Additional credentialing requirements

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

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

Services that can be billed

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

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

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

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

General information

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

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

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

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

Requirements for billing

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

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

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

Services that aren't covered

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

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

Supplemental payment policy: Podiatrist (DPM)

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

Services that can be billed

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

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

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

Supplemental payment policy: Psychologists (PhD/PsyD)

General information

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

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

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

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

Services that can be billed

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

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

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

Payment policy: Consultations

General Information

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

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

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

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

Who must perform these services to qualify for payment

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

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

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

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

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

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

Prior authorization

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

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

Services that can be billed

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

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

Requirements for billing

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

Teleconsultations

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

How to bill for consultations

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

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

If the provider is a(n):

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

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

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

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

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

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

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

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

Documentation Requirements

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

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

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

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

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

Services that aren't covered

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

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

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

Payment limits

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

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

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

Split billing

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

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

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

Services that can be billed

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

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

Services that aren't covered

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

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

Documentation requirements

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

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

Payment limits

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

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

Split billing

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

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

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

Payment policy: Radiology consultation services

General Information

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

Who must perform these services to qualify for payment

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

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

Services that aren't covered

CPT® code **76140** isn't covered.

Requirements for billing

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

Documentation requirements

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

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

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

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

Payment limits

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

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules and resources provider accounts and credentialing	WAC 296-20-01010 through WAC 20-01090 available in WAC 296-20 WAC 296-20-12401 Chapter 2: Information for All Providers Become a Provider
Administrative rules for Advanced Registered Nurse Practitioners (ARNP)	WAC 296-23-245 WAC 296-23-240 WAC 296-23-245
Administrative rules for claim reopenings	WAC 296-20-097
Administrative rules for dentists	WAC 296-23-160 WAC 296-20-110
Administrative rules for eye glasses and refraction coverage	WAC 296-20-100
Administrative rules for initial visit and transfer of attending providers	WAC 296-20-01002 WAC 296-20-015 WAC 296-20-025 WAC 296-20-12401 WAC 296-20-065
Administrative rules for medical aid definitions	WAC 296-20-01002
Administrative rules for non-covered services	WAC 296-20-03002 WAC 296-20-03012
Administrative rules for Physician Assistants (PAs)	WAC 296-20-01501 WAC 296-20-12501

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

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

Need more help?

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