

VOCATIONAL SERVICES

Vocational services providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions (F248-095-000). Maximum fees apply equally to both State Fund and self-insured vocational services.

BILLING CODES BY REFERRAL TYPE

All vocational services require **prior authorization**. Vocational services are authorized by referral type. The State Fund uses 6 referral types.

- Early intervention
- Assessment
- Plan development
- Plan implementation
- Forensic
- Stand alone job analysis

Each referral is a separate authorization for services. Insurers will pay interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate and forensic evaluators at 120% of the VRC professional rate. All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. See [fee caps](#), page **180** for more information.

Early Intervention

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0800V	Early Intervention Services (VRC)	\$ 8.77
0801V	Early Intervention Services (Intern)	\$ 7.47
0802V	Early Intervention Services Extension (VRC)	\$ 8.77
0803V	Early Intervention Services Extension (Intern)	\$ 7.47

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0810V	Assessment Services (VRC)	\$ 8.77
0811V	Assessment Services (Intern)	\$ 7.47

Vocational Evaluation, Job and Pre-job Modification Consultation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0821V	Vocational Evaluation (VRC)	\$ 8.77
0823V	Pre-job or Job Modification Consultation (VRC)	\$ 8.77
0824V	Pre-job or Job Modification Consultation (Intern)	\$ 7.47

Plan Development

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0830V	Plan Development Services (VRC)	\$ 8.77
0831V	Plan Development Services (Intern)	\$ 7.47

Plan Implementation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0840V	Plan Implementation Services (VRC)	\$ 8.77
0841V	Plan Implementation Services (Intern)	\$ 7.47

Forensic Services

The VRC assigned to a forensic referral must directly perform ALL the services needed to resolve the vocational issues and make a supportable recommendation.

Exception: Vocational evaluation services may be billed by a third party, if authorized by the insurer.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0881V	Forensic Services (Forensic VRC)	\$ 10.50

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses. For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager. Bills for dates of service beyond the 15th day will not be paid.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0808V	Stand Alone Job Analysis (VRC)	\$ 8.77
0809V	Stand Alone Job Analysis (Intern)	\$ 7.47
0378R	Stand Alone Job Analysis (non-VRC)	\$ 8.77

Other billing codes

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC) 1 unit = 6 minutes	\$ 4.38
0892V	Travel/Wait Time (Intern) 1 unit = 6 minutes	\$ 4.38
0893V	Professional Mileage (VRC) 1 unit = 1 mile	State rate
0894V	Professional Mileage (Intern) 1 unit = 1 mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	By report
0896V	Ferry Charges (VRC, Intern or Forensic VRC)	By report
0897V	Hotel Charges (VRC, Intern or Forensic VRC) out-of-state only	By report

Travel/Mileage Billing

The insurer pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The insurer **doesn't pay** for travel time or mileage between two different service locations or branch offices where a provider is working cases. Providers may bill from the branch office where the referral was assigned by the VRC to necessary destinations. Examples include: going to the location of the employer of record, visiting an attending physician's office and the meeting of a VRC with an injured worker at the worker's home. For out of state cases, VRC may only bill from the branch office nearest the worker.

Special Services, Nonvocational Providers

L&I established a procedure code to be used for special services provided during Assessment Plan Development, and Plan Implementation, for example: commercial driver's license (CDL), physicals, background checks, driving abstracts and fingerprinting.

The code must be billed by a medical or a miscellaneous nonphysician provider on a miscellaneous services billing form. The referral ID and referring vocational provider account number must be included on the bill. Limit 1 unit per day, per claim.

The code requires **prior authorization**. For State Fund claims, VRCs must contact the vocational services specialist (VSS) to arrange for prior authorization from the claim manager. For self-insured claims, contact the SIE/TPA for prior authorization.

The code can't be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

Code	Description	Maximum Fee
0388R	Plan , providers	By report

Vocational Evaluation and Related Codes for Nonvocational Providers

Certain nonvocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	\$ 10.66
0390R	Vocational Evaluation, 1 unit = 6 minutes	\$ 8.77
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	\$ 4.83
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry Charges (non-VRC) ⁽¹⁾	State rate

(1) Requires documentation with a receipt in the case file.

A provider can use the **R** codes if he or she is a:

- Nonvocational provider such as an occupational or physical therapist, or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you), you can't bill as a vocational provider (provider type 68). You must either use another provider account number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider account number (type 97) and bill the appropriate codes for those services.

NOTE: These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, and
- The service provider ID for the assigned vocational provider in the "Name of physician or other referring source" box at the top of the form, and
- Nonvocational provider's own provider account numbers at the bottom of the form.

FEE CAPS

Vocational services are subject to fee caps. The following fee caps are by referral. All services provided for the referral are included in the cap. Travel, wait time and mileage charges aren't included in the fee cap for any referral type.

Description	Applicable Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	\$1,801.00
Assessment Referral Cap, per referral	0810V, 0811V	\$3,003.00
Plan Development Referral Cap, per referral	0830V, 0831V	\$6,014.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	\$6,818.00
Stand Alone Job Analysis Referral Cap, per referral	0808V, 0809V, 0378R	\$ 459.00

The fee cap for vocational evaluation services applies to multiple referral types.

Description	Applicable Codes	Maximum Fee
Work Evaluation Services Cap	0821V, 0390R	\$1,316.00

For example, if \$698.00 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment under another referral type.

Referrals that Reach the Fee Cap

Fee cap requirements:

- The vocational provider must track costs associated with their referrals to assure the fee cap isn't exceeded
- When a fee cap is reached, vocational providers aren't required to continue to provide services over and above the fee cap without payment. However, providers must notify the VSS or SIE/TPA of the situation. Providers must continue to deliver services as required by [WAC 296-19A](#) until the cap is reached.
- Providers must comply with all requirements in [WAC 296-19A](#) with regard to closing referrals, including submitting a closing report, even if the claim manager has closed the referral.
- Providers shouldn't enter any closure outcome with their closing report. Only the CM can enter the ADM7 closure code for fee cap reached.
- Vocational providers must not recommend the claim manager close a referral with an alternative closure code to avoid reaching the fee cap. After closing a referral due to reaching a fee cap, any subsequent referral of the same type may not be assigned to the same vocational counselor.
- Early Intervention Fee Cap Extension
- For early intervention referrals, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **1 time only per claim** and doesn't create a new referral. The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills. The claim manager must authorize the extension. No other early intervention professional services (for example, services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.
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Description	Applicable Codes	Maximum Fee
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	\$ 1,756.00

Fee Cap Exceptions for AWAs and Plan Implementation Referrals

- Exception codes must be used to authorize an extra number of billable hours. Any use of these exception codes requires prior authorization by the VSS for State Fund claims, or by the SIE/TPA for self-insured claims.
- For AWA referrals, 2 new exception codes are available with an additional fee cap of \$877.00.

Code	Description	Maximum Fee
0812V	Assessment Services Exception (VRC)	\$ 8.77 per 6 minutes
0813V	Assessment Services Exception (Intern)	\$ 7.47 per 6 minutes

- For Plan Implementation referrals, 2 new exception codes are available with an additional fee cap of \$2,026.00.

Code	Description	Maximum Fee
0842V	Plan Implementation Services Exception (VRC)	\$ 8.77 per 6 minutes
0843V	Plan Implementation Services Exception (Intern)	\$ 7.47 per 6 minutes

Fee-Cap Exception Request

The vocational provider assigned to the referral may request additional time:

- Within 2 hours (\$175.00) of reaching the fee cap; and
- NOTE:** Extra time isn't available if the original cap has been reached.
- Plan must demonstrate that the extra time will allow for resolution of the referral; and
 - Referrals must have started on or after January 1, 2008

Denial of Request

The vocational provider must follow department policy on referrals that reach the fee cap.

Approval of Request

- The vocational provider may bill the exception code up to the additional cap.
 - Once the added cap has been reached, the provider exhausts the original fee cap.
- NOTE:** Extra time isn't available if the original cap has been reached.

Not Complete After Fee-Cap Exception

The provider must follow department policy on referrals that reach the fee cap.

ADDITIONAL REQUIREMENTS

ADMA Billing

Vocational providers may use ADMA outcome-- VRC declines referral--for up to 14 days after the referral assignment. This outcome is to be used when VRC determines that the referral isn't appropriate. Examples include:

- Conflict of interest
- Not ready for a referral due to medical issues, etc

Prior to entering an ADMA outcome, VRC needs to contact the claims manager to discuss the reasons for declining the referral.

A maximum of three professional hours may be billed for reviewing the file and preparing a brief rationale, using the standard VCLOS routing sheet.

Preferred Worker Certification for workers who choose Option 2

Vocational providers must consider assisting a worker in obtaining Preferred Worker Certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining Preferred Worker Certification for up to 14 days after an Option 2 selection has been made.

Insurer Activity Prescription Form (APF), 1073M

Only the insurer or VRC can request that a health care provider complete an Insurer APF. For State Fund claims, healthcare providers will not be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

- Employers can obtain physical capacity information by:
- Using completed APFs available on the department's Claim and Account Center at <http://www.Lni.wa.gov/ORLI/LoGon.asp>, or
- Requesting an APF through the claim manager when updated physical capacity information is needed.

Other Requests for Return-to-Work Information

Health care providers may bill 1074M for written responses to employer requests regarding return-to-work issues. Examples include:

- Concurrence with performance based physical capacities evaluation (PBPCE)
- Authorization for worker to participate in PBPCE
- Job modification or pre-job modification reviews
- Proposed work hardening program
- Plan for graduated, transitional, return to work

Vocational Evaluation

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing
- Interest testing
- Work samples
- Academic achievement testing
- Situational assessment
- Specific and general aptitude and skill testing

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational providers, provider type 68, must use procedure code 0821V to bill for vocational evaluation services.

Use code 0821V for the formal testing itself, or for a meeting that is *directly* related to explaining the purposes or findings of testing.

Non-vocational providers must use procedure code 0390R. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, and
- Service provider ID for the assigned vocational provider in the "Name of the physician or other referring source" box at the top, and
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form and
- Obtain the vocational referral ID number from the VRC and place on the billing form and
- Obtain the VRC's service provider number and place in the "Name of the physician or other referring source" box at the top, and
- Place the school's provider account number at the bottom of the form.

Retraining Plans that Exceed Statutory Benefit Limit

- The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit.
- The VSS won't approve a plan with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers may not develop or submit such a plan.

How Multiple Providers Who Work on a Single Referral Bill for Services

Multiple providers may deliver services on a single referral if they have the **same** payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where 1 provider covers the caseload of an ill provider. When more than 1 provider works on a referral, each provider must bill separately for services delivered on the referral; and each provider must use:

- His/her individual provider account number,
- The payee provider account number and
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the **assigned** provider's performance rating.

Split Billing across Multiple Referrals

When a worker has 2 or more open time-loss claims, State Fund may make a separate referral for each claim. In cases where State Fund makes 2 (or more) concurrent referrals for vocational services, State Fund will specify if the vocational provider is to split the billing.

When billing for vocational services on multiple referrals and/or claims, follow these instructions:

1. Split billable hours over a larger interval of work (up to the entire billing date span), rather than per each single activity.

Example: Provider XYZ has 2 open referrals for the same worker. If the provider bills once a week, one approach would be to total all the work done with that worker on both referrals in a day, or in the entire week, then divide by 2.

2. Bills must be split equally, in whole units, charging the same dollar amount on each claim/referral.

3. If, after totaling all work done during the billing period, the total is still not an even number of units, round to the nearest even whole number of units, then divide by 2 as directed above.
4. If split bills don't contain the same number of units, they will be denied and must be rebilled in the correct format. If there are 3 (or more) claims requiring time-loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received.

Vocational providers must document multiple referrals and split billing for audit purposes.

Referral Resolution

A vocational referral initially made to a firm, and then assigned to a VRC must close if the same VRC is no longer available to provide services. Referrals made directly to the VRC may be transferred by the claim manager to the VRC's new firm, only if the VRC has already *established a relationship with a new firm within the same service location*, via the Vocational Provider Account Application process.

Vocational providers **must** notify the insurer if the VRC assigned to a referral is no longer available to provide services on that referral. Following are guidelines for notifying the insurer:

Example 1:

For referrals made to the firm and assigned to a VRC:

- It is the responsibility of the assigned VRC to close the referral on Voc Link Connect with the outcome, "VRC no longer available". This outcome must be entered immediately on the VRC's change in status.
- It is the responsibility of the vocational manager of the firm to notify the claim manager(s) of the change in status for that referral. State Fund must be notified by telephone and/or fax within 3 working days of the change in status. Notification by the vocational manager isn't necessary if the VRC assigned to the referrals successfully closes the referral as noted above.

The VRC assigned to the referral(s) **may not** contact the claim manager(s) for the purpose of informing them of a change in employment. This would be considered marketing, which is prohibited by department policy. The resolution (for example, re-referral) of the referral is at the sole discretion of the claim manager.

Example 2:

For referrals made directly to the VRC:

- The VRC is responsible for notifying the claim manager of his/her new status, and should be prepared to inform the claim manager of the payee provider account number of the new firm, as well as the VRC's new service provider account number associated with that firm
- The claim manager, at his/her sole discretion, may transfer the referral(s) to the VRC at the new firm, provided that the VRC is available to work in the same service location in which the original referral was made

Appropriate Timing of VocLink Connect Outcome Recommendations for State Fund Claims

State Fund has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral. The VRC must complete the report before a *VocLink* outcome recommendation is made to State Fund. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which isn't complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include "VRC no longer available" and "VRC declines referral".

In all other cases, the paper report must be submitted to State Fund at the same time the recommendation is made.

Submitting a Vocational Assessment or Retraining Plan for Self-Insured Claims

- What is the Self-Insurance Vocational Reporting Form? (See: [WAC 296-15-4302](#))
- What must the self-insurer do when an assessment report is received? ([WAC 296-15-4304](#))
- When must a self-insurer submit a vocational rehabilitation plan to the department? ([WAC 296-15-4306](#))
- What must the vocational rehabilitation plan include? ([WAC 296-15-4308](#))
- What must the self-insurer do when the department denies the vocational rehabilitation plan? ([WAC 296-15-4310](#))
- What must the self-insurer do when the vocational rehabilitation plan is successfully completed? ([WAC 296-15-4312](#))
- What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? ([WAC 296-15-4314\(5\)](#))

Responsibilities of Service Providers and Firms in Regard to Changes in Status

NOTE: Change in status responsibilities apply to both State Fund and self-insurance vocational providers.

The insurer must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status include:

- VRC or intern ends their association with a firm.
- VRC assigned to a referral is no longer available to provide services on the referral(s).
- Firm closes.

Notification to L&I requires:

1. Resolution of the open referral(s) and
2. Submission of the Vocational Provider Change Form(s) to Private Sector Rehabilitation Services (L&I, PO Box 44326, Olympia WA 98504-4326).

These forms may be found at L&I's vocational services web site

<http://www.lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/Default.asp>.

A firm or service provider that fails to notify L&I of changes in status may be in violation of WAC and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in [WAC 296-19A-260](#) and [WAC 296-19A-270](#).

Approved Plan Services that Occur Prior to the Plan Start Date

The following are services/fees that the insurer may cover prior to a plan start date and outlines the procedure for adjudicating bills for dates of service prior to a plan start date.

- Registration fees billed as retraining tuition, R0310.
- Rent, food, utilities and furniture rental. (Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.)

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, R0330, **isn't payable** prior to a plan start date. Travel that occurs prior to a plan start date is generally to a jobsite to evaluate whether a particular job goal is reasonable, or to a school to pay for registration, books or look over the campus. These types of trips aren't part of a retraining plan and should be billed by the worker under V0028. Travel to appointments with the VRC should also be billed under V0028.

Selected Plan Procedure Code Definitions

L&I has defined the following retraining codes:

- R0312 Retraining supplies are consumable goods such as:
 - Paper
 - Pens
 - CDs
 - Disposable gloves
- R0315 Retraining equipment, tools such as:
 - Calculator
 - Software
 - Survey equipment
 - Welding gloves & hood
 - Bicycle repair kits
 - Mechanics tools
- R0350 Other, includes professional uniforms, including uniform shoes, required for training, and other items that don't fit the more defined categories. Items purchased using R0350 must be for vocational rehabilitation retraining.

The insurer doesn't have the authority to purchase glasses, hearing aids, dental work, clothes for interviews, or other items as a way to remove barriers during retraining.

Reimbursement for Food

The insurer reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan.

The vocational provider must review charges for these expenses for inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.) and to ensure each date of purchase is itemized on the bill. Charges for food, combined in weekly or monthly date spans, **aren't allowed**. Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable. The provider and/or the worker should also retain a copy of receipts.

The worker won't be reimbursed over the monthly-allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker doesn't exceed their monthly allotment for food.

The vocational provider will review the receipts, deduct personal and other noncovered items and sign the Statement for Retraining and Job Modification Services form.

Once the vocational provider signs the Statement for Retraining and Job Modification Services form the insurer will assume the provider has reviewed the bill and receipts, removed inappropriate charges and has verified the charges are within the worker's per diem allotment for that month.

Mileage on Transportation Cost Encumbrance

The insurer reimburses mileage only in whole miles. Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Transportation Cost Encumbrance form should be referred to the VSS.