

Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS) and Provider Bulletins.

If there are any services, procedures or text contained in the CPT[®] and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence (See WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. Hospital payment policies established by L&I are reflected in Chapters [296-20](#), [296-21](#), [296-23](#) and [296-23A](#) WAC and in the Hospital Billing Instructions. No copayments or deductibles are required or allowed from workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to workers must be submitted on the UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications. Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for patients admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via a POAC rate.

For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance. For a current copy of the Hospital Billing Instructions, contact the L&I Provider Hotline at 1-800-848-0811.

HOSPITAL ACQUISITION COST

Any item covered under the acquisition cost policy will be paid using a hospital specific percent of allowed charges (POAC). Non-hospital facilities will be paid a statewide average POAC.

HOSPITAL INPATIENT ACUTE CARE PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital specific POAC factors for all hospitals (see [WAC 296-23A-0210](#)).

Crime Victims Compensation Program Payment Method

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using DSHS POAC factors (see [WAC 296-30-090](#)).

State Fund Payment Methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. An All Patient Diagnosis Related Group (AP DRG) system. See [WAC 296-23A-0470](#) for exclusions and exceptions. L&I currently uses AP DRG Grouper version 23.0.
2. A statewide per diem rate for those AP DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A POAC rate for hospitals excluded from the AP DRG system.

The following tables provide a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Acute Care Services
Hospitals not in Washington	Paid by an out-of-state POAC factor. Effective July 1, 2011 the rate is 57.8% .
Washington excluded Hospitals: <ul style="list-style-type: none"> • Children’s Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities 	Paid 100% of allowed charges.
<ul style="list-style-type: none"> • Washington Major Teaching Hospitals; • Harborview Medical Center • University of Washington Medical Center 	Paid on a per case basis for admissions falling within designated AP DRGs. ⁽¹⁾ For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: <ul style="list-style-type: none"> • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP DRGs. ⁽¹⁾ For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: <ul style="list-style-type: none"> • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See <http://feeschedules.Lni.wa.gov> for the current AP DRG Assignment List.

Hospital Inpatient Acute Care AP DRG Base Rates

Effective **July 1, 2011** the AP DRG Base Rates

Hospital	Base Rate
Harborview Medical Center	\$11,055.17
University of Washington Medical Center	\$9,725.63
All Other Washington Hospitals	\$9,244.08

Hospital Inpatient Acute Care AP DRG Per Diem Rates

Effective **July 1, 2011** the AP DRG per diem Rates are as follows:

Payment Category	Rate ⁽¹⁾	Definition
Psychiatric AP DRG Per Diem	\$888.39 Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs 424-432
Chemical Dependency AP DRG Per Diem	\$733.32 Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs 743-751
Rehabilitation AP DRG Per Diem	\$1,532.58 Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRG 462
Medical AP DRG Per Diem	\$2,108.32 Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs identified as medical
Surgical AP DRG Per Diem	\$4,131.83 Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter [296-23A](#) WAC. The AP DRG Assignment List with AP DRG codes and descriptions and length of stay is in the fee schedules section and is available online at <http://feeschedules.Lni.wa.gov>.

Additional Inpatient Acute Care Hospital Rates

Payment Category	Rate	Definition
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP DRGs average length of stay. If the worker's stay is less than the average length of stay, a per-day rate is established by dividing the AP DRG payment amount by the average length of stay for the AP DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the worker's stay is equal to or greater than the average length of stay, the AP DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost ⁽¹⁾ of the stay is less than 10% of the statewide AP DRG rate or \$581.63 , whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost ⁽¹⁾ of the stay exceeds \$17,446.32 or 2 standard deviations above the statewide AP DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital outpatient care provided to workers covered by self-insurers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see [WAC 296-23A-0221](#)).

Crime Victims Compensation Program Payment Method

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either DSHS POAC factors or the Professional Services Fee Schedule (see [WAC 296-30-090](#)).

State Fund Payment Methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system. See Chapter [296-23A WAC](#) (Section 4), WACs [296-23A-0220](#), [296-23A-0700](#) through [296-23A-0780](#) for a description of L&I's OPPS system.
2. An amount established through L&I's Professional Services Fee Schedule for items not covered by the APC system
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an out-of-state POAC factor. Effective July 1, 2011 the rate is 57.8%
Washington Excluded Hospitals: <ul style="list-style-type: none"> • Children’s Hospitals • Military Hospitals ⁽¹⁾ • Veterans Administration • State Psychiatric Facilities 	Paid 100% of allowed charges
<ul style="list-style-type: none"> • Rehabilitation Hospitals • Cancer Hospitals • Critical Access Hospitals • Private Psychiatric Facilities 	Paid a facility-specific POAC or Fee Schedule amount depending on procedure
All other Washington Hospitals	Paid on a per APC ⁽²⁾ basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC ⁽¹⁾ .

(1) Military hospitals may bill HCPCS code T1015 for all outpatient clinic services.

(2) Hospitals will be sent their individual POAC and APC rates each year.

Pass-Through Devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device has not already been incorporated into an APC. Hospitals will be paid fee schedule or if no fee schedule exists, a hospital-specific POAC for new or current pass-through devices. New or current drug or biological pass-through items will be paid by fee schedule or POAC (if no fee schedule exists).

Hospital OPPS Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Don't Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Don't Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC ⁽¹⁾
4. Is the service packaged?	No	Go to question 5
	Yes	Don't Pay, but total the Costs for possible outlier ⁽²⁾ consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier ⁽²⁾ consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier? ⁽¹⁾	No	No outlier payment
	Yes	Pay outlier amount ⁽³⁾

(1) If only 1 line item on the bill is inpatient (IP), the entire bill will be paid POAC.

(2) Only services packaged or paid by APC are used to determine outlier payments.

(3) Outlier amount is in addition to regular APC payments.

OPPS Relative Weights and Payment Rates

The relative weights used by CMS will be used for the OPPS program. Each hospital's blended per-APC rate was determined using a combination of the average hospital-specific per APC rate and the statewide average per APC rate. Additional information on the formulas used to establish individual hospital rates can be found in WAC [296-23A-0720](#). Hospitals will receive notification of their blended per-APC rate via separate letter from L&I or by accessing <http://feeschedules.Lni.wa.gov> and going to the hospital rates link.

OPPS Outlier Payments

L&I follows the current CMS outlier payment policy. See the most current federal register for a complete description of the policy.

AMBULATORY SURGERY CENTER PAYMENT POLICIES

GENERAL INFORMATION

Information about L&I's ambulatory surgery center (ASC) requirements can be found in Chapter [296-23B](#) WAC.

WHO MAY BILL FOR ASC SERVICES

An ASC is an outpatient facility where surgical services are provided and that meets the following 3 requirements:

1. Must be licensed by the state(s) in which it operates, unless that state doesn't require licensure;
2. Must have at least 1 of the following credentials:
 - a. Medicare Certification as an ambulatory surgery center or
 - b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS) and
3. Must have an active ASC provider account with L&I.

BECOMING ACCREDITED OR MEDICARE CERTIFIED AS AN ASC

Providers may contact the following organizations for information:

National Accreditation

American Association for Accreditation of Ambulatory Surgery Facilities

5101 Washington Street, Suite #2F

PO BOX 9500 Gurnee, IL 60031

888-545-5222; www.aaaasf.org/

Accreditation Association for Ambulatory Health Care

3201 Old Glenview Rd., Suite 300

Wilmette, IL 60091

847-853-6060; www.aaahc.org/

American Osteopathic Association

142 East Ontario Street

Chicago, IL 60611

800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities

4891 East Grant Road

Tucson, AZ 85712

888-281-6531; <http://www.carf.org/>

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

630-792-5862; www.jcaho.org/

Medicare Certification

Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47852
Olympia, WA 98504-7852
360-236-2905; e-mail: fslhhacs@doh.wa.gov
Web: www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note it may take 3-6 months to get certification or accreditation.

ASC PAYMENTS FOR SERVICES

The insurer pays the lesser of the billed charge (the usual and customary fee) or L&I's maximum allowed rate.

L&I's rates are based on a modified version of the current system developed by Medicare for ASC services.

ASC Procedures Covered for Payment

L&I uses the CMS list of procedures covered in an ASC plus additional procedures determined to be appropriate. All procedures covered in an ASC are listed online at:

<http://feeschedules.Lni.wa.gov>

L&I expanded the list that CMS established for allowed procedures in an ASC. L&I added some procedures CMS identified as excluded procedures.

ASC Procedures Not Covered for Payment

Procedures not listed in the ASC fee schedule section of MARFS aren't covered in an ASC.

ASCs won't receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Noncovered Procedure

Under certain conditions, the director, the director's designee or self-insurer, at their sole discretion, may determine that a procedure not on L&I's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. The written request must contain:

- A description of the proposed procedure with associated CPT[®] or HCPCS procedure codes,
- The reason for the request,
- The potential risks and expected benefits and
- The estimated cost of the procedure.

The healthcare provider must provide any additional information about the procedure requested by the insurer.

ASC BILLING INFORMATION

Modifiers Affecting Payment for ASCs

-50 Bilateral Procedures

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

-51 Multiple Procedures

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus

50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

-52 Reduced Services

Modifier -52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier -52, signifying that the service is reduced.

Beginning July 1, 2008 a **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that don't require anesthesia (ASCs should use modifier -52 to report such an occurrence).

-73 Discontinued procedures prior to the administration of anesthesia

Modifier -73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedures after administration of anesthesia

Modifier -74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers

Modifier -99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, modifier -99 must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

BRAIN INJURY REHABILITATION SERVICES

Billing for Separate Services and Therapies

The brain injury rehabilitation services policy is being revised. Until the new policy is written, and upon approval by an ONC or SIE/TPA, individual services and therapies can be done separately through outpatient services when the provider submits a coordinated plan of care. Services can include but aren't limited to:

- Psychotherapy services
- Speech therapy
- Medical services
- Neural therapy
- Occupational therapy

Providers wishing to bill and be paid using the current L&I brain injury local codes must follow the policy and meet the qualifications and conditions listed below:

Qualified Providers

Only providers approved by the insurer can provide post-acute brain injury rehabilitation services for workers. When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to

Department of Labor & Industries
Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Special L&I Provider Account Number Required

Providers participating in the Brain Injury Program must have a special provider account number if they have CARF accreditation to treat and bill for a complete course of evaluation and treatment. Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at 1-800-848-0811.

NOTE: Billing for State Fund claims: Providers participating in the Brain Injury Program must bill for brain injury rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. Providers billing for individual services and therapies don't need to obtain a special provider account number.

QUALIFYING PROGRAMS

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation
- Treatment
- Follow-up

AUTHORIZATION REQUIREMENTS

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment. For State Fund claims, cases requiring post-acute brain injury rehabilitation will be reviewed by the ONCs and by L&I claim managers prior to making a determination or authorization. The Provider Hotline can't authorize brain injury treatment.

An ONC and an L&I claim manager will separately review a brain injury claim to determine whether prior authorization will be granted. The Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

For self-insured claims, contact the SIE/TPA for authorization.
<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

Approval Criteria

Before a worker can receive treatment all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim; and
- The brain injury is related to the industrial injury or is retarding recovery; and
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program; and
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury; and
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Comprehensive Brain Injury Evaluation Requirements

A Comprehensive Brain Injury Evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in-depth analysis of the workers mental, emotional, social and physical status and functioning.

The evaluation must be provided by a multidisciplinary team that includes a

- Medical physician,
- Psychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist,
- Speech therapist and
- Neuropsychologist.

Additional medical consultations are referred through the program's physician. For State Fund claims, each consultation may be billed under the provider account number of the consulting physician. Services must be **preauthorized** by an L&I claim manager or the self-insured employer.

BILLING INFORMATION

Tests Included in the Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation and **may not be billed separately**. They may be performed in any combination depending on the workers condition

- Neuropsychological Diagnostic Interview(s), testing and scoring
- Initial consultation and exam with the program's physician
- Occupational and Physical Therapy evaluations
- Vocational Rehabilitation evaluation
- Speech and language evaluation
- Comprehensive report

Preparatory Work Included in the Comprehensive Brain Injury Program Evaluation

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is considered part of the provider's administrative overhead. It includes but isn't limited to:

- Obtaining and reviewing the workers historical medical records
- Interviewing family members, if applicable
- Phone contact and letters to other providers or community support services
- Writing the final report
- Office supplies and materials required for service(s) delivery

Therapies Included in the Treatment

The following therapies, treatments and/or services are included in the Brain Injury Program maximum fee schedule amount for the full-day or half-day brain injury rehabilitation treatment and **may not be billed separately**:

- Physical therapy and occupational therapy
- Speech and language therapy
- Psychotherapy
- Behavioral modification and counseling
- Nursing and health education and pharmacology management
- Group therapy counseling
- Activities of daily living management
- Recreational therapy (including group outings)
- Vocational counseling
- Follow-up interviews with the worker or family, which may include home visits and phone contacts

Preparatory Work Included in Treatment

Ancillary work, materials and preparation that may be necessary to carry out Brain Injury Program functions and services that are considered part of the provider's administrative overhead and aren't **payable separately** include, but aren't limited to:

- Daily charting of patient progress and attendance
- Report preparation
- Case management services
- Coordination of care
- Team conferences and interdisciplinary staffing
- Educational materials (for example, workbooks and tapes)

Follow Up Included in Treatment

Follow up care is included in the cost of the full day or half day program. This includes, but isn't limited to:

- Telephone calls
- Home visits
- Therapy assessments

THErapy ASSESSMENTS DOCUMENTATION REQUIREMENTS

The following documentation is required of providers when billing for post-acute brain injury rehabilitation treatment programs:

- Providers are required to keep a daily record of a workers attendance, activities, treatments and progress
- All test results and scoring must also be kept in the workers medical record. Records should also include:
 - Documentation of interviews with family and
 - Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program
- Progress reports should be sent to the insurer regularly, including all preadmission and discharge reports

FEES

Non-Hospital Based Programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs are effective **July 1, 2011**.

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	\$4,297.53
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	\$974.87
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	\$678.97

Hospital Based Programs

The following revenue codes and payment amounts for hospital based outpatient post-acute brain injury rehabilitation treatment programs are effective **July 1, 2011**.

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	\$4,297.53
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	\$974.87
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	\$678.97

NURSING HOME, RESIDENTIAL, HOSPICE AND SUB ACUTE CARE SERVICES

COVERED SERVICES

The insurer covers proper and necessary residential care services that require 24-hour institutional care to meet the worker's needs, abilities and safety. The insurer will also cover medically necessary hospice care comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Prior authorization is required by an L&I ONC or the self-insured employer.

Services must be:

- Proper and necessary and
- Required due to an industrial injury or occupational disease and
- Requested by the attending physician and
- Authorized by an L&I ONC or self-insured employer before care begins.

Facilities

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for 24-hour institutional care including:

- Skilled Nursing Facilities (SNF)
- Nursing Homes (NH)
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital
- Critical Access Hospitals (CAHs) licensed by DOH using swing beds to provide sub acute care
- Adult Family Homes/Boarding Homes including
 - Assisted Living Facilities
 - Adult Residential Care
 - Enhanced Adult Residential Care
- Hospice care providers

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

NONCOVERED SERVICES

Services in adult day care centers **aren't covered** by L&I or by self insurers.

AUTHORIZATION REQUIREMENTS

Initial Admission

Residential care services require **prior authorization**. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator.

For authorization procedures on a self-insured claim, contact the self-insurer directly.

Nursing Facilities. Nursing facilities and transitional care units must complete a Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker within 10 working days of admission. Forms are available from CMS.

MDS 2.0:

http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage

MDS 3.0:

http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews. Failure to assess the worker or report the appropriate payment group to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

L&I has forms available that can be substituted for MDS forms. Forms F245-052-000, for use with MDS 2.0, and F245-392-000, for use with MDS 3.0, are available at

<http://www.lni.wa.gov/FormPub/results.asp?Keyword=Provider%20Billing>

Adult Family Homes, Boarding Homes and Assisted Living Facilities.

At the insurers' request, a Long Term Care Assessment Tool must be completed by an independent Registered Nurse (RN) within 10 days of admission. The tool will determine the appropriate L&I payment grouping. Failure to complete the assessment tool may result in delayed or reduced payment. An assessment must be completed at least once per year after the initial assessment.

The tool is available at

<http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2345>

Critical Access Hospitals Using Swing Beds for Sub Acute Care

As of July 1, 2011, critical access hospitals will be paid for swing bed services utilizing a hospital specific POAC rate.

You may contact an occupational nurse consultant (ONC) for approval. To obtain information for contacting an ONC, call the provider hotline at 800-831-5227.

Upon approval from a Labor & Industries ONC, critical access hospitals should bill their customary charge for sub acute care (swing bed use) on the UB-04 billing form. Identify these services in the Type of Bill Field (Form Locator 04) with 018x series (hospital swing beds).

When Care Needs Change

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for re-authorization of the workers care.

Find contact information for self-insured claims at:

<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

BILLING INFORMATION

Billing Requirements

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this section.

The primary billing procedures applicable to residential facility providers can be found in WAC [296-20-125](#), Billing procedures.

All Residential Care Services should be billed on form F245-072-000 Statement for Miscellaneous Services found at <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627>

Pharmaceuticals and Durable Medical Equipment

Residential facilities **can't bill** for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed by a pharmacy or DME supplier.



Inappropriate use of CPT[®] and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

REVIEW OF RESIDENTIAL SERVICES

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to, on-site review of the worker and review of medical records.

All services rendered to workers are subject to audit by L&I. See RCW [51.36.100](#) and RCW [51.36.110](#).

FEES

Negotiated payment arrangements; Insurers with existing negotiated arrangements:

Code	Description	Maximum Fee
8902H	Negotiated payment arrangements	By report

NOTE: Insurers with existing negotiated arrangements made prior to January 1, 2005 may continue their current arrangements and continue to use code 8902H until the worker's need for services no longer exists or the worker is transferred to a new facility.

Hospice Care

Hospice claims are paid on a by report basis. Occupational, physical and speech therapies are included in the daily rate and aren't separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following HCPCS codes:

Code	Abbreviated Description	Maximum Fee
Q5003	Hospice Care Prov in Nrsng Lng-Trm Care Facility	By report
Q5004	Hospice Care Prov in Skill Nursing Facility	By report
Q5005	Hospice Care Prov in Inpatient Hospital	By report
Q5006	Hospice Care Prov in Inpatient Hospice Facility	By report
Q5007	Hospice Care Prov in Lng Trm Care Facility	By report
Q5008	Hospice Care Prov in Inpatient Psychiatric Facility	By report
Q5009	Hospice Care Prov in Place NOS	By report

Boarding Homes, Assisted Living Facilities and Adult Family Homes

For dates of service **July 1, 2011** or after:

The numeric score determined by the Long Term Care Assessment Tool will determine which billing code to use. The payment rates below are daily payment rates.

Billing Code	Description	Assessment Score	Maximum Fee
8893H	L&I RF Low	6 - 20	\$161.60
8894H	L&I RF Medium	21 - 36	\$196.23
8895H	L&I RF High	37 - 57	\$230.86

These three levels of care will be applied to all non nursing home facility types. Don't bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

The tool is available at

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345>

Nursing Home, Transitional Care Unit and Swing Bed Fees

L&I uses a modified version of the skilled nursing facility prospective payment system for developing the residential facility payment system.

The fee schedule for Nursing Home beds, Transitional Care Unit beds and swing beds is a series of daily facility payment rates including room rates, therapies and nursing components depending on the needs of the worker. Medications aren't included in the L&I rate.

Fee Schedule – NH, TCU and Swing Beds Effective **July 1, 2011**

Billing Code	Description	Included Medicare RUG Groups	Maximum Fee
		REHAB GROUPS	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	\$646.57
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	\$484.37
8882H	Rehab-High	RHX, RHL, RHC, RHB, RHA	\$451.47
8883H	Rehab-Medium	RMX, RML, RMC, RMB, RMA	\$417.36
8884H	Rehab-Low	RLX, RLB, RLA	\$325.47
		NURSING SERVICES GROUPS	
8885H	Extensive Services	ES3, ES2, ES1	\$403.96
8886H	Special Care High	HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1	\$300.90
8887H	Special Care Low	LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1	\$299.26
8888H	Clinically Complex	CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1	\$220.75
8889H	Behavioral Symptoms and Cognitive Performance	BB2, BB1, BA2, BA1	\$219.12
		REDUCED PHYSICAL FUNCTION GROUPS	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	\$230.86

CHRONIC PAIN MANAGEMENT

COVERAGE DECISION

Injured workers eligible for benefits under [Title 51 RCW](#) may be evaluated for and enrolled in a comprehensive treatment program for chronic noncancer pain if it meets the definition of a structured, intensive, multidisciplinary program (SIMP). Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain.

Special conditions and requirements apply to workers who are considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease (referred to as lumbar surgery candidates as defined in [WAC 296-20-12065](#)). These conditions and requirements are noted throughout this policy.

Lumbar surgery candidates must successfully complete a SIMP to obtain authorization for a lumbar fusion or a lumbar intervertebral artificial disc replacement.

GOALS

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic noncancer pain.

POLICY INFORMATION

Portions of this policy are supported by [WAC 296-20-12055](#) through [WAC 296-20-12095](#).

Definitions

Defined terms throughout this bulletin are noted in *italics*.

The following definitions apply to this policy:

SIMP: means a chronic pain management program with the following four components:

Structured means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed health care practitioners. Workers follow a *treatment plan* designed specifically to meet their needs.

Intensive means the Treatment Phase is delivered on a daily basis, 6-8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs.

Multidisciplinary (interdisciplinary) means that structured care is delivered and directed by licensed health care professionals with expertise in pain management in *at least* the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits.

Program means an interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Uncomplicated Degenerative Disc Disease (UDDD) means chronic low back pain of discogenic origin without objective clinical evidence of any of the following conditions:

- Radiculopathy;
- Functional neurologic deficits;
- Spondylolisthesis (> Grade 1);
- Isthmic spondylolysis;
- Primary neurogenic claudication associated with stenosis;
- Fracture, tumor, infection, inflammatory disease; or
- Degenerative disease associated with significant deformity.

Lumbar surgery candidate means an injured worker who is considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease.

Important Associated Conditions means medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

Treatment Plan means an individualized plan of action and care developed by licensed health care professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

Valid Tests and Instruments means those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

PHASES OF AN APPROVED SIMP

See the Referral and Prior Authorization Requirements section for information about how and when each phase may be prior authorized by the claim manager.

Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes *treatment plan* development and a report. Only one evaluation is allowed per authorization but it can be conducted over 1-2 days. The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pre-treatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF);
- Review of medical records and reports, including diagnostic tests and previous efforts at pain management;
- Assessment of any *important associated conditions* that may hinder recovery e.g. opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease. If such conditions exist, see "Referral and Prior Authorization Requirements" section.
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs;
- Psychological and social assessment by a licensed clinical psychologist using *valid tests and instruments*;
- Identification of the worker's family and support resources;
- Identification of the worker's reasons and motivation for participation and improvement;
- Identification of factors that may affect participation in the program;

- Assessment of pain and function using *valid tests and instruments*; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
 - Activities of Daily Living (ADLs)
 - Range of Motion (ROM)
 - Strength
 - Stamina
 - Capacity for and interest in returning to work
- If the claim manager has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see "Vocational Services" section);
- A summary report of the evaluation and a preliminary recommended *treatment plan*; if there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances;
- For lumbar surgery candidates, the report should address their expectation and interest in having surgery.

Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6-8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- Graded Exercise: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence;
- Cognitive Behavioral Therapy: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner; and
- Coordination of Health Services: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the *treatment plan*;
 - For lumbar surgery candidates, communication and consultation with the spine surgeon is recommended;
 - Education and skill development on the factors that contribute to pain, responses to pain, and effective pain management;
 - For lumbar surgery candidates, this includes provision and review of a patient education aid, provided by the insurer, describing the risks associated with lumbar fusion;
- Tracking of Pain and Function: Individual medical assessment of pain and function levels using valid tests and instruments;
- Ongoing assessment of *important associated conditions*, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment;
- Performance of real or simulated work or daily functional tasks;
- SIMP vocational services may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made; and
- A discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase;
- A report at the conclusion of the Treatment Phase that addresses all the following questions:

- To what extent did the worker meet his or her treatment goals?
- What changes if any, have occurred in the worker's medical and psycho-social conditions, including dependence on opioids and other medications?
- What changes if any, have occurred in the worker's pain level and functional capacity as measured by *valid tests and instruments*?
- What changes if any, have occurred in the worker's ability to manage pain?
- What is the status of the worker's readiness to return to work or daily activities?
- What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
- How much and what kind of follow up care does the worker need?
- For lumbar surgery candidates, what is the worker's current expectation and interest in having surgery?

Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase isn't a substitute for and cannot serve as an extended Treatment Phase. The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Site of the Follow up Phase

The activities of the Follow up Phase may occur at the original multidisciplinary clinic (clinic based) or at the worker's home, workplace, or health care provider office (community based). This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to health care resources.

Face to face vs. Non face to face Services

Follow up services are payable as "face to face" and "non face to face" services. Face to face services are when the provider interacts directly with the worker, the worker's family, employer, or other health care providers. Non face to face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other health care providers for the purpose of coordinating care in the worker's home community. Both are subject to the following limits:

- Face to face services: up to 24 hours are allowed with a maximum of 4 hours per day; and
- Non face to face services: up to 40 hours are allowed.

Reporting Requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems;

- What was done during the Follow up Phase;
- What resulted from the follow up care; and
- Measures of pain and function using valid tests and instruments.

This summary report must be submitted at the following intervals:

- For non lumbar surgery candidates: at 1 and 3 months;
- For lumbar surgery candidates (regardless of whether they had lumbar surgery after successfully completing SIMP treatment): at 1, 3, and 6 months.

The Follow up Phase should include the following kinds of activities according to the worker's identified needs and goals, and may be done either face to face at the clinic or in the community; or as non face to face coordination of community based services:

Evaluation and Assessment Activities during Follow up Phase

- Assess pain and function with valid tests and instruments.
- Evaluate whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase.
- Evaluate the worker's dependence, if any, on opioids and other medications for pain.
- Assess important associated conditions and psychological status especially as related to reintegration in the workplace, home and community.
- Assess what kind of support the worker has in the work place, home, and community.
- Assess the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment Activities during Follow up Phase

- Provide brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist.
- Adjust the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work.
- Reinforce goals to improve or maintain progress made during or since the Treatment Phase.
- Teach new techniques or skills that were not part of the original Treatment Phase.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Community Care Coordination during Follow up Phase

- Communicate with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain.
- Make recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support Activities during Follow up Phase

- Contact or visit the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources.
- Hold case conferences with the interdisciplinary team of clinicians and/or the worker's attending provider and/or other individuals closely involved with the worker's care and functional recovery.

Special Considerations

When determining what follow up services the worker needs, SIMP providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other health care providers who are treating the worker is subject to the 24 hour limit on face to face services.
- If a SIMP provider plans to travel to the worker's community to deliver face to face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed.
- The required follow up evaluations must be done face to face with the worker and are subject to the 24 hour limit on face to face services.
- When the SIMP provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately.
- Authorized follow up services can be provided, even if the worker has lumbar surgery during the follow up period.
- If a SIMP provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that for workers covered by the State Fund, these therapies are often subject to prior authorization and utilization review. For further information, visit:
- <http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/default.asp>

POLICY REQUIREMENTS

Requirements the SIMP Provider Must Meet

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all the requirements listed in this section. They must:

- Meet the definition of a Structured Intensive Multidisciplinary Program; and
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF). Providers must maintain CARF accreditation and provide the Department of Labor & Industries (L&I) with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed; and
- Provide the services described in each phase; and
- Communicate with providers who are involved with the worker's care; and
- Ensure care is coordinated with the worker's attending provider; and
- Inform the claim manager whether the worker stops services prematurely, has unexpected adverse occurrences, or doesn't meet the worker requirements; and
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment; and
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed; and
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Requirements the Worker Must Meet

An injured worker must make a good faith effort to participate and comply with the *treatment plan* prescribed for him or her by the SIMP provider. To successfully complete a SIMP, the worker must meet all the requirements in this section. The worker must:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her *treatment plan*; and
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her *treatment plan*; and
- Agree to be evaluated and comply with treatment prescribed for any *important associated conditions* that hinder progress or recovery (e.g. opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease); and
- Attend each day and each session that is part of his or her *treatment plan*. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward *treatment plan* goals; and
- Cooperate and comply with his or her *treatment plan*; and
- Not pose a threat or risk to himself or herself, to staff, or to others; and
- Review and sign a participation agreement with the provider; and
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

Referral and Prior Authorization Requirements

1. All SIMP services require:
 - Prior authorization by the claim manager; and
 - A referral from the worker's attending provider.

An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider.

2. When the attending provider refers a worker to a chronic pain management program (SIMP), the claim manager may authorize an evaluation if the worker has had unresolved chronic pain for longer than 3 months despite conservative care and has one or more of the following conditions:
 - Is unable to return to work due to the chronic pain;
 - Has returned to work but needs help with chronic pain management;
 - Has significant pain medication dependence, tolerance, abuse, or addiction;
 - Is a lumbar surgery candidate. It is recommended that lumbar surgery candidates be evaluated by a SIMP prior to requesting the surgery.
3. Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the SIMP provider verifies the worker meets the requirements set forth in the "Requirements the Worker Must Meet" section, and can fully participate in the program. If the worker:
 - Meets the requirements and the SIMP provider recommends the worker move on to the Treatment Phase, the SIMP provider must provide the insurer with a report and treatment plan as described under the Evaluation Phase.
 - Doesn't meet the requirements, the SIMP provider must provide the insurer with a report explaining what requirements aren't met and the goals the worker must meet before he or she can return and participate in the program. If the worker is found to have important associated conditions during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the SIMP provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

4. The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.
5. SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.
6. If a lumbar surgery candidate previously participated in a SIMP as a lumbar surgery candidate but didn't successfully complete treatment, one additional SIMP may be authorized only if:
 - The worker obtains an additional surgical recommendation noting clinical changes one year or more after the date first referred to a SIMP; *or*
 - The reason the worker didn't participate fully or successfully complete a SIMP the first time was because of *important associated conditions* that are now fully resolved.
7. If a lumbar surgery candidate successfully completed a SIMP and didn't have the surgery, and in the future becomes a lumbar surgery candidate again, another SIMP may be authorized, but isn't required.
8. If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the claim manager may authorize resuming or restarting the SIMP if recommended by the SIMP provider.
9. If a SIMP provider plans to travel to the worker's community to deliver face to face services, mileage may be reimbursed, but only if it is prior authorized. Lodging and meals (per diem expenses) aren't reimbursable. Actual travel time isn't included in the 24 hour limit. When requesting prior authorization for mileage, the SIMP provider must explain the reason for the visit and how it will benefit the worker.

VOCATIONAL SERVICES

Vocational Referrals

The claim manager will determine, based on the facts of each case, whether to make a vocational referral prior to authorizing participation in a SIMP. The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable. The claim manager won't make a vocational referral when the worker:

- Is working; or
- Is scheduled to return to work; or
- Has been found employable or not likely to benefit from vocational services.

Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with SIMP treatment and the claim manager assigns a vocational counselor.

The Return to Work Action Plan provides the focus for vocational services during a worker's participation in a chronic pain management program. The Return to Work Action Plan may be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the outcomes listed in the Return to Work Action Plan must be included with the Treatment Phase summary report. If a vocational counselor is assigned, he or she will work with the SIMP vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

Return to Work Action Plan Roles and Responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the SIMP vocational counselor, the attending provider, and the worker are involved. Their specific roles and responsibilities are listed below.

- The SIMP Vocational Counselor:
 - Co-develops the Return to Work Action Plan with the insurer assigned vocational counselor;
 - Presents the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the SIMP recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal;
 - Communicates with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.
- The insurer assigned vocational counselor:
 - Co-develops the Return to Work Action Plan with the SIMP vocational counselor;
 - Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone;
 - Negotiates with the attending provider when the initial Return to Work Action Plan isn't approved in order to resolve the attending provider's concerns;
 - Obtains the worker's signature on the Return to Work Action Plan;
 - Communicates with the SIMP vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan;
 - Implements the Return to Work Action Plan following the conclusion of the Treatment Phase.
- The attending provider:
 - Reviews and approves/disapproves the initial Return to Work Action Plan within 15 days of receipt;
 - Reviews and signs the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt;
 - Communicates with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.
- The worker:
 - Will participate in the selection of a return to work goal;
 - Will review and sign the final Return to Work Action Plan;
 - Will cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan. Should the worker fail to be cooperative, the sanctions as set out in [RCW 51.32.110](#) shall be applied.

BILLING RULES

SIMP Fee Schedule

The fee schedule and procedure codes for these phases are listed in the following table. The fee schedule applies to injured workers only in an outpatient program. These outpatient chronic pain management programs must bill using the local codes listed in the following table on a CMS-1500 form.

Description	Local Code	Duration / Limits	Units of Service	Fee Schedule
SIMP Evaluation Services	2010M	1 evaluation per authorization, which may be conducted over 1-2 days	Bill only 1 unit for evaluation even if conducted over 2 days	\$1,106.63
SIMP Treatment Services, each 6-8 hour day	2011M	Not to exceed 20 treatment days (6-8 hours per day)	1 day equals 1 unit of service	\$708.82 per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or health care providers, either in the clinic or in the worker's community	2014M	Not to exceed 4 hours per day and not to exceed 24 hours total (time must be billed in 1 minute units)	1 minute equals 1 unit of service	\$1.48 per minute (\$88.80 per hour)
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or health care providers in the worker's community	2015M	Not to exceed 40 hours (time must be billed in 1 minute units)	1 minute equals 1 unit of service	\$1.17 per minute (\$70.20 per hour)
Mileage for traveling to and from the worker's community	0392R	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

Billing For Partial Days in the Evaluation and Treatment Phases

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the patient was scheduled for less than 8 hours). Examples:

1. Only one evaluation is payable. If half the evaluation is completed on day one and half is completed on day two, the clinic would bill half of the evaluation rate ($\$1106.63 \times 50\% = \553.32) on each day.
2. The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill $\$708.82 \times 25\% = \177.21 .

MORE INFORMATION

For Crime Victims

- **Phone:** (800) 762-3716 (toll free)
- **Fax:** (360) 902-5333
- Additional information is available at: www.CrimeVictims.Lni.wa.gov

For Self-Insured Claims

Contact the self-insured employer (SIE) or their third party administrator (TPA) to request authorization. For a list of SIE/TPAs, go to:

<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp>