Washington State Department of
Labor & Industries

Chapter 5: Care Coordination

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

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

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

Links to appendices

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

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

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

Updates and corrections

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

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

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Payment policy: Case management telephone calls

General information

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

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

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

Who must perform these services to qualify for payment

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

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

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

Who is a covered participant

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

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

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

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

Services that can be billed

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

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

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

Services that aren't covered

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

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

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

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

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

Audio-Only Services

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

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

Requirements for billing

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

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

Documentation requirements

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

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

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

Payment limits

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

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

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

Worker discussion limits

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

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

Split billing

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

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

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

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

General information

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

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

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

Who must perform these services to qualify for payment

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

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

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

Services that can be billed

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

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

The following activities are billable per 6-minute unit:

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

HSC and SHSC fee schedule

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

Code	Description	Program	Fee
1088M	**Surgical Quality Care Program health services coordination** Can be billed as a stand-alone service. Can be billed with the modifier -8S. 1 unit = 6 minutes. Max 16 hours per claim per incentive program.	Surgical Quality Care Program (SQCP)	**$10.12**

Billing units

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

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

Services that aren't covered

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

In addition, the following activities aren't payable:

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

Requirements for billing

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

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

When completing a second billable case note on the same day for the same worker, bill using the modifier **-8S**. Modifier **-8S** is paid at 50%.

Documentation requirements

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

Approved application and attestations are required by each incentive program.

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

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

Payment limits

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

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

Payment policy: Nurse case management

General information

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

What's new in the 2025 version

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

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

Eligibility for nurse case management referrals

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

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

Prior authorization

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

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

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

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

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

Pausing and resuming referrals

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

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

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

Who must perform these services to qualify for payment

Required qualifications

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

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

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

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

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

NPIs for NCMs

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

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

Services that can be billed

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

Referral structure

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

Nurse case management services

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

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

Mileage and travel expenses

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

Requirements for billing

Reporting periods

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

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

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

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

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

Billing examples

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

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

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

Billing units

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

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

Documentation requirements

Reporting deadlines

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

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

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

Goals for referrals

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

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

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

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

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

Required report elements

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

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

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

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

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

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

Split billing

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

Payment limits

Initial Reports are billable once per referral.

Progress Reports are billable once every 30 days.

Closing Reports are billable once per referral.

Services that aren't covered

Non-billable services and expenses include:

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

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

Payment policy: Nurse case management annual assessments

General information

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

Who must perform these services to qualify for payment

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

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

Prior authorization

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

Services that can be billed

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

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

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

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

Annual assessments and nurse case management referrals

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

Mileage and travel expenses

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

Multiple annual assessments in a one-year period

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

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

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

Payment policy: Online communications

General information

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

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

Who must perform these services to qualify for payment

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

Who is a covered participant

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

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

Requirements for billing

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

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

Services that can be billed

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

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

Services that aren’t covered

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

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

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

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

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

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

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

Requirements for billing

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

Documentation requirements

Online communication documentation must include:

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

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

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

Payment limits

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

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

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

Split billing

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

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

Payment policy: Team conferences

Who must perform team conferences to qualify for payment

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

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

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

Requirements for billing

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

The following criteria must be met for team conferences:

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

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

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

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

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

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

Services that aren't covered

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

Documentation requirements

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

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

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

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

- Objective measures of function.

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

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

Payment limits

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

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

Split billing

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

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

Links to related topics

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

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

Need more help?

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