

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

Chapter 2: Information for All Providers

Effective July 1, 2016



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

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/



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Definitions

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.



Link: For the legal definition of **Bundled codes**, see: [WAC 296-20-01002](#).

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 the legal definition of **By report (BR)**, see [WAC 296-20-01002](#).

CPT[®], HCPCS, modifiers and local code modifiers are listed in the “More Info” section at the end of this chapter.:

Initial Visit: The first visit to a healthcare provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers compensation.

Medical Records: Includes all documentation to support the services billed.



Link: For more information, see [WAC 296-20-01002](#), [WAC 296-20-015](#), [WAC 296-20-025](#), [WAC 296-20-12401](#), and [WAC 296-20-065](#).



General information: All payment policies and fee schedules

Effective date of these policies and fee schedules

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2016.



Link: Find the L&I fee schedule at <http://feeschedules.Lni.wa.gov/>.

Who these rules, decisions, and policies apply to and when

Providers

All providers must follow the administrative rules, medical coverage decisions, and payment policies contained within the MARFS when providing services to injured workers, and when submitting bills either to the State Fund or to self-insurers.

Conflicting policies in CPT[®] or HCPCS

If there are any services, procedures or text contained in the physicians' Current Procedural Terminology (CPT[®]) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with the MARFS, the Department of Labor and Industries' (L&I) rules and policies take precedence.



Link: For more information, see WAC 296-20-010.

Claimants

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



Links: For more information on L&I WACs, go to:
www.Lni.wa.gov/ClaimsIns/Rules/MedicalAid/.

For more information on the Revised Code of Washington (RCW), go to:
<http://search.leg.wa.gov/>.

Questions may be directed to the:

- Provider Hotline at **1-800-848-0811**, *or*
- Crime Victims Compensation Program at **1-800-762-3716**, *or*
- Self-Insurance Section at **360-902-6901**.

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

MARFS updates and corrections

On occasion, between annual publications, updates and corrections are made to either the policies or the fee schedules. L&I publishes such updates and corrections on their website (see Links, below).

L&I Medical Provider News email listserv

To receive notices about payment policy and fee schedule updates and corrections, you can join the L&I Medical Provider News email listserv. Via email, listserv participants will receive:

- Updates and changes to the Medical Aid Rules and Fee Schedules, *and*
- Notices about courses, seminars, and new information available on L&I's website.



Links: Find updates and corrections at: <http://feeschedules.Lni.wa.gov/> under “Fee Schedules,” then “Updates & Corrections.”

Interested parties may join the L&I Medical Provider News electronic mailing list at:
www.Lni.wa.gov/Main/Listservs/Provider.asp.

How state agencies develop fee schedules and payment policies

To be as consistent as possible in developing billing and payment requirements for healthcare providers, Washington State government payers coordinate the development of their respective fee schedules and payment policies. The state government payers are:

- The Washington State Fund Workers' Compensation Program (administered by the Department of Labor and Industries, also known as "L&I"), *and*
- The State Medicaid Program (administered by the Medical Purchasing Administration within the Health Care Authority); *and*
- The Department of Corrections.

These agencies comprise the interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own funding source, benefit contracts, rates and conversion factors.

Maximum fees, not minimum fees

L&I establishes maximum fees for services; it doesn't establish minimum fees.

[RCW 51.04.030\(1\)](#) states that L&I shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule.

[WAC 296-20-010\(2\)](#) reaffirms that the fees listed in the fee schedule are maximum fees.



Link: For more information, see [RCW 51.04.030\(2\)](#) and [WAC 296-20-010\(2\)](#).

Payment review (audits)

All services rendered to workers' compensation claims are subject to audit by L&I.



Link: For more information, see [RCW 51.36.100](#) and [RCW 51.36.110](#).

Workers' choice of healthcare provider



Note: Also see information about the medical provider network (MPN) in the General information: Becoming a provider section of this chapter (under Provider credentialing and compliance).

Workers are responsible for choosing their healthcare providers. If provider network requirements apply, the worker may choose any network provider.

At the same time, the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow L&I and self-insured employers (collectively known as the insurer) to recommend particular providers or to contract for services:

- [RCW 51.04.030\(2\)](#) allows the insurer to recommend to the worker particular healthcare services or providers where specialized or cost effective treatment can be obtained; *however*,
- [RCW 51.28.020](#) and [RCW 51.36.010](#) stipulate that workers are to receive proper and necessary medical and surgical care from licensed providers of their choice.



Link: For more information, see [RCW 51.04.030\(2\)](#), [RCW 51.28.020](#), and [RCW 51.36.010](#).



General information: Becoming a provider

Provider credentialing and compliance



Note: Also see information about the Workers' choice of healthcare provider in the General information: All payment policies and fee schedules section of this chapter (above).

Medical provider network (MPN)

As part of Workers' Compensation Reform laws passed by the 2011 Washington Legislature, L&I created a statewide workers' compensation MPN. Network requirements apply to care delivered in Washington State.



Note: Network requirements don't apply to Crime Victim services.

The following types of providers treating workers (including those used by self-insured employers) **must be enrolled** in the network to continue treatment **beyond the initial visit**:

- Physicians,
- Osteopathic physicians,
- Naturopathic physicians,
- Podiatric physicians,
- Physician assistants,
- Chiropractors,
- Dentists,
- Advanced registered nurse practitioners, *and*
- Optometrists.

See definition of [initial visit](#).

Out-of-state providers and other types of providers are currently exempt and may continue to treat injured workers without joining the network.



Links: For more information on the MPN, see:

- [RCW 51.36.010](#), which establishes the legal framework of the network, *and*
- [WAC 296-20-01010](#), which establishes the scope of the network, *and*
- WAC 296-20-01020 through WAC 296-20-01090, available in [WAC 296-20](#), *and*
- The Join the Network webpage, which includes application materials as well as current information for affected providers, at: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/Network/, *and*
- The Provider Network and COHE Expansion webpage, which includes complete information on the network and the new standards, at: www.Lni.wa.gov/ClaimsIns/Providers/Reforms/.

Treating Washington's injured workers

A provider must have an active L&I provider account number to treat Washington's injured workers and receive payment for medical services. This includes all types of providers, regardless of whether they are required to join the network. For State Fund claims, this proprietary account number is necessary for L&I to accurately set up its automated billing systems.

The federally issued National Provider Identifier (NPI) must be registered with L&I before it can also be used on bills and correspondence submitted to L&I.

Applying for provider account numbers

Providers who aren't required to join the network can apply for L&I provider account numbers by completing the **Non-Network Provider Account Application** and **Statewide Payee Registration** form ([F248-011-000](#)).



Links: These L&I provider account forms and information on how to apply or make changes to your provider account are available at www.becomeprovider.Lni.wa.gov or can be requested by contacting:

- L&I's Provider Credentialing and Compliance section at **360-902-5140**, or
Provider Credentialing and Compliance
Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
- L&I's Provider Hotline at **1-800-848-0811**.

More information about the provider account application process is published in [WAC 296-20-12401](#).

Providers can apply for NPIs at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

Requirements of providers

All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure they are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

Billing for services

Once the L&I provider account number is established, and the federally issued NPI is also registered with L&I, either number can be used on bills and correspondence submitted to L&I.

Find a Doctor (FAD) website

If you have an active L&I provider account number, you may be listed on the searchable, online FAD database.



Link: FAD is available at: www.findadoc.Lni.wa.gov.

Keep your provider account up-to-date

To prevent payment delays, keep us informed of any changes to your account information by completing a **Provider Credentialing Change Form** (form [F245-365-000](#)) and the **Statewide Payee Registration** form (form [F248-036-000](#)).



Link: These forms are available at:

www.Lni.wa.gov/FormPub/Detail.asp?DocID=1650 and
www.Lni.wa.gov/FormPub/Detail.asp?DocID=1655.

Also, accurate information helps ensure smooth communication between:

- You,
- L&I,
- Workers, *and*
- Employers.

Self-insured employer accounts



Note: For information about setting up provider account(s) to bill for treating self-insured injured workers, see the “General information: Self-insured employers (SIEs)” section of this chapter, below.

Crime Victims Compensation Program accounts

Healthcare providers can use the same L&I provider number to bill for treating State Fund injured workers and crime victims.

Crime Victim providers are exempt from the provider network.

New providers can sign up for both programs at the same time using one provider application.



Links: You can contact the Crime Victims Compensation Program at **1-800-762-3716**, or

Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520

Also, provider resources for the Crime Victims Compensation Program are available on L&I's website at:

www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/.



General information: Charting format

Required format: SOAP-ER

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, and Plan and progress) format (see below). In workers' compensation there is a unique need for work status information. To meet this need, L&I requires that you add **ER** to the **SOAP** contents. Chart notes must document:

S Worker's Subjective complaints:

- What the worker states about the illness or injury.
- Those symptoms perceived only by the senses and feelings of the person being examined which can't be independently proven or established.



Link: For more information, refer to [WAC 296-20-220\(1\)\(j\)](#).

O Objective findings:

- What is directly observed and noticeable by the medical provider.
- This includes factual information, for example, physical exam – skin on right knee is red and edematous, lab tests – positive for opiates, X-rays – no fracture.
- Essential, elements of the injured worker's medical history, physical examination and test results that support the attending doctor's diagnosis, the treatment plan and the level of impairment.
- Those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examining physicians.



Link: For more information, refer to WAC [296-20-220\(1\)\(j\)](#).

A Assessment:

- What conclusions the medical provider makes after evaluating all the subjective and objective information. Conclusions may appear as:
 - A definite diagnosis (dx.),
 - A "Rule/Out" diagnosis (R/O), *or*
 - Simply as an impression.

- This can also include the:
 - Etiology (ET), defined as the origin of the diagnosis, *and/or*
 - Prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P Plan and Progress:

- What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment, and the plan must state how long the treatment will be administered.
- Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to workers.

E Employment issues:

- Has the worker been released or returned to work?
- When is release anticipated?
- Is the patient currently working, and if so, at what job?
- Include a record of the patient's physical and medical ability to work.
- Include information regarding any rehabilitation that the worker may need to enable them to return to work.

R Restrictions to recovery:

- Describe the physical limitations (temporary and permanent) that prevent or limit return to work.
- What other limitations, including unrelated conditions, are preventing return to work?
- Are any unrelated condition(s) impeding recovery?
- Can the worker perform modified work or different duties while recovering (including transitional, part time, or graduated hours)?
- Is there a need for return to work assistance?

Office notes, chart notes, progress notes, and 60-day reports should include the SOAPER contents.



Note: For additional information about chart note documentation requirements, please see General Information: Documentation Requirements.

For additional information about radiology documentation requirements, please see Chapter 26: [Radiology Services](#).



Link: For more information, refer to [WAC 296-20-010\(8\)](#) and [WAC 296-20-01002](#) (Chart notes).



General information: Documentation requirements How improper documentation could impact payment for services

Documentation of services

Providers must maintain documentation in workers' individual records to verify the level, type, and extent of services provided to workers.



Note: Chart notes: Must be submitted by each individual provider. Joint chart notes aren't acceptable.

- Each entry must be written for a single date of service.
- For treatment, must include a full description of treatment rendered as well as documentation of the area of the body treated.

Documentation must include the amount of time spent for each time-based service performed when:

- Procedures have a timed component in their descriptions, *and*
- Time is a determining factor in choosing the appropriate code.



Note: Documenting a range of time (for example, 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

All documentation to support the service billed must be received by the insurer prior to submitting your bill or within 30 days of the date of service, whichever comes first. The insurer may recoup, deny or reduce a provider's level of payment for a specific visit or service if the required documentation isn't provided or the level or type of service doesn't match the procedure code billed. Refer to [WAC 296-20-015](#).



Note: No additional amount is payable for documentation required to support billing.

Required content

The insurer **won't pay** for services unless the documentation includes the name and title of the person performing the service.



Links: For the legal definition of Chart notes, see [WAC 296-20-01002](#).



Note: Providers can submit forms with a signature stamp or an electronic signature from the medical provider.

Requirements in addition to CPT®

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. These requirements are described in the provider specific payment policy chapters of this document (MARFS) and in [WAC 296-20-06101](#).



Note: The insurer may pay separately for specialized reports or forms required for claims management.



Links: For more information, see [WAC 296-20-06101](#).

Changes to medical records

Changes made **after bill submission** won't be accepted. If a change to the medical record is made after bill submission, only the original record will be considered in determining appropriate payment of services billed to the insurer.

Changes to the **medical records** amended **prior to bill submission** may be considered in determining the validity of the services billed. All changes to medical records must be made according to the policies below.

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of services. A late entry, addendum, or correction to the medical record must:

- Note the current date of that entry, *and*
- Be signed by the person making the addition or change.



Note: This policy is based on American Health Information Management Association (AHIMA) and Centers for Medicare & Medicaid Services (CMS) guidelines.

Late entries

A late entry may be necessary to supply additional information that was omitted from the original entry or to provide additional documentation to supplement entries previously written. The late entry must:

- Note the current date,
- Be added as soon as possible, *and*
- Be written by the provider who performed the original service and only if the provider has total recall of the omitted information.

To document a late entry:

- Identify the new entry as a “late entry,” *and*
- Enter the current date and time – don’t try to give the appearance that the entry was made on a previous date or an earlier time, *and*
- Identify or refer to the date and incident for which the late entry is written, *and*
- If the late entry is used to document an omission, validate the source of additional documentation as much as possible.

Addendums

An addendum is used to provide information that wasn’t available at the time of the original entry.

To document an addendum:

- Identify the entry as an “addendum” and state the reason for the addendum referring back to the original entry, *and*
- Document the current date and time, *and*
- Identify any sources of information used to support the addendum.

Corrections

A correction to the **medical record** requires that these proper error correction procedures are followed:

- Draw a line through the entry making sure that the inaccurate information is still legible, *and*
- Initial and date the entry, *and*
- State the reason for the error, *and*
- Document the correct information.



Note: Late entries, addendums, and correction of electronic medical records should follow the same principles of tracking the information as noted above.

Falsified documentation

Deliberately falsifying **medical records** is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creating new records when records are requested, *or*
- Backdating entries, *or*
- Postdating entries, *or*
- Predating entries, *or*
- Writing over, *or*
- Adding to existing documentation (except as described in late entries, addendums, and corrections, above).



Links: For more information, see [RCW 51.48.270](#), [RCW 51.48.290](#) and [RCW 51.48.250](#).

Documentation requirements when referring worker for care outside of local community

Whenever it is necessary to refer an injured worker for specialty care or for services outside of the local community, include in the medical notes:

- The medical reason for the referral, *and*
- A statement of why it is reasonable or necessary to refer outside of the community.

Special reports and documentation for industrial insurance claims

In addition to the documentation requirements published by the American Medical Association in the Physicians’ Current Procedural Terminology book, L&I or the self-insurer has additional reporting and documentation requirements to adequately manage industrial insurance claims.

L&I or the self-insurer may request the reports listed in the following table. No additional amount is payable for these reports as they are required to support billing. L&I’s **Report of Accident** or the self-insurer’s **Physician’s Initial Report** are payable separately.



Notes:

- “Narrative report” (as used in the following table) merely signifies the absence of a specific form.
- Level of service is based on the documentation of services and the medical/clinical complexity as defined in the CPT® Evaluation & Management (E/M) coding requirements.
- Office/chart notes are expected to be legible and in the SOAP-ER format.



Links: For more information about the SOAP-ER format, see the “General information: Charting format” of [Chapter 2: Information for All Providers](#).

For any additional information on documentation requirements, see [WAC 296-20-06101](#).

If the service is...	And the relevant billing code(s) is...	Then the requirements are:
Case management, Telephone calls, <i>and</i> Online communications	CPT® 99366-99368 CPT® 99441-99444 CPT® 98966-98969	Documentation in the medical record should include: <ul style="list-style-type: none"> • The date, • The participants and their titles, • The length of the call or visit, • The nature of the call or visit, <i>and</i> • Any decisions made during the call.

If the service is...	And the relevant billing code(s) is...	Then the requirements are:
Chiropractic care visit	Local 2050A & 2051A	Office/chart notes.
	Local 2052A	Narrative report or office/chart notes showing the increased clinical complexity.
Consultation	CPT® 99241-99255	Narrative consultation report (for more information, see WAC 296-20-051). Due to the insurer within 15 days of consult.
Critical Care	CPT® 99291 & 99292	Narrative report or daily chart notes.
Emergency Room	CPT® 99281 & 99282	Report of Accident and ER report/notes in the hospital medical record.
	CPT® 99283-99285	Report of Accident and ER report.
Hospital	CPT® 99221-99223	Report of Accident and H&P.
	CPT® 99231-99238	Narrative report or an interval progress note.
Naturopathic Care Visit	Local 2130A, 2131A, & 2132A	Narrative reports and Report of Accident .
	Local 2133A	Chart notes.
	Local 2134A	Narrative report.
Nursing Facility	CPT® 99301-99303	Narrative report or facility notes and orders.
	CPT® 99311	Narrative or an interval progress note.
	CPT® 99312 & 99313	Narrative report or facility notes and orders.
Office Visit	CPT® 99201 & 99202	Report of Accident and office/chart notes due to the insurer in 5 days.
	CPT® 99203-99205	Report of Accident and office/chart notes. Due to the insurer in 5 days.
	CPT® 99211 & 99212	Office/chart notes.
	CPT® 99213-99215	Narrative report or office/chart notes showing the increased level of complexity.

If the service is...	And the relevant billing code(s) is...	Then the requirements are:
Prolonged Services	CPT® 99354-99359	Narrative or office/chart notes showing dates and times.
Psychiatric Services	CPT® 90785-90853	Narrative report.
Standby	CPT® 99360	Narrative or office/chart notes showing dates and times.
Miscellaneous	CPT® 99288 & 99499	Narrative report or emergency transport notes.



General information: Recordkeeping requirements

Which records a provider must keep

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. In the records you keep for each worker, you must include:

- Subjective and objective findings,
- Records of clinical assessment (diagnoses),
- Reports,
- Interpretations of X-rays,
- Laboratory studies,
- Other key clinical information in patient charts, *and*
- Any other information to support the level, type and extent of services provided.

How long a provider must keep records

All records

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years.



Note: The insurer may request records before, during or after the delivery of services to ensure workers receive proper and necessary medical care and to ensure provider compliance with the department's MARFS. The provider must submit the requested records within 30 calendar days from receipt of the request. Failure to do so may result in denial or recoupment of bill payment(s).



Link: For more information, see [WAC 296-20-02005 and WAC 296-20-02010](#).

X-rays

Providers are required to keep all X-rays for a minimum of 10 years.



Link: For more information, see [WAC 296-20-121](#) and [WAC 296-23-140](#).



General information: Self-insured employers (SIEs)

How Self-Insurance works in Washington

SIEs or their third party administrators (TPA) administer their own claims instead of paying premiums to the State Fund for L&I to administer.

SIEs must authorize treatment and pay bills according to [Title 51 RCW](#) and the Medical Aid Rules (WACs) and Fee Schedules of the state of Washington ([WAC 296-15-330\(1\)](#)), including the payment policies described in this manual.

For SIE claims, healthcare providers should send their bills, reports, requests for authorization, and other correspondence directly to the SIE/TPA.



Links: For a list of SIE/TPAs go to:

www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

SIE/TPA provider identification numbers

To bill SIE/TPAs for workers' compensation claims, contact the individual insurer directly for their provider identification number requirements.

Medical Provider Network providers should use their individual NPI in Box 24J of the CMS 1500 form to facilitate prompt payment.

Special SIE claim forms

Self-Insurer Accident Report (SIF-2)

SIEs use the **SIF-2** to establish a new claim and assign a claim number.

Only the SIE and the worker complete the **SIF-2**.



Link: Employers: To order a supply of SIF-2s, go to:

www.Lni.wa.gov/FormPub/Detail.asp?DocID=2466.

Provider's Initial Report (PIR)

PIR forms are supplied to providers to assist self-insured injured workers in filing claims. The PIR is used in the same way the **Report of Accident (ROA)** Workplace Injury or Occupational Disease form is used for State Fund covered workers.

Only the provider and the worker complete the PIR.



Link: Providers: To order a supply of PIRs, go to:
www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467.

Providers may bill for interest on medical bills for self-insured claims only

Providers are entitled to bill interest for late payment of any proper medical bills on self-insured claims ([RCW 51.36.085](#)).

- Use Local Code 1159M to bill for interest.
- Use the [Self-Insurance Medical Bill Interest Calculator](#) to calculate the correct interest due. Call (360) 902-6938 with questions.



Link: Self-Insurance Medical Bill Interest Calculator:
<http://www.Lni.wa.gov/apps/SIMBIC/>

Disputes between providers and SIEs

The Self-Insurance (SI) Program of L&I regulates the SIEs for compliance with RCW, WAC, Policies, and fee schedules.

If a dispute arises between a provider and an SIE, the provider may ask the SI program to intervene and help resolve the dispute. For disputes related to:

- **Treatment authorization or nonpayment of bills**, the SI Claims Adjudicator assigned to the claim will handle the dispute. Call the Self-Insurance Program's receptionist at 360-902-6901 to be directed to the appropriate claim adjudicator.
- **Underpayments of bills**, the SI section medical compliance consultant will handle the dispute. Complete and submit Self-Insurance Medical Provider Billing Dispute form ([F207-207-000](#)). Call 360-902-6938 with questions.



Link: Self-Insurance Medical Provider Billing Dispute form:
www.Lni.wa.gov/FormPub/Detail.asp?DocID=2557



General information: Submitting claim documents to the State Fund

How to submit

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. The imaging system can't read some types of paper and has difficulty passing other types through automated machinery.

Documents faxed to the department are automatically routed to the claim file; paper documents are manually scanned and routed to the claim file.



Note: Don't fax bills! (See more information in the table under "Where to submit," below.)

Do's

When submitting documents:

- Submit documents on white 8 ½ x 11-inch paper (one side only), *and*
- Leave ½ inch at the top of the page blank, *and*
- Put the patient's name and claim number in the upper right hand corner of each page, *and*
- If there is no claim number available, substitute the patient's social security number, *and*
- Reference only one worker/patient in a report or letter. *and*
- Staple together all documents pertaining to one claim, *and*
- Emphasize text using asterisks or underlines, *and*
- Include a key to any abbreviations used, *and*
- Submit legible information.

Don'ts

When submitting documents:

- Don't use colored paper, particularly hot or intense colors, *and*
- Don't use thick or textured paper, *and*

- Don't send carbonless paper, *and*
- Don't use any highlighter markings, *and*
- Don't place information within shaded areas, *and*
- Don't use italicized text, *and*
- Don't use paper with black or dark borders, especially on the top border, *and*
- Don't staple documents for different workers/patients together.

Where to submit

Submitting State Fund bills, reports, and correspondence to the correct addresses or fax numbers:

- Helps L&I process your documents promptly and accurately,
- Can prevent significant delays in claim management,
- Can help you avoid repeated requests for information you have already submitted, *and*
- Helps L&I pay you promptly.



Note: Attending providers have the ability to send secure messages through the Claim and Account Center at: www.Lni.wa.gov/ORLI/LoGon.asp.

The following table shows where you may fax or send correspondence and reports.

If you are submitting...	Then you can fax to:	Or send to this State Fund mailing address:
<p>Report of Accident (ROA) Workplace Injury or Occupational Disease (also known as "Accident Report" or "ROA") (F242-130-000)</p>	<p>360-902-6690 800-941-2976</p> <p>Hot ROA Fax for hospital admissions 360-902-4980</p> <p>These fax numbers are for ROAs only!</p>	<p>Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299</p>
<ul style="list-style-type: none"> • Correspondence, 	<p>360-902-4567</p>	<p>Department of Labor & Industries</p>

If you are submitting...	Then you can fax to:	Or send to this State Fund mailing address:
<ul style="list-style-type: none"> • Activity Prescription Forms (APFs), • Reports and chart notes for State Fund Claims, <i>and</i> • Claim related documents other than bills. 		PO Box 44291 Olympia, WA 98504-4291 Reports and chart notes must be submitted separately from bills.
Provider Account information updates	360-902-4484	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261
Bills , including: <ul style="list-style-type: none"> • UB-04 forms, • CMS 1500 forms, • Retraining & job modification bills, • Home nursing bills, • Miscellaneous bills, • Pharmacy bills, • Compound prescription bills, <i>and</i> • Requests for adjustment. 	Don't fax bills!	Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund refunds (attach copy of remittance advice)	n/a	Cashier's Office Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835



Link: [Billing Forms and Publications:
www.Lni.wa.gov/MedicalProviderBillingPaymentDocs](http://www.Lni.wa.gov/MedicalProviderBillingPaymentDocs)



Payment policy: All professional services

Coverage of procedures

Medical coverage decisions

To ensure quality of care and prompt treatment of workers, L&I makes general policy decisions (called “medical coverage decisions”). Medical coverage decisions include or exclude a specific healthcare service as a covered benefit.



Link: For more information on coverage decisions and covered services, refer to www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/

Procedure codes that aren’t covered

Procedure codes listed as “**not covered**” in the fee schedules aren’t covered for the following reasons:

1. The treatment isn’t safe or effective, or is controversial, obsolete, investigational, or experimental, *or*
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases, *or*
3. The procedure or service is payable under another code.

On a case by case basis, the insurer may pay for procedures in the first two categories above. To be paid, the healthcare provider must:

- Submit a written request, *and*
- Obtain approval from the insurer prior to performing any procedure in these categories.

The request must contain:

- The reason,
- The potential risks and expected benefits,
- The relationship to the accepted condition, *and*
- Any additional information about the procedure that may be requested by the insurer.



Link: For more information on coverage decisions and covered services, refer to [WAC 296-20-01505](#), WAC 296-20-02700 through -02850 available in [WAC 296-20](#), WAC 296-20-030 through -03002 available in [WAC 296-20](#), and [WAC 296-20-1102](#).

Requirements for billing

Unlisted codes

Some covered procedures don't have a specific code or payment level listed in the fee schedule. When reporting such a service, the appropriate unlisted procedure code may be used. A special report is required as supporting documentation including a full description of the procedure or services performed and an explanation of why the services were too unusual, variable or complex to be billed using the established procedure codes and modifiers. Whenever possible, list the most similar procedure code or codes to the services performed including units of service.



Note: No additional payment is made for the supporting documentation.



Links: For more information, refer to: [WAC 296-20-01002](#) and to the fee schedules available at: <http://feeschedules.Lni.wa.gov>.

Physician Assistants (PAs)

To be paid for services, PAs must:

- Be certified and have valid individual L&I provider account numbers, *and*
- Bill for services using their provider account numbers, *and*
- Use the appropriate billing modifiers outlined at the end of this chapter. For example, to bill for Assistant at Surgery, the PA would use **modifier –80, –81, or –82** as appropriate.

Payment limits

Units of service

Payment for billing codes that don't specify a time increment or unit of measure is limited to one unit per day. For example, only one unit is payable for CPT[®] code **97022** regardless of how long the therapy lasts.

Physician Assistants (PAs)

Physician assistant services are paid to the supervising physician or employer at a **maximum of 90%** of the allowed fee.



Link: For more information about physician assistant services and payment, see [WAC 296-20-12501](#) and [WAC 296-20-01501](#).

PAs may sign any documentation required by the department. Consultations and impairment ratings services related to workers' compensation benefit determinations aren't payable to physician assistants.



Link: For more information, see [RCW 51.28.100](#) and [WAC 296-20-01501](#).



Payment policy: Billing codes and modifiers

Procedure codes used in the fee schedules

L&I's fee schedules use the federal HCPCS and agency unique local codes (see more information, below).

Procedure codes and modifiers



Note: The descriptions and complete coding information are found in the current CPT[®] or HCPCS manuals.

The fee schedule lists all covered codes (including bundled, by report and the maximum fee) and some non-covered codes. If a code isn't listed in the fee schedule, it isn't covered.



Link: For more information, please see our complete fee schedule available at:

www.lni.wa.gov/ClaimsIns/Files/ProviderPay/FeeSchedules/2016FS/fsallcsv.csv

Code description limits

Due to space limitations, only partial descriptions of HCPCS or CDT[®] codes appear in the fee schedules.

Due to copyright restrictions, there aren't descriptions for CPT[®] codes in the fee schedules.

Providers' responsibility when billing

Providers must bill according to the full text descriptions published in the CDT[®], CPT[®], and HCPCS books. These books can be purchased from private sources.



Link: For more information, refer to [WAC 296-20-010\(1\)](http://www.wac.wa.gov/WAC296200101).

CPT[®] codes (HCPCS Level I codes)

Codes

HCPCS (commonly pronounced “hick picks”), Level I codes are the CPT[®] codes developed, updated, and copyrighted annually by the American Medical Association (AMA). There are three categories of CPT[®] codes:

- **CPT[®] Category codes** are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, and don't include newly emerging technologies. The codes consist of five numbers (for example, **99201**), *and*
- **CPT[®] Category II codes** are optional and used to facilitate data collection for tracking performance measurement. The codes consist of four numbers followed by an **F** (for example, **0001F**), *and*
- **CPT[®] Category III codes** are temporary and used to identify new and emerging technologies. The codes consist of four numbers followed by a **T** (for example, **0001T**).

Modifiers

HCPCS Level I modifiers are the CPT[®] modifiers developed, updated, and copyrighted by the AMA. These modifiers are used to indicate that a procedure or service has been altered without changing its definition.

These modifiers consist of two numbers (for example, **-22**).



Note: L&I doesn't accept the five digit modifiers.

HCPCS Level II codes and modifiers

Codes

HCPCS Level II codes (usually referred to simply as “HCPCS codes”) are updated by the Center for Medicare & Medicaid Services (CMS). HCPCS codes are used to identify:

- Miscellaneous services,
- Supplies,
- Materials,
- Drugs, *and*
- Professional services.

These codes begin with one letter, followed by four numbers (for example, **K0007**).

Codes beginning with **D** are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3[®]).

Modifiers

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered.

These modifiers consist of either:

- Two letters (for example, **-AA**), or
- One letter and one number (for example, **-E1**).

Local codes and modifiers

Codes

Local codes are used to identify unique services or supplies.

These codes consist of four numbers followed by one letter (except F and T). For example, **1040M**, which must be used to code completion of the State Fund’s **Report of Accident** and Self-Insurer’s **Providers Initial Report** forms.

L&I will modify local code use as national codes become available.

Modifiers

Local code modifiers are used to identify modifications to services.

These modifiers consist of one number and one letter (for example, **-1S**).

L&I will modify local modifier use as national modifiers become available.

Quick reference guide for all billing codes and modifiers

If the billing code type is...	Then the purpose of the code is:	And the code format is:	And the modifier format is:	And the source of the code is:
HCPCS Level I: CPT® Category I	Professional services, pathology and laboratory tests.	5 numbers	2 numbers	AMA/ CMS

If the billing code type is...	Then the purpose of the code is:	And the code format is:	And the modifier format is:	And the source of the code is:
HCPCS Level I: CPT® Category II	Tracking codes, to help collect data for tracking performance measurement.	4 numbers followed by F	n/a	AMA/ CMS
HCPCS Level I: CPT® Category III	Temporary codes for new and emerging technologies.	4 numbers followed by T	n/a	AMA/ CMS
HCPCS Level II (HCPCS code)	Miscellaneous services, supplies, materials, drugs, and professional services.	1 letter followed by 4 numbers	2 letters, <i>or</i> 1 letter followed by 1 number	AMA/ CMS
Local code (unique to L&I)	L&I unique services, materials, and supplies.	4 numbers followed by 1 letter (but not F or T)	1 number followed by 1 letter	L&I



Payment policy: Billing instructions and forms

Who to bill (which insurer)

Each insurer uses a unique format for claim numbers. This will help you identify which insurer to bill for a specific claim:

- **State Fund** claims either begin with:
 - The letters **A, B, C, F, G, H, J, K, L, M, N, P, X, Y** or **Z** followed by six digits, *or*
 - **Double alpha letters** (example AA) followed by five digits.
- **Self-insured claims** either begin with:
 - **S, T, or W** followed by six digits, *or*
 - **Double alpha letters** (example SA) followed by five digits.



Note: Claims for contractors hired to clean up the Hanford Nuclear Reservation for the Department of Energy (US) are self-insured.

- **Crime Victims claims** either begin with:
 - **V** followed by six digits, *or*
 - **Double alpha letters** (example VA) followed by five digits.
- **Federal claims** begin with **A13** or **A14**.



Link: Questions and billing information about federal claims should be directed to the U.S. Department of Labor at **202-693-0036** or **206-470-3100** or **866-692-7487** (Northwest district) or their website at: www.dol.gov/owcp/.

Medicare claims

If a worker has an allowable workers' compensation injury or illness, workers' compensation is always the primary insurance for the injury or illness.

- Medicare is never a secondary payer for workers' compensation claims. The workers' compensation insurer's payment is the full payment.
- Medicare can't be billed for allowed workers' compensation claims.

- If Medicare is incorrectly billed for a workers' compensation claim, the provider is required to reimburse all payments made by Medicare. Covered services provided to injured workers may only be billed to L&I or the self-insurer.

Report of Accident (ROA/PIR) requirements

Providers now have the option to file State Fund ROAs online via FileFast.

Online filing of the State Fund accident report reduces delays in claim management.

Benefits of filing a ROA online:

- Immediate confirmation of receipt.
- Faster authorization for treatment and prescription refills.
- Increases accuracy (reduces common mistakes).
- The provider is instantly assigned to the claim.
- Pharmacists can fill additional prescriptions.
- Quick access to the claim at www.ClaimInfo.Lni.wa.gov.
- \$10 additional reimbursement for online filing (code **1040M**).

ROAs/PIRs submitted within 5 business days after an injured worker's initial visit are paid at a higher rate than ROAs/PIRs submitted after 5 business days. The insurer pays for completion of ROAs/PIRs on a graduated scale based on when they are received by the insurer following the "Initial visit"/"This exam date" (box 15b on the paper ROA form, and box 3 on the PIR form).

	Within 5 days	6-8 days	9 days or more
Max fee via paper or fax	\$40.28	\$30.18	\$20.08
Max fee via FileFast – State Fund only (additional \$10 incentive)	\$50.38	\$40.28	\$30.18



Note: When filing State Fund ROAs via [FileFast](#) make sure to add the \$10 web incentive to your bill.



Link: Information about online filing options is available at www.filefast.Lni.wa.gov or by calling 877-561-3453.

Payment adjustments on State Fund claims

Providers should bill their usual and customary charges. For ROAs received more than 5 business days from “This exam date” (box 15b on paper ROA), L&I’s payment system automatically reduces the ROA payment.

Payments are increased for participation in the Centers of Occupational Health and Education (COHE) or for online claim-filing ([FileFast](#)).

Payment for completion of the ROA/ Providers Initial Report (PIR)

A provider with a valid provider account number may be paid for completing an ROA or PIR if they are licensed as one of the following:

- Advanced Registered Nurse Practitioner (ARNP)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (DPM)
- Medical Doctor (MD)
- Naturopathic Doctor (ND)
- Doctor of Optometry (OD)
- Physician Assistant Certified (PA-C)

Billing requirements

- Bill only one ROA or PIR per claim, using local code **1040M**.

- Submit the ROA or PIR to the insurer immediately following the “Initial visit”/“This exam date”.
- Complete the ROA [F242-130-000](#) (English) or [F242-130-999](#) (Spanish) using the instructions on the form.
- Complete the PIR using instructions on the back of form [F207-028-000](#). If you need additional space:
 - Attach the information to the application, *and*
 - Include the claim number at the top of the page.



Note: Reimbursement amount is based on the date the healthcare provider includes in box 15b of the paper ROA, and in box 3 of the PIR, Attending Health Care Provider section, (This exam date.). If that box is blank, the department’s payment system will look at box 16 of the paper ROA (Signature of the health care provider.) and the self-insurer will look at box 13, (Date) in the Attending Health Care Provider section. To ensure correct payment, make sure the ROA/PIR is filled out completely.

Billing procedures



Link: Information on billing procedures is outlined in [WAC 296-20-125](#).

Billing manuals and billing instructions

The **General Provider Billing Manual** ([F248-100-000](#)) and L&I’s provider specific billing instructions contain:

- Billing guidelines,
- Reporting and documentation requirements,
- Resource lists, *and*
- Contact information.



Link: Providers can download this manual on L&I’s website at www.Lni.wa.gov/FormPub/

Billing workshops

L&I offers providers free billing workshops to help you save time and money by:

- Learning to bill L&I correctly,
- Getting new tools for doing business with L&I, *and*
- Meeting your Provider Account Representatives.



Link: Additional information on the workshops is available at www.Lni.wa.gov/ClaimsIns/Providers/Billing/Workshop/.

Electronic billing for State Fund bills

Electronic billing is available to all providers of services to injured workers covered by the State Fund. Electronic billing is helpful because it:

- Allows greater control over the payment process,
- Eliminates entry time,
- Allows L&I to process payments faster than paper billing,
- Reduces billing errors, *and*
- Decreases the costs of bill processing.



Link: See “Electronic/Paper Bill Cost Comparison Estimator” at www.Lni.wa.gov/ClaimsIns/Files/providers/EstimatorFinal042009.xls.

There are three secure ways providers can bill L&I electronically:

1. Free online billing form (no specific software/clearinghouse required), *or*
2. Upload bills using your software (the department doesn't supply billing software for electronic billing), *or*
3. Use an [intermediary/clearinghouse](#).



Note: Your correspondence and reports may be faxed to L&I.



Links: Fax numbers can be found in the “Submitting claim documents to the State Fund” payment policy section (later in this chapter) or on L&I’s website at: www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/How/.

For additional information on electronic billing:

- Go to www.ElectronicBilling.Lni.wa.gov, or
- Contact the Electronic Billing Unit at:

Phone: **360-902-6511**

Fax: **360-902-6192**

Email: ebulni@Lni.wa.gov

Billing forms

Providers must use L&I’s current billing forms.



Note: Using out of date billing forms may result in delayed payment.



Links: **Medical provider forms** can be found on L&I’s website at: <http://www.Lni.wa.gov/FormPub/>

When to submit a billing adjustment vs. a new bill to the State Fund

Submit a new bill when an entire bill was previously denied.

Submit an adjustment when you were paid for part of previously submitted bill.



Link: Additional information on adjustments is available at www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/.

When provider can bill worker for missing scheduled appointment

Workers are expected to attend scheduled appointments.

[WAC 296-20-010\(5\)](#) states: L&I or self-insurers won't pay for a missed appointment unless the appointment is for an examination arranged by L&I or the self-insurer.

A provider may bill a worker for a missed appointment per [WAC 296-20-010\(6\)](#) if the provider:

- Has a missed appointment policy that applies to all patients regardless of payer, *and*
- Routinely notifies all patients of the missed appointment policy.

Providers must notify the claim manager immediately when an injured worker misses an appointment.



Note: L&I or self-insurers aren't responsible or involved in the implementation and/or enforcement of any provider's missed appointment policy.



Link: For more information, see [WAC 296-20-010\(5\) and \(6\)](#).



Payment policy: Current coverage decisions for medical technologies and procedures

Coverage decisions for medical technologies and procedures



Link: For more information on these decisions, see www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/.



Payment policy: Overview of payment methods

Ambulatory Surgery Center (ASC) payment methods

ASC rate calculations

Insurers use a modified version of the ASC payment system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC.



Link: For more information on this payment method, see Chapter 32: [Ambulatory Surgery Centers \(ASCs\)](#) or refer to [WAC 296-23B](#).

By report

Insurers pay for some covered services on a **by report** basis. Fees for **by report** services may be based on the value of the service as determined by the report.



Note: See definition of **by report** in “Definitions” at the beginning of this chapter.

Maximum fees

For services covered in ASCs that aren't priced with other payment methods, L&I establishes maximum fees.

Hospital inpatient payment methods



Link: The following is an overview of the hospital inpatient payment methods. For more information, see Chapter 35: [Hospitals](#) or refer to [WAC 296-23A](#).

Self-insurers

Self-insurers use Percentage of Allowed Charges (POAC) to pay for all hospital inpatient services.



Link: For more information, see [WAC 296-23A-0210](#).

All Patient Refined Diagnosis Related Groups (APR DRG)

L&I uses All Patient Refined Diagnosis Related Groups (APR DRGs) to pay for most inpatient hospital services.



Link: For more information, see [WAC 296-23A-0200](#).

Per diem

L&I uses statewide average per diem rates for five APR DRG categories:

- Chemical dependency,
- Psychiatric,
- Rehabilitation,
- Medical, *and*
- Surgical.

Hospitals paid using the APR DRG method are paid per diem rates for APR DRGs designated as low volume.

Percent of Allowed Charges (POAC)

L&I uses a POAC payment method:

- For some hospitals exempt from the APR DRG payment method, *and*
- As part of the outlier payment calculation for hospitals paid by the APR DRG.

Hospital outpatient payment methods



Link: The following is an overview of the hospital outpatient services payment methods. For more information, see Chapter 35: [Hospitals](#) or refer to [WAC 296-23A](#).

Self-insurers

Self-insurers use the maximum fees in the Professional Services Fee Schedule to pay for:

- Radiology,
- Pathology,
- Laboratory,
- Physical therapy, *and*
- Occupational therapy services.

Self-insurers use POAC to pay for hospital outpatient services that aren't paid with the Professional Services Fee Schedule.



Link: For more information, see [WAC 296-23A-0221](#).

Ambulatory Payment Classifications (APC)

L&I pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.



Link: For more information, see [WAC 296-23A-0220](#).

Professional Services Fee Schedule

L&I pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.



Link: The Professional Services Fee Schedule is available at <http://feeschedules.Lni.wa.gov>.

Percent of Allowed Charges (POAC)

Hospital outpatient services are paid by a POAC payment method **when they aren't paid:**

- With the APC payment method, *or*
- The Professional Services Fee Schedule, *or*
- By L&I contract.

Out-of-state hospital payment methods



Link: For information on out-of-state hospital outpatient, inpatient, and professional services payment methods, see [WAC 296-23A-0230](#).

Pain management payment methods

Chronic Pain Management Program fee schedule

Insurers pay for Chronic Pain Management Program Services using an all-inclusive, phase based, per diem fee schedule.

Professional provider payment methods



Links: The following is an overview of the payment methods for professional provider services. For more information, see the relevant payment policy chapters or refer to [WAC 296-20](#), [WAC 296-21](#), and [WAC 296-23](#).

The Professional Services Fee Schedule is available at www.FeeSchedules.Lni.wa.gov.

Resource Based Relative Value Scale (RBRVS)

Insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services.

Services priced according to the RBRVS fee schedule have a fee schedule indicator of **R** in the Professional Services Fee Schedule.



Links: More information about RBRVS is contained in Chapter 31: [Washington RBRVS Payment System](#).

Anesthesia fee schedule

Insurers pay for most anesthesia services using anesthesia base and time units.



Link: For more information, see Chapter 4: [Anesthesia Services](#).

Pharmacy fee schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule.



Link: For more information, see Chapter 24: [Pharmacy Services](#).

Drugs paid using Average Wholesale Price (AWP)

L&I's maximum fees for some covered drugs administered in or dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug.

Drugs priced with an AWP method have **AWP** in the "Dollar Value" columns and a **D** in the fee schedule indicator ("FSI") column of the Professional Services Fee Schedule.



Links: For more information, see Chapter 24: [Pharmacy Services](#).

For a definition of “Average Wholesale Price” (AWP), see [WAC 296-20-01002](#).

Clinical laboratory fee schedule

L&I’s clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS.

Services priced according to L&I’s clinical laboratory fee schedule have a fee schedule indicator (“FSI”) of **L** in the Professional Services Fee Schedule.

Flat fees

L&I establishes rates for some services that are priced with other payment methods.

Services priced with flat fees have a fee schedule indicator (“FSI”) of **F** in the Professional Services Fee Schedule.

State Fund contracts

State Fund pays for utilization management services by contract.

Services paid by contract have a fee schedule indicator (“FSI”) of **C** in the Professional Services Fee Schedule.



Note: The Crime Victims Compensation Program doesn’t contract for these services.

By report

Insurers pay for some covered services on a **by report** basis. Fees for **by report** (BR) services may be based on the value of the service as determined by the report.

Services paid **by report** have a fee schedule indicator (“FSI”) of **N** in the Professional Services Fee Schedule and **BR** in other fee schedules.



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

Program only

Insurers pay for some unique services under specific programs. Example programs include:

- Centers for Occupational Health Education (COHE), *and*
- Orthopedic and Neurological Surgeon Quality Project.

Residential facility payment methods

Boarding Homes and Adult Family Homes

Insurers use per diem fees to pay for medical services provided in Boarding Homes and Adult Family Homes.

Nursing Homes and Transitional Care Units utilizing swing beds for long term care

Insurers use modified Resource Utilization Groups (RUGs) to develop daily per diem rates to pay for Nursing Home Services.

Critical Access Hospitals and Veterans Hospitals utilizing swing beds for sub-acute care or long term care

Insurers use hospital specific POAC rates to pay for sub-acute care (swing bed) services.



Payment policy: Split billing – treating two separate conditions

Requirements for billing

If the worker is treated for two separate conditions at the same visit, the charge for the service must be divided equally between the payers.



Links: For more information, see [WAC 296-20-06101\(10\)](#), and the **General Provider Billing Manual** (publication [F248-100-000](#)), and [Chapter 10. Evaluation and Management \(E/M\) Services](#).

Related Topics: Modifiers that affect payment



Note: Only modifiers that affect payment are listed in this section. Refer to current CPT® and HCPCS books for a complete list of modifiers, with their descriptions and instructions.

CPT® code modifiers

–22 Increased Procedural Services

Procedures with this modifier may be individually reviewed prior to payment. A report detailing the increased complexity of the procedure is required for this review. Payment varies based on the report submitted.

–24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period

Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

–25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

–26 Professional component

Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the –26 nor the –TC modifier should be used. (See above for information on the use of the –TC modifier.)

–47 Anesthesia by surgeon

–50 Bilateral surgery

The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier –50 should be applied to the second line item.

–51 Multiple surgeries

For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

–52 Reduced services

Payment is made at the fee schedule level or billed charge, whichever is less.

–53 Discontinued services

CMS has established reduced RVUs for CPT® code **45378** when billed with **modifier –53**. L&I prices this code-modifier combination according to those RVUs.

–54 Surgical care only (see Note, below)

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

–55 Postoperative management only (see Note, below)

When one physician performs the postoperative management and another physician has performed the surgical procedure.

–56 Preoperative management only (see Note, below)

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.



Note: When providing less than the global surgical package, providers should use modifiers **–54**, **–55**, and **–56**. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

–57 Decision for surgery

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

–58 Staged or related procedure or service by the same physician during the postoperative period

Used to report a surgical procedure that is staged or related to the primary surgical procedure and is performed during the global period.

–62 Two surgeons

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases. Both surgeons must submit separate operative reports describing their specific roles.

–66 Team surgery

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Each surgeon must submit separate operative reports describing their specific roles.

–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.

–78 Return to the operating room for a related procedure during the postoperative period

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–79 Unrelated procedure or service by the same physician during the postoperative period

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–80 Assistant surgeon (see below)**–81 Minimum assistant surgeon (see below)****–82 Assistant surgeon (when qualified resident surgeon not available)**

Assistant surgeon modifiers. Physicians who assist the primary physician in surgery should use **modifiers –80, –81, or –82** depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to

the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable. If fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in your report to receive payment.

–91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)

Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test don't qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient record.

–99 Multiple modifiers

This modifier should only be used when two or more modifiers affect payment.

Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only **modifier –99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.**

HCPCS code modifiers

–AA Anesthesia services performed personally by anesthesiologist

–E1 Upper left eyelid

–GM Multiple patients on one ambulance trip

–GT Interactive telecommunication

Teleconsultations via interactive audio and video telecommunication systems.



Link: Payment policies for teleconsultations are located in [Chapter 10: Evaluation and Management \(E/M\) Services](#).

–LT Left side

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–NU New purchased DME

Use the **–NU** modifier when a new DME item is to be purchased.

–P1 A normal healthy patient

- P2 A patient with mild systemic disease**
- P3 A patient with severe systemic disease**
- P4 A patient with severe systemic disease that is a constant threat to life**
- P5 A moribund patient who is not expected to survive without the operation**
- P6 A declared brain-dead patient whose organs are being removed for donor purposes**
- QK Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals**
- QX CRNA service: with medical direction by a physician**
- QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**
- QZ CRNA service: without medical direction by a physician**
- RR Rented DME**

Use the **–RR** modifier when DME is to be rented.
- RT Right side**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.
- SG Ambulatory surgical center (ASC) facility service**

Bill the appropriate CPT® surgical code(s) adding this **modifier –SG** to each surgery code.
- SU Procedure performed in physician's office**

Denotes the use of facility and equipment while performing a procedure in a provider's office.
- TC Technical component**

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the **–26 nor the –TC modifier should be used.** (See above for information on the use of the **–26** modifier.)
- UN Two patients served**
- UP Three patients served**
- UQ Four patients served**
- UR Five patients served**

–US Six or more patients served

Local code modifiers

–1S **Surgical dressings for home use**

Bill the appropriate HCPCS code for each dressing item using this **modifier –1S** for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

–3R **Billing for advanced imaging procedures**

This code is billed by gold card providers when billing advanced imaging procedures subject to utilization review.

–7N **X-rays and laboratory services in conjunction with an IME**

When X-rays, laboratory, and other diagnostic tests are provided with an exam, identify the service(s) by adding the **modifier – 7N** to the usual procedure number.

–8R **COHE modifier for case management codes and consultations**

Identifies when COHEs bill for these codes and adjusts payments.

–8S **COHE modifier for health services coordinators (HSCs)**

This modifier allows HSCs to bill for some services more than once per day.



Link: Procedure codes are listed in the L&I Professional Services Fee Schedules, Radiology and Laboratory Sections, available at <http://feeschedules.Lni.wa.gov>.



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Administrative rules for billing procedures	WAC 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
Administrative rules for charting requirements	WAC 296-20-220: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-220 WAC 296-20-01002: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01002
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Administrative rules for missed appointments (worker no shows)	WAC 296-20-010(5) and (6): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-010
Administrative rules for Physician Assistants (PAs)	WAC 296-20-12501: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-12501 WAC 296-20-01501: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01501
Administrative rules for provider credentialing and compliance	WAC 296-20-01010 through WAC 20-01090 available in WAC 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20 WAC 296-20-12401: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-12401
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Fee schedules for all healthcare and vocational services	L&I's website: http://feeschedules.Lni.wa.gov
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General Provider Billing Manual (publication F248-100-000)	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2148
Join the Network	L&I's website: www.JoinTheNetwork.Lni.wa.gov
Laws (from Washington state Legislature) for documentation requirements	Revised Code of Washington (RCW) 51.48.290: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.48.290 RCW 51.48.270: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.48.270 RCW 51.48.250: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.48.250
Laws for Medical Aid	RCW 51.04.030(2): http://apps.leg.wa.gov/rcw/default.aspx?cite=51.04.030 RCW 51.28.020: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.28.020

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Laws for Physician Assistants (PAs)	RCW 51.28.100: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.28.100
L&I's Claim and Account Center	L&I's website: www.Lni.wa.gov/ORLI/LoGon.asp
L&I Medical Provider News electronic mailing list	L&I's website: www.Lni.wa.gov/Main/Listservs/Provider.asp
Payment policies for Ambulatory Surgery Centers (ASCs)	Chapter 32: Ambulatory Surgery Centers (ASCs)
Payment policies for anesthesia services	Chapter 4: Anesthesia Services
Payment policies for hospitals	Chapter 35: Hospitals
Payment policies for pharmacy services	Chapter 24: Pharmacy Services
Payment policies for radiology services	Chapter 26: Radiology Services
Payment policies for the Resource Based Relative Value Scale (RBRVS)	Chapter 31: Washington RBRVS Payment System
Provider Accounts Change Form (form F245-365-000)	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1650
Provider's Initial Report form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467
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