

New L&I Billing Code for Helping Workers Transfer to Network Providers

The new medical provider network for Washington workers' compensation became effective January 1, 2013. Now only medical providers in the network will be able to provide care beyond the initial office or emergency room visit.

L&I recognizes that some workers will have complex cases that make finding a network provider more difficult. The department has therefore created a new billing code that can be used by both the State Fund and Self-insured employers to pay network providers for the additional work and coordination that may be needed in becoming the attending physician (AP) for these workers.

The use of this new billing code is voluntary and at the discretion of the Department or self-insured employer when the new network provider needs to spend an extraordinary amount time reviewing the file, coordinating a treatment plan with multiple caregivers, or identifies other care needs that make treatment more difficult. The code is a tool, in addition to what is already required in RCW and WAC, that may be helpful in asking providers to do additional work associated with complex cases that must transfer from a non-network provider to a network provider.

The code is: 1158M – Complex Claim Coordination.

This code can be used when the self-insured employer has asked a provider to review a claim for an injured worker who needs to find a new Attending Provider, *and the provider has agreed to become the new AP for the claim*. This service is only payable when requested and preauthorized by the self-insured employer. The self-insured employer should clarify their expectations with the provider when pre-authorizing this code.

A consultation (codes 99241-99245) is separate from the Complex Claim Coordination Code (1158M) and may be paid even if the provider decides not to become the injured worker's Attending Provider.

However, if the provider decides to accept the Attending Provider role and the treatment plan is in place, the insurer may reimburse for both the Complex Claim Coordination Code (1158M) and the consultation code.

Payment for the code:

- Code maximum fee: \$500.00
- Fee is only payable to a network AP
- Payable one time per provider per claimant
 - If the provider becomes the claimant's AP on multiple claims, the billing should be split among these claims.

Provider is eligible for payment of code when:

- The self-insurer authorizes transfer of care to network provider.
- Network provider accepts the Attending Provider role.
- Treatment plan must be in place before authorization.

Services expected from provider for complex claims:

Network provider assumes AP role on a complex case: These cases typically require more review and attention, due to multiple medical and/or non-medical issues affecting recovery and progress. There may be more allied health and medical personnel with whom to coordinate. There may be issues about

return to work, opioid or other substance abuse/addiction issues, or other factors that render treatment more difficult. The new network AP is expected to coordinate the necessary care to help these injured workers to recover and/or move the workers' compensation claim closer to resolution. This includes identification of barriers to recovery and a treatment plan to address those barriers.