

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

Chapter 30: Vocational Services

Effective July 1, 2015



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

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



Note: Vocational services providers must use the codes listed in this chapter to bill for services. Maximum fees apply equally to both State Fund and self-insured vocational services.



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Definitions

- ▶ **By report (BR):** A code listed in the fee schedule as BR doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.



Link: For more information, see [WAC 296-20-01002](#).



Payment policy: Billing by referral type



Link: For more detailed information on billing, consult the **Miscellaneous Services Billing Instructions (F248-095-000)**, available at: <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627>

▶ Prior authorization

All vocational services require prior authorization.

Vocational services are authorized by referral type. The State Fund uses six referral types:

- Early intervention,
- Assessment,
- Plan development,
- Plan implementation,
- Forensic, *and*
- Stand-alone job analysis.

Each referral is a separate authorization for services.

▶ How insurers will pay

Insurers will pay:

- Interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate, *and*
- Forensic evaluators at 120% of the VRC professional rate.



Note: All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. For more information, see the payment policy for Fee caps later in this chapter.

► Services that can be billed

The following several tables show billing codes by referral type.

Early intervention

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0800V	Early intervention services (VRC)	\$9.06
0801V	Early intervention services (intern)	\$7.72
0802V	Early intervention services extension (VRC)	\$9.06
0803V	Early intervention services extension (intern)	\$7.72

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0810V	Assessment services (VRC)	\$9.06
0811V	Assessment services (Intern)	\$7.72

Vocational evaluation, pre-job and job modification consultation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0821V	Vocational evaluation (VRC)	\$9.06
0823V	Pre-job or job modification consultation (VRC)	\$9.06
0824V	Pre-job or job modification consultation (Intern)	\$7.72

Plan development

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0830V	Plan development services (VRC)	\$9.06
0831V	Plan development services (Intern)	\$7.72

Plan implementation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0840V	Plan implementation services (VRC)	\$9.06
0841V	Plan implementation services (Intern)	\$7.72

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.



Note: 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)	\$10.84

Standalone job analysis

The codes in the following table are used for **stand alone and provisional job analyses**. (Also see Payment limits, below.)

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0808V	Stand-alone job analysis (VRC)	\$9.06
0809V	Stand-alone job analysis (intern)	\$7.72
0378R	Stand-alone job analysis (non-VRC)	\$9.06

Travel, wait time, and mileage: The insurer pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. (Also see Services that aren't covered, below.)

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, *or*
- The meeting of a VRC with an injured worker at the worker's home.



Note: For **out of state** cases, VRC may only bill from the branch office nearest the worker.

Code	Description	Maximum fee
0891V	Travel/wait time (VRC or forensic VRC) 1 unit = 6 minutes	\$4.54
0892V	Travel/wait time (intern) 1 unit = 6 minutes	\$4.54
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



Note: See definition of **By report** in Definitions at the beginning of this chapter.

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	\$11.02
0390R	Vocational evaluation, 1 unit = 6 minutes	\$9.06
0391R	Travel/wait (non-VRC), 1 unit = 6 minutes	\$4.99
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry charges (non-VRC) (See Note below this table.)	State rate



Note: Code **0393R** requires documentation with a receipt in the case file.

▶ Services that aren't covered

Travel, wait time, and mileage

The insurer doesn't pay for travel time or mileage between two different service locations or branch offices where a provider is working cases.

The insurer pays for travel time and mileage only once per trip, even if there is more than one claim. Charges must be split equally between all the claims.

When billing for travel to and from a service location, branch office or necessary location to provide vocational services for 2 or more claims, follow these instructions:

- Split charges equally between all claims, round to the nearest number if necessary.
- For 2 claims, bill half to each claim.
- For 3 or more claims split the charges accordingly (3 claims = by thirds, 4 claims = by fourths)

▶ Payment limits

Stand alone job analysis

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 won't be paid.



Payment policy: Fee caps for vocational services

► Fee cap policy for referrals

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.



Note: Travel, wait time, and mileage charges aren't included in the fee cap for any referral type.

If the description of the fee cap referral is...	Then the applicable codes are:	And the maximum fee is:
Early intervention referral cap, per referral	0800V, 0801V	\$1,861.00
Assessment referral cap, per referral	0810V, 0811V	\$3,103.00
Plan development referral cap, per referral	0830V, 0831V	\$6,215.00
Plan implementation referral cap, per referral	0840V, 0841V	\$7,046.00
Stand alone job analysis referral cap, per referral	0808V, 0809V, 0378R	\$474.00

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

If the description of the fee cap referral is...	Then the applicable codes are:	And the maximum fee is:
Vocational evaluation services cap	0821V, 0390R	\$1,360.00

How the vocational evaluation fee cap works

For example, if **\$698.00** of vocational 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.

▶ Fee cap requirements

Referrals that reach the fee cap

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,
- Providers must notify the VSS or SIE/TPA of the situation, *and*
- 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.



Link: For more information, see [WAC 296-19A](#).

▶ 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 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.

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. 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.

Description	Applicable codes	Maximum fee
Extension of early Intervention referral cap, once per claim	0802V, 0803V	\$1,814.00

▶ **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.

AWA referrals

For AWA referrals, 2 exception codes are available with an additional fee cap of **\$906.00**.

Code	Description	Maximum fee
0812V	Assessment services exception (VRC)	\$9.06 per 6 minutes
0813V	Assessment services exception (intern)	\$7.72 per 6 minutes

Plan Implementation referrals

For Plan Implementation referrals, 2 exception codes are available with an additional fee cap of **\$2,094.00**.

Code	Description	Maximum fee
0842V	Plan implementation services exception (VRC)	\$9.06 per 6 minutes
0843V	Plan implementation services exception (intern)	\$7.72 per 6 minutes

Fee cap exception request

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

- Within 2 hours (\$181.20) of reaching the fee cap (see Note below this list),
- 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.



Note: Extra time isn't available if the original cap has been reached.

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.



Payment policy: Special services, nonvocational providers

▶ Prior authorization

Code **0388R** (for special services provided during Assessment Plan Development and Implementation) requires prior authorization.

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

▶ Who must perform these services to qualify for payment

A nonvocational provider can use the **R** codes. A vocational provider delivering services for a referral assigned to a different payee provider may also use the **R** codes.

▶ Services that can be billed

L&I established procedure local billing code **0388R** to be used for special services provided during Assessment Plan Development and Plan Implementation, such as:

- Commercial driver's license (CDL),
- Pre-employment physical examinations,
- Background checks,
- Driving abstracts, *and*
- Fingerprinting.

Code **0388R** has a description of "Plan, providers," and pays **by report**.



Note: See definition of **By report** in Definitions at the beginning of this chapter.

► Requirements for billing

Code **0388R** must be billed by a medical or a miscellaneous non-physician provider on a **Statement for Miscellaneous Services** billing form ([F245-072-000](#)). The referral ID and referring vocational provider account number must be included on the bill.

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**), *and*
- 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.

These providers use the Statement for Miscellaneous Services billing form but must include the following specific information to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider,
- 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*
- The nonvocational provider's own provider account numbers at the bottom of the form.



Link: The **Statement for Miscellaneous Services** billing form is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627.

► Payment limits

Code **0388R** 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.

For code **0388R**, there is a limit of 1 unit per day, per claim.



Payment policy: Additional requirements for all vocational services providers

▶ Inappropriate referral: 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 the VRC determines that the referral isn't appropriate. Examples include:

- Conflict of interest, *or*
- Not ready for a referral due to medical or other issues.

Prior to entering an ADMA outcome, the VRC needs to contact the claim 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 healthcare provider complete an Insurer APF.

For State Fund claims, healthcare providers won't 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, *or*
- Requesting an APF through the claim manager when updated physical capacity information is needed.



Link: Visit L&I's Claim and Account Center at: www.Lni.wa.gov/ORLI/LoGon.asp.

▶ Other requests for return to work information

Healthcare providers may bill **1074M** for written responses to employer requests regarding return to work issues. Examples include:

- Concurrence with a functional capacity evaluation (FCE),
- Authorization for worker to participate in FCE,
- Job modification or pre-job modification reviews,
- Proposed work hardening program, *and*
- Plan for graduated, transitional, return to work.

▶ Pre-job and Job Modification Consultation

Services that can be billed

Billable activities for procedure codes 0823V and 0824V are:

- Consultation time with the worker,
- Composing the report,
- Communication,
- Instruction in work practices, and
- When indicated:
 - Obtaining bids
 - Completing and submitting assistance application packet.

Services don't include performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals.

Resume Services (State Fund claims only)

Vocational providers may develop a resume for workers who are in an open vocational referral, within the following parameters:

- Participation of the worker is voluntary.

- The resume accurately reflects the workers work experience and education. Volunteer experience, other relevant information, and/or hobbies should also be included if applicable.
- The VRC assigned to the referral meets in-person with the worker to review the resume.
- The worker is provided with paper copies of the resume and is also provided with the resume on a portable digital storage device.
- The worker is encouraged to take their resume to WorkSource and register for job finding assistance. The VRC should coordinate referral to L&I WorkSource partnership staff if feasible.
- The resume is submitted to the claim file and the resume service activities are documented in the next vocational report.
- The service is available once per claim.
- The maximum payable for these services is 3 hours of VRC and/or intern time.

A cover letter may be developed as part of these services.

Code	Description	Maximum fee
0844V	Resume services (VRC)	\$9.06 per 6 minutes
0845V	Resume services (intern)	\$7.72 per 6 minutes

Services that can’t be billed

Billable services don’t include performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals (except for activities noted in WAC 296-19A-340). Activities associated with reports (other than composing or dictating complete draft of the report) not billable include:

- Editing, revising, or typing,
- Filing, or
- Distributing or mailing.

Also not billable is time spent on any administrative and clerical activity to include:

- Typing,
- Copying,
- Faxing, mailing, or distributing,

- Filing,
- Payroll,
- Recordkeeping, or
- Delivering or picking up mail.

► 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, *and*
- 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.



Note: When billing for testing services on multiple referrals and/or claims, test administration time must be split equally in whole units, charging the same dollar amount on each claim/referral.

For example, if a provider performs 4.5 hours of group testing for 3 workers, then billing for each worker shouldn't exceed 1.5 hours.

Vocational providers

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*
- A meeting that is directly related to explaining the purposes or findings of testing.

Nonvocational providers

Nonvocational 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*
- Nonvocational 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,
- Obtain the vocational referral ID number from the VRC and place on the billing form,
- 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, the insurer may make a separate referral for each claim. In cases where the insurer makes 2 (or more) concurrent referrals for vocational services, vocational providers are expected to split the billing. When providing vocational services on multiple referrals and/or claims, follow these instructions:

- To accurately capture the work done without overbilling, combine billable hours over a larger interval of work (up to the entire billing period) rather than bill for each single activity.

Examples:

- A provider has 2 open referrals for the same worker and the provider bills once per week. They provided a total of 90 minutes during this billing period. They would bill 8 units under each claim.

- A provider has 2 open referrals for the same worker and the provider bills daily. They provided a total of 40 minutes during this billing period. They would bill 4 units under each claim.
- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims as directed above.
- 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.



Note: These requirements also apply when billing for testing services.

For example, if provider performs 4.5 hours of testing for a worker with more than one claim and referral, the billing must be split equally among the claims.



Note: 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 a VSS supervisor 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:

Guideline 1: Referrals made to the firm and assigned to a VRC

It is the responsibility of the **assigned VRC** to close the referral on *VocLink 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.



Note: The VRC assigned to the referral(s) can't 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 of the referral (for example, re-referral) is at the sole discretion of the claim manager.

Guideline 2: 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*
- 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



Links: Answers to the following questions can be found in various WACs (the specific WAC is noted following each question):

- What is the Self-Insurance Vocational Reporting Form? (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))

▶ Change in status: Responsibilities of service providers and firms



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 includes:

- 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), *or*
- Firm closes.

Notification to L&I requires:

- Resolution of the open referral(s), *and*

- Submission of the Vocational Provider Change Form(s) to:

Private Sector Rehabilitation Services at L&I
PO Box 44326
Olympia WA 98504-4326



Link: These forms may be found at L&I's vocational services website:

www.Lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/Default.asp
www.Lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/



Note: 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](#).



Link: For more information, see [WAC 296-19A-260](#) and [WAC 296-19A-270](#).

▶ Approved plan services that occur prior to plan start date

The insurer may cover these are services/fees prior to a plan start date:

- Registration fees billed as retraining tuition (billing code **R0310**), *and*
- Rent, food, utilities, books, supplies and equipment, 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, *and*
 - Disposable gloves.
- **R0315**, Retraining equipment, tools such as:
 - Calculator,
 - Software,
 - Survey equipment,
 - Welding gloves & hood,
 - Bicycle repair kits, *and*
 - 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.

Food charges 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.



Note: The provider and/or the worker should also retain a copy of receipts.

The vocational provider must review food charges being billed:

- To remove 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.

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 non-covered items, *and*
- Sign the Statement for Retraining and Job Modification Services form (F245-030-000).



Link: The form is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1617.

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*
- 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.



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



Links: Related topics

If you're looking for more information about...	Then go here:
Administrative rules for corrective action for failure to notify about changes in status	Washington Administrative Code (WAC) 296-19A-260: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-19A-260 WAC 296-19A-270: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-19A-270
Administrative rules for fee caps on vocational services	Washington Administrative Code (WAC) 296-19A: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-19A
Becoming an L&I provider	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare and vocational services	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Files/ProviderPay/FeeSchedules/2015FS/fsAll.xls
L&I's Claim and Account Center	L&I's website: www.Lni.wa.gov/ORLI/LoGon.asp
Miscellaneous Services Billing Form and Instructions	L&I's website: http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627
Statement for Retraining and Job Modification form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1617
Submission of the Vocational Provider Change Form	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/

If you're looking for more information about...	Then go here:
<p>Submitting a vocational assessment or retraining plan for self-insured claims</p>	<p>What is the Self-Insurance Vocational Reporting Form? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4302</p> <p>What must the self-insurer do when an assessment report is received? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4304</p> <p>When must a self-insurer submit a vocational rehabilitation plan to the department? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4306</p> <p>What must the vocational rehabilitation plan include? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4308</p> <p>What must the self-insurer do when the department denies the vocational rehabilitation plan? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4310</p> <p>What must the self-insurer do when the vocational rehabilitation plan is successfully completed? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4312</p> <p>What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4314</p>

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