Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 27: Reports and Forms

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, see WAC 296-20-01002.

- **Job analysis (JA):** A JA is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

- **Job description:** A job description is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

- **Job offer:** A job offer is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis.

Link: For more information about job offers, see RCW 51.32.090(4).

Payment policy: Copies of medical records

Who must perform these services to qualify for payment

Only providers who have provided healthcare services to the worker may bill HCPCS codes **S9981** or **S9982**.

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Services that can be billed

If the insurer requests records from a healthcare provider, the insurer will pay for the requested services.

Note: The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury.

Providers may bill for CD/DVDs of medical records requested by the insurer using HCPCS code **S9981** (maximum fee is **$26.20)**.

Payment will be made per complete record requested by the insurer.

Providers may bill for paper copies of medical records requested by the insurer using HCPCS code **S9982** (maximum fee is **$)0.52** per page).

Payment will be made per copied page.

Payment limits

Payment for **S9981** and **S9982** includes all costs, including postage.

S9981 and **S9982** aren't payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

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Payment policy: Reports and forms

Services that can be billed

To bill for special reports or forms required by the insurer, providers should use the CPT® or local billing codes listed in the following table. The fees listed in the table below include postage for sending documents to the insurer.

Note: When required, the insurer will send special reports and forms.

If the **report or form** is…	Then bill using this **CPT® or local billing code:**	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
60 Day Report	99080	**$46.32**	60 day reports are required per WAC 296-20-06101 and don't need to be requested by the insurer. Payment will not be made for records required to support billing or for review of records included in other services. Limit of 1 per provider per 60 days per claim.
Special Report (Requested by insurer or VRC)	99080	**$46.32**	**Must be requested by insurer or vocational counselor.** Payment will not be made for records or reports required to support billing or for review of records included in other services. Don't use this code for forms or reports with assigned codes. Limit of 1 per day.
AP Final Report	1026M	**$26.61**	**May be requested by insurer or submitted by attending provider.** Payable only to attending provider. Limit of 1 per day.
Loss of Earning Power (LEP)	1027M	**$20.15**	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per day.

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If the **report or form** is…	Then bill using this **CPT® or local billing code:**	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Report of **Accident** (ROA) Workplace Injury, or Occupational Diseasefor State Fund claims	**1040M**		MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.
		$40.28	**When submitted within 5 business days after first treatment date**
		$30.18	**When submitted 6-8 business days after first treatment date**
		$20.08	**When submitted 9 or more business days after first treatment date**
Provider's Initial Report (PIR) – for Self Insured claims	**1040M**		MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.
		$40.28	**When submitted within 5 business days after first treatment date**
		$30.18	**When submitted 6-8 business days after first treatment date**
		$20.08	**When submitted 9 or more business days after first treatment date**
Application to Reopen Claim	**1041M**	**$52.36**	MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.

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If the **report or form** is…	Then bill using this **CPT® or local billing code:**	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Occupational Disease History Report	**1055M**	**$195.40**	**Must be requested by insurer.** Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s). See the Attending Doctor's Handbook for specific instructions in preparing this report.
Attending Doctor Review of Independent Medical Exam (IME)	**1063M**	**$40.28**	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per request.
Attending Doctor IME Written Report	**1065M**	**$30.21**	**Must be requested by insurer.** Payable only to attending provider when submitting a separate report of IME review. Limit of 1 per request.
Provider Review of Video Materials with report	**1066M**	**By report**	**Must be requested by insurer.** Payable once per provider per day. Report must include actual time spent reviewing the video materials. Won't pay in addition to CPT® code **99080** or local codes **1104M** or **1198M**.

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If the **report or form** is…	Then bill using this **CPT® or local billing code:**	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Activity Prescription Form (APF)	**1073M**	**$52.36**	Submit the Activity Prescription Form (APF): • With the Report of Accident when there are work related physical restrictions, or • When documenting a change in your patient's medical status or capacities. Limits: A provider may submit up to 6 APFs per worker within the first 60 days of the initial visit date and then up to 4 times per 60 days thereafter. The insurer will review and allow or deny any APFs submitted over the limits listed above. Providers will be paid for properly completed APFs. requested by the insurer, even if the provider has already reached the limit by self-generating prior APFs. Payable once per provider per worker per day.
AP response to VRC/Employer request about RTW	**1074M**	**$32.22**	For written communication with vocational counselors (VRC) and employers. Team conference, office visit, telephone call, or online communication with a VRC or employer can't be billed separately. A copy of the written communication must be sent to the insurer.
Subacute Opioid Request	**1076M**	**$32.22**	Use this code if submitting the Subacute Opioid Request Form but

If the **report or form** is…	Then bill using this **CPT® or local billing code:**	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Form for Pain without Documentation			results of screenings are documented in the medical record. (See WAC 296-20-03056.)
Subacute Opioid Request Form for Pain with Documentation	**1077M**	**$60.43**	Use this code if submitting the Subacute Opioid Request Form and copies of all required screenings (urine drug test, risk of opioid addiction, current or former substance use disorder and depression, if indicated) for increased reimbursement. (See WAC 296-20-03056.)
Opioid Request Form for Chronic Pain	**1078M**	**$32.22**	Use this code if submitting the Chronic Opioid Request Form. (See WAC 296-20-03057 and WAC 296-20-03058.)

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

Links: More information on some of the reports and forms listed above is provided in WAC 296-20-06101.

Many L&I forms are available and can be downloaded from: www.Lni.wa.gov/FormPub/ and all reports and forms may be requested from the Provider Hotline at **1-800-848-0811**.

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Payment policy: Review of job offers and job analyses

(See definitions of **Job analysis (JA), Job description** and **Job offer** in Definitions at the beginning of this chapter.)

Prior authorization

Prior authorization is required for review of JAs and job descriptions if not requested by the insurer, employer or vocational provider.

Who must perform these services to qualify for payment

Job offers

Attending providers must review the physical requirements documented in the job description or job analysis of any job offer submitted by the employer of record and determine whether the worker can perform that job.

Note: Whenever the employer asks, the attending provider should send the employer an estimate of physical capacities or physical restrictions and review each job description or job analysis submitted by the employer to determine whether the worker can perform that job. A copy of the estimate of physical capacities or physical restrictions and each job description or job analysis reviewed must be sent to the insurer.

JAs and job descriptions

Attending providers, independent medical examiners and consultants will be paid for review of job descriptions or JAs.

Notes: A job description/JA review may be performed at the request of the employer, the insurer, vocational rehabilitation counselor (VRC), or TPA. This service is payable in addition to other services performed on the same day. The provider must send a copy of each job description or job analysis reviewed to the insurer.

Reviews requested by other persons (for example, attorneys or workers) won't be paid.

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Services that can be billed

If the **report or form** is…	Then bill using this **CPT® or local billing code:**	Which has a **maximum fee** of:	Also, be aware of these **special notes** about the report or form:
Review of Job Descriptions or JA	**1038M**	**$52.36**	**Must be requested by insurer, employer or vocational provider.** Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Isn't payable to IME examiner on the same day as the IME is performed.
Review of Job Descriptions or JA, each additional review	**1028M**	**$39.28**	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Bill to L&I. For IME examiners on day of exam: may be billed for each additional JA after the first 2. For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using **1038M**).

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for information in this chapter	Washington Administrative Code (WAC) 296-20-06101: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-06101 WAC 296-20-097: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-097 WAC 296-20-03056: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03056 WAC 296-20-03057: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03057 WAC 296-20-03058: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03058
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare services	L&I's website: www.feeschedules.Lni.wa.gov
L&I forms	L&I's website: www.Lni.wa.gov/FormPub/

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