

Payment Policies for Healthcare Services Provided to Injured Workers and Crime Victims

Chapter 21: Other Services

Effective July 1, 2015



Link: Look for possible **updates and corrections** to these payment policies at:

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2015/



Table of contents

Page

Payment policies:

After hours services.....	21-2
Locum tenens.....	21-3
Provider mileage	21-4
Ventilator management services.....	21-5

More info:

Related topics.....	21-6
---------------------	------



Payment policy: After hours services

▶ Services that can be billed

CPT[®] codes **99050** through **99060** will be considered for separate payment in the following circumstances:

- When the provider's office isn't regularly open during the time the service is provided, *or*
- When services are provided on an emergency basis, out of the office, that disrupt other scheduled office visits.



Note: Also see Payment limits, below.

▶ Documentation requirements

Medical necessity and urgency of the service must be documented in the medical records and be available upon request.

▶ Payment limits

Only one code for after hours services will be paid per worker per day.

A second day can't be billed for a single episode of care that carries over from one calendar day to the next.

CPT[®] codes **99050** through **99060** aren't payable when billed by:

- Emergency room physicians,
- Anesthesiologists/anesthetics,
- Radiologists, *or*
- Laboratory clinical staff.



Payment policy: Locum tenens

▶ Who must perform these services to qualify for payment

A locum tenens physician must provide these services.



Link: For information about requirements for Who may treat, see [WAC 296-20-015](#).

▶ Requirements for billing

The department requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered.



Note: Modifier –Q6 isn't covered and the insurer won't pay for services billed under another provider's account number.



Payment policy: Provider mileage

▶ Prior authorization

Prior authorization is required for a provider to bill for mileage.

The round trip mileage must exceed 14 miles.



Note: Reimbursement for such provider mileage is limited to extremely rare circumstances.

▶ Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **\$5.12** per mile.



Note: (Also see Prior authorization, above.)



Payment policy: Ventilator management services

▶ Services that can be billed

The insurer pays for **either** the:

- Ventilation management service code (CPT[®] codes **94002-94005, 94660, and 94662**), *or*
- E/M service (CPT[®] codes **99201-99499**),
- But won't pay both (also see Payment limits, below).

▶ Payment limits

The insurer doesn't pay for ventilator management services when the same provider reports an E/M service on the same day. If a provider bills a ventilator management code and an E/M service for the same day, payment:

- Will be made for the E/M service, *and*
- Won't be made for the ventilator management code.



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules for "Who may treat"	Washington Administrative Code (WAC) 296-20-015: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-015
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services	L&I's website: http://feeschedules.Lni.wa.gov

▶ **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**.