Washington State Department of
Labor & Industries
Workers' Compensation Services

Medical Aid Rules and Fee Schedules (MARFS)

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

Effective July 1, 2016

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This document is also on the department's Internet web site at http://feeschedules.Lni.wa.gov/.

Washington State Department of
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Workers' Compensation Services

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

Chapter 1: Introduction

Effective July 1, 2016

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General information: About MARFS and this manual

What is MARFS?

The Medical Aid Rules and Fee Schedules (MARFS) is a package of information about how workers' compensation insurers in Washington State pay for healthcare and vocational services provided to injured workers and crime victims.

MARFS includes three things:

- **Medical aid rules** published in the Washington Administrative Codes (WACs) for industrial insurance (workers' compensation),
- **Fee schedules** for healthcare and vocational professional provider and facility services, *and*
- This **payment policies manual**.

What is in this manual?

This manual contains 36 chapters, of payment policies for healthcare and vocational services provided by individual professional providers or facilities.

A payment policy for a specific service can include information about:

- Prior authorization,
- Who must perform specific services to qualify for payment,
- Services that can be billed or that aren't covered,
- Requirements for billing,
- Payment limits, *or*
- Other information, such as payment methods, background information on coverage decisions, unique requirements, and examples to illustrate billing procedures.

Note: Not every payment policy includes all of these elements. When one of the above elements isn't included, it is because the information isn't applicable. When the elements do appear, they are consistently presented in the same order.

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Beyond this introductory chapter, in this manual you will find:

- One chapter on **general policies and information** for all providers,
- 29 chapters for **professional services**, which contain payment policies for individual professional healthcare and vocational providers, and interpreters, *and*
- 5 chapters for **facility services**, which contain payment policies for healthcare facilities.

Note: Within each of the services sections, the chapters appear alphabetically.

What part of MARFS isn't in this manual?

This manual doesn't include:

- **Fee schedules**, which contain the maximum fees (payment amounts) for the authorized billing codes providers use to bill for services,
- The **field key**, which explains the column headings and abbreviations that appear in the fee schedules,
- **Medical aid rules**, which are the L&I specific WACs, *or*
- **Updates and Corrections**, which contains any changes to policies and fees that occur between annual publications of this manual (see more about these changes, below, under, How do I know if a policy is current?).

Links: The fee schedules (including the field key) are available on L&I's website, at http://feeschedules.Lni.wa.gov.

Medical Aid Rules are available in Title 296 WAC on the Washington State Legislature's website, at http://apps.leg.wa.gov/wac/default.aspx?cite=296.

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How do I know if a policy is current?

The policies in this manual are updated and published at the start of each fiscal year (July 1), and are effective for services provided on or after that date (until the next publication of this manual).

Sometimes changes do occur between publications of this manual. Such changes are communicated to providers through L&I's Medical Provider News email listserv and are also documented on an Updates & Corrections page on L&I's website.

Links: To see the Updates and Corrections webpage, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/Updates2016.

For information about how to join the email listserv, see the "General information: All payment policies and fee schedules" section of Chapter 2: Information for All Providers.

General information: About the layout and design

How is each chapter organized?

Payment policies for general types of services are organized into individual chapters. Each chapter contains:

- A title page with a **Table of contents** for the chapter,
- Followed by **payment policies** for specific services, or **general information**, *and*
- At the end of the chapter, a table with links to **related topics**.

Some chapters also include **definitions** of key terms, including descriptions of billing code modifiers. When a chapter does contain definitions, they appear immediately following the Table of contents.

Visual cues

Visual cues and icons appear consistently throughout the payment policies manual. The following is a list of these icons and visual cues, with descriptions of how they are used:

Bulleting:

Bullet lists are used to organize complex information and break it up into manageable pieces.

Link:

Direct links to related information that may be of interest and assistance are provided. These include links to other chapters within the payment policies manual, to internet website addresses, or to specific WACs and RCWs.

Note:

Notes appear throughout the manual to draw attention to additional useful information.

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Table of contents:

The same icon always appears next to the Table of contents.

Definitions or general policy information:

The same icon always appears next to Definitions or next to general policies that aren't payment policies.

Payment policy:

The same icon always appears next to each payment policy.

Sample pages

Below are illustrations of actual chapter content (from the printable version of the manual) to show how information appears throughout.

Sample title page:

Each state fiscal year (which begins July 1), L&I publishes updated policies.

Sometimes updates or corrections occur between annual publications. The Link on the title page will bring you to the website that lists such changes.

The Payment policies appear in alphabetical order.

To jump to a specific page, click on a page number.

Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 7: Chiropractic Services

Effective July 1, 2011

Link: Look for possible **updates and corrections** to these payment policies at
www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2011/default.asp#3

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Sample payment policy page:

On every page, the printable version tells you what chapter you're reading.

To help you track down the specific information you need more quickly, each policy topic stands out in large, bold-faced type.

Each page number includes:

- The chapter number,
- A dash, *and*
- The page number.

Payment policy: Physical capacities evaluation

Who must perform these services to qualify for payment

To quality for payment, a physical capacities evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

Services that can be billed

Qualified providers can bill local code **1045M** (performance based physical capacities evaluation with report and summary of capacities), which has a maximum fee of **$705.78**.

Requirements for billing

The evaluation must be provided as a one on one service.

Payment limits

Local code **1045M** is payable only once per 30 days.

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General information: Highlights of policy changes since July 1, 2015

Note: These highlights are intended for general reference; they aren't a comprehensive list of all the changes in the payment policies or fee schedules.

For complete code descriptions and lists of new, deleted, or revised codes, refer to the 2015 CPT© and HCPCS coding books.

Washington Administrative Code (WAC) and payment changes

The following changes to WACs and payment rates occurred:

- Cost of living adjustments were applied to RBRVS and anesthesia services or to most local codes,
- WAC 296-20-135 increases the anesthesia conversion factor to $3.41 per minute ($51.15 per 15 minutes) and the RBRVS conversion factor increases to $61.52,
- WAC 296-23-220 and WAC 296-23-230 increases the maximum daily cap for physical and occupational therapy services to **$125.68**, *and*
- WAC 296-23-250 set a daily cap for massage therapy of **75%** of the daily cap for PT/OT services. The rate for July 1, 2016 increases to **$94.26**.

Policy & fee schedule additions, changes, and clarifications

Professional services chapters

- All Appendices have been removed and pertinent information moved into the appropriate chapters.

Information previously found in:	Can now be found in:
Appendix A: Bundled Services and Appendix D: Endoscopy Families	Feeschedules.Lni.wa.gov
Appendix B: Bundled Supplies	Chapter 28: Supplies, Materials and Bundled Services

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Appendix C: Documentation Requirements Appendix E: Modifiers Effecting Payment	Chapter 2: Information for All Providers
Appendix F: Non-covered Codes and Modifiers	Feeschedules.Lni.wa.gov shows non-covered codes Chapter 2: Information for All Providers which lists non-covered modifiers

- The Psychiatric Services Chapter has been renamed Mental Health Services and chapters have been renumbered accordingly.
- In Chapter 2: Information for All Providers, language was added clarifying documentation requirements, modifiers, and how to change medical records. A definition of medical records was added.
- In Chapter 5: Audiology and Hearing Services, wax guards are reimbursed at $1.25 each up to a maximum 150 per calendar year. Wax guards are billed using code 5095V. This service can't be billed as part of a repair.
- In Chapter 5, Audiology and Hearing Services, the insurer will reimburse service for replacement of tubes and domes at $25 per visit. This amount includes binaural replacement. Tubes and domes are billed using code 5094V. This service:
    - can be billed a maximum 18 times per calendar year,
    - can be billed in conjunction with a quarterly cleaning visit,
    - can't be billed as part of a repair.
- In Chapter 12: Impairment Rating Services, local billing code 1190M has been added for a comprehensive hearing loss exam.
- In Chapter 14: Interpretive Services, face-to face interpretive services must be recorded on the updated L&I Interpreting Services Appointment Record (ISAR) 06-2015 form. **The insurer will no longer accept provider created services forms.** The revised L&I ISAR form must be used and must be signed by the interpreter. The ISAR form is available at: http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1625. To avoid bill denial the completed ISAR form must be in the claim file by the time the bill is processed. Mileage has been clarified to state it is payable only for personally owned vehicles and is reimbursed only in **whole miles**. Calculate mileage from point to point, rounding each trip up to the nearest whole mile.

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In Chapter 23: Pathology and Laboratory Services, new codes have been added and old codes have been deleted for drug screens.

- In Chapter 29: Surgery Services, links have been added to L&I's coverage decisions. A link to L&I's coverage decision on tobacco cessation for surgical candidates has been added.

Facility services chapters

In the facility services chapters, fees including Hospital APR DRG rates have been updated.

Fee schedules

With the exception of the comma delimited files, the Field Keys are integrated into the fee schedules.

The following fee schedules, factors, and rates have been updated:

- Professional fees,
- Durable medical equipment fees,
- Prosthetics and orthotics fees,
- Laboratory fees,
- Pharmacy fees,
- Dental fees,
- Interpreter fees,
- Hospital percent of allowed charge (POAC) factors,
- Hospital rates,
- Hospital ambulatory payment classification (APC) rates,
- Residential fees, *and*
- Ambulatory surgery center (ASC) fees.

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General information: Tips on finding information in the printable version

To navigate through this manual

Table of contents

In the Table of contents, the page numbers are links to the page.

"Bookmarks"

The Bookmarks tab (see the far left of this manual in the PDF viewer) is a feature of Adobe Acrobat. You can use the bookmark links to jump around this manual. If the "Bookmarks" tab isn't open, you can open it by clicking on "Bookmarks":

- Click on any text in the list to go to the information within this manual,
- Click on the plus (+) sign to open each section's list for more information, *and*
- Click on the minus (-) sign to close the section.

Search

The Find box is another feature of Adobe Acrobat. Follow the instructions to search for the item or topic you need.

To search for a word, press Ctrl+F. Follow the instructions to search for the item or topic you need.

Note: In Adobe Acrobat, the search function won't find an item if it is misspelled.

Hyperlinks

Use the two kinds of hyperlinks within this manual. Internal jump links are similar to the Bookmark links mentioned above.

To find information on a specific procedure

There are two places to look for information about a specific procedure:

- Review the payment policy, (which is inside this manual), *or*
- Review the fee schedule, (which is outside of this manual).

Link: The fee schedules are available at: http://feeschedules.Lni.wa.gov.

To print information within this manual

Use the Print icon, which is on the same menu as the Binocular Search icon.

Note: This print feature will give you options specific to printing this Adobe Acrobat file (PDF), which allows you to print a specific page or the entire document.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for industrial insurance (workers' compensation)	Washington Administrative Code (WAC) Title 296: http://apps.leg.wa.gov/wac/default.aspx?cite=296
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 professional services	L&I's website: http://feeschedules.Lni.wa.gov

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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/.

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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.

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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**.

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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.

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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/.

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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)(i).

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.

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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

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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.

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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, *and* Online communications	CPT® **99366-99368** CPT® **99441-99444** CPT® **98966-98969**	Documentation in the medical record should include: • The date, • The participants and their titles, • The length of the call or visit, • The nature of the call or visit, *and* • Any decisions made during the call.

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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.

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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.

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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.

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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.

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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.

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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*

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- 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**:
Report of Accident (ROA) Workplace Injury or Occupational Disease (also known as "Accident Report" or "ROA") (F242-130-000)	**360-902-6690** **800-941-2976** Hot ROA Fax for hospital admissions **360-902-4980** **These fax numbers are for ROAs only**!	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
• **Correspondence**,	**360-902-4567**	Department of Labor & Industries

If you are **submitting**…	Then you can **fax** to:	Or send to this **State Fund mailing address**:
• Activity Prescription Forms (**APFs**), • **Reports and chart notes** for State Fund Claims, *and* • **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: • UB-04 forms, • CMS 1500 forms, • Retraining & job modification bills, • Home nursing bills, • Miscellaneous bills, • Pharmacy bills, • Compound prescription bills, *and* • 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

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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.

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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.

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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).

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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.

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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

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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, *or* 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.

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- 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**.

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- 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.

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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).

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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.

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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.

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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.

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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.

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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.

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–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.

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–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

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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**

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–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, identity 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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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for Ambulatory Surgery Center (ASC) payment methods	Washington Administrative Code (WAC) 296-23B: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23B
Administrative rules for average wholesale price (AWP)	WAC 296-20-01002: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01002
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
Administrative rules for coverage decisions	WAC 296-20-01505: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01505 WAC 296-20-02700 through -02850 available in WAC 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20 WAC 296-20-030 through -03002 available in WAC 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20 WAC 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102
Administrative rules for documentation requirements	WAC 296-20-06101: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-06101
Administrative rules for hospital payment methods	WAC 296-23A: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23A

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Administrative rules for initial visit	WAC 296-20-01002 http://app.leg.wa.gov/WAC/default.aspx?cite=296-20-01002 WAC 296-20-015: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-015 WAC 296-20-025 http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-025 WAV 296-20-12401 http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-12401 WAC 296-20-065 http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-065
Administrative rules for Medical Aid	WAC 296-20-010: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-010
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
Administrative rules for recordkeeping requirements	WAC 296-20-121: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-121

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Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing adjustments	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/
Billing workshops for providers	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Billing/Workshop/
Cost Comparison Estimator for electronic versus paper billing	L&I's website: www.Lni.wa.gov/ClaimsIns/Files/providers/EstimatorFinal042009.xls
Crime Victims Compensation Program	L&I's website: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/
Coverage decisions for medical technologies and procedures	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/
Electronic billing	L&I's website: www.ElectronicBilling.Lni.wa.gov
Fax numbers for **sending correspondence** to the State Fund	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/How/
Federal injured worker claims	U.S. Department of Labor website: www.dol.gov/owcp/

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Federally issued **National Provider Identifier (NPI)**	National Plan & Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov/NPPES/Welcome.do
Fee schedules for all healthcare and vocational services	L&I's website: http://feeschedules.Lni.wa.gov
FileFast website	L&I's website: www.filefast.Lni.wa.gov
Find a Doctor (FAD) website	L&I's website: www.Lni.wa.gov/ClaimsIns/Claims/FindaDoc/
Forms and Publications	Download on L&I's website: http://www.Lni.wa.gov/FormPub/
General information about **WACs and RCWs**	Info on WACs, on L&I's website: www.Lni.wa.gov/ClaimsIns/Rules/MedicalAid/ Info on RCWs, on Washington State Legislature's website: http://apps.leg.wa.gov/rcw/
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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	RCW 51.36.010: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.010 RCW 51.36.100: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.100 RCW 51.36.110: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.110
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
Provider Network and COHE	L&I's website:

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Expansion	www.Lni.wa.gov/ClaimsIns/Providers/Reforms/
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Report of Accident (ROA) Workplace Injury or Occupational Disease form (also known as "Accident Report" or "ROA"; form F242-130-000)	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599
Self-Insurer Accident Report (SIF-2) form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2466
Self-insured employer (SIE) or third party administrator (TPA) contact information	L&I's website: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 3: Ambulance Services

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

- **Bed confined criteria:** The worker is:
  - Unable to get up from bed without assistance, *and*
  - Unable to ambulate, *and*
  - Unable to sit in a chair or wheelchair.
- **Destination:** Nearest place of proper treatment.
- **HCPCS code modifier mentioned in this chapter:**

  –GM Multiple patients on one ambulance trip
- **Loaded miles:** Miles traveled from the pickup of the worker(s) to their arrival at the destination.

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Payment policy: All ambulance services

(See definitions of **loaded miles** and **destination** in Definitions at the beginning of this chapter.)

When these services are paid

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated.

Payment is based on the level of medically necessary services provided, not only on the vehicle used.

How mileage is paid

The insurer pays for **mileage** (ground and/or air) based only on **loaded miles**, which are the miles traveled from the pickup of the worker(s) to their arrival at the **destination**.

Note: The **destination** is defined as the nearest place of proper treatment.

Vehicle and crew requirements

To be eligible to be paid for ambulance services for workers, the provider must meet the criteria for vehicles and crews established in WAC 246-976 Emergency Medical Services and Trauma Care Systems and other requirements as established by the Washington State Department of Health for emergency medical services.

Links: Key sections of this WAC are:

- **General:** WAC 246-976-260 Licenses required,
- **Ground ambulance vehicle requirements:**
  - WAC 246-976-290 Ground ambulance vehicle standards,
  - WAC 246-976-300 Ground ambulance and aid vehicles—Equipment,
  - WAC 246-976-310 Ground ambulance and aid vehicles--Communications equipment,

  - WAC 246-976-390 Trauma verification of prehospital EMS services,

- **Air ambulance services:** WAC 246-976-320 Air ambulance services,
- **Personnel:**
  - WAC 246-976-182 Authorized care,
  - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines.

Services that can be billed

HCPCS code	Description	Fee schedule
A0425	Ground mileage, per statute mile	**$13.62** per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	$674.74
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	$700.33
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	$368.59
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	$589.76
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	$6,017.77
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	$6,996.52
A0433	Advanced Life Support, Level 2 (ALS 2)	$1,013.65
A0434	Specialty care transport (SCT)	$1,197.94
A0435	Fixed wing air mileage, per statute mile	$33.49
A0436	Rotary wing air mileage, per statute mile	**$77.82** per mile
A0999	Unlisted ambulance service	By report restrictions: (1) Reviewed to determine if a more appropriate billing code is available, *and* (2) Reviewed to determine if medically necessary.

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Payment policy: Arrival of multiple providers

Payment limits

When multiple providers respond to a call for services:

- Only the provider that transports the worker(s) is eligible to be paid for the services provided, *and*
- No payment is made to the other provider(s).

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Payment policy: Emergency air ambulance transport

Payment limits

Air ambulance transportation services, either by helicopter or fixed wing aircraft, will be paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that couldn't have been provided by ground ambulance, *or*
- The point of pickup is inaccessible by ground vehicle, *or*
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

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Payment policy: Multiple patient transportation

How these services are paid

The insurer pays the appropriate base rate for each worker transported by the same ambulance.

When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported.

Requirements for billing

The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

The provider must use HCPCS code **modifier –GM** (Multiple patients on one ambulance trip) for the appropriate mileage billing codes.

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Payment policy: Nonemergency transport

Who may arrange for these services

Only medical providers may arrange for nonemergency ambulance transportation.

Note: Workers may not arrange nonemergency ambulance transportation.

Medical necessity requirements

Nonemergency transportation by ambulance is appropriate if:

- The worker is **bed confined** (see **bed confined** criteria, below), and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated, *or*
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Note: **Bed confined** criteria are that the worker is:

- Unable to get up from bed without assistance, *and*
- Unable to ambulate, *and*
- Unable to sit in a chair or wheelchair.

Nonemergency transportation may be provided on a **scheduled** (repetitive or nonrepetitive) or **unscheduled** basis:

- **Scheduled**, nonemergency transportation may be repetitive (for example, services regularly provided for diagnosis or treatment of the worker's accepted medical condition) or nonrepetitive (for example, single time need).
- **Unscheduled** services generally pertain to nonemergency transportation for medically necessary services.

Note: The insurer reserves the right to perform a post audit on any nonemergency ambulance transportation billing to ensure medical necessity requirements are met.

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Payment policy: Proper facilities

What makes a facility a place of proper treatment

To be a place of proper treatment, the facility must be generally equipped to provide the needed medical care for the worker.

A facility isn't considered a place of proper treatment if no bed is available when inpatient medical services are required.

Payment limits

The insurer pays the provider for ambulance services to the nearest place of proper treatment.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for ambulance services	Washington Administrative Code (WAC) 246-796: http://apps.leg.wa.gov/wac/default.aspx?cite=246
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 professional services (including ambulance services)	L&I's website: http://feeschedules.Lni.wa.gov

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

Chapter 4: Anesthesia Services

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

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

–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.

–47 **Anesthesia by surgeon**

–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.

–AA **Anesthesia services performed personally by anesthesiologist**

–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**

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Payment policy: All anesthesia services

Who must perform these services to qualify for payment

Payment for anesthesia services will only be made to:

- Anesthesiologists, *and*
- Certified registered nurse anesthetists.

Services that can be billed

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes **00100** through **01999** and the appropriate anesthesia modifier.

Some selected services are paid using the RBRVS method.

Note: For information on **base and time units** and **RBRVS** methods for anesthesia services, see other payment policy sections of this chapter.

Services that aren't covered

Anesthesia isn't payable for procedures that aren't covered.

The insurer doesn't cover anesthesia assistant services.

Payment for CPT® codes **99100, 99116, 99135**, and **99140** is considered bundled and isn't payable separately.

CPT® physical status **modifiers** (**–P1** to **–P6**) and CPT® 5-digit **modifiers** aren't accepted.

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Requirements for billing

Anesthesia add-on codes

Anesthesia add-on codes must be billed with a primary anesthesia code. There are three anesthesia add-on CPT® codes: **01953, 01968**, and **01969**:

- Add-on code **01953** should be billed with primary code **01952**,
- Add-on codes **01968** and **01969** should be billed with primary code **01967**,
- Add-on codes **01968** and **01969** should be billed in the same manner as other anesthesia codes paid with base and time units.

Note: Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the **CMS 1500** form (F245-127-000).

Anesthesia for burn excisions or debridement (CPT® add-on code 01953)

The anesthesia add-on code for burn excision or debridement must be billed as follows:

If the **total body surface area** is…	Then the **primary code** to bill is:	And the **units to bill of add-on code 01953** is:
Less than 4 percent	**01951**	None
4 - 9 percent	**01952**	None
Up to 18 percent	**01952**	1
Up to 27 percent	**01952**	2
Up to 36 percent	**01952**	3
Up to 45 percent	**01952**	4
Up to 54 percent	**01952**	5
Up to 63 percent	**01952**	6
Up to 72 percent	**01952**	7
Up to 81 percent	**01952**	8
Up to 90 percent	**01952**	9
Up to 99 percent	**01952**	10

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Anesthesia base units

List only the time in minutes on your bill. Don't include the base units (L&I's payment system automatically adds the base units).

Note: Most of L&I's anesthesia base units are the same as the units adopted by CMS. L&I differs from the CMS base units for some procedure codes based on input from the ATAG (see more about the ATAG in Additional information: How anesthesia payment policies are established, below).

Link: The anesthesia codes, base units, and base sources are listed in the Professional Services Fee Schedule, available at: http://feeschedules.Lni.wa.gov.

Anesthesia time

Anesthesia must be billed in one-minute time units. Anesthesia time:

- **Begins** when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent), *and*
- **Ends** when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision).

Anesthesia billing code modifiers for anesthesia paid with base and time units

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs should use the CPT® or HCPCS **modifiers** in the following table.

Note: For complete **modifier** descriptions and instructions, refer to a current CPT® or HCPCS book.

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Note: Except for **modifier –99**, the **modifiers** listed in the following table aren't valid for anesthesia services paid by the RBRVS method.

For use by:	CPT® or HCPCS code modifier	Brief description	Notes:
Anesthesiologists and CRNAs	**–99**	Multiple modifiers	Use this modifier when 5 or more modifiers are required. Enter **–99** in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.
Anesthesiologists	**–AA**	Anesthesia services performed personally by anesthesiologist	—
	–QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
CRNAs[(1)]	**–QX**	CRNA service: with medical direction by a physician	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
	–QZ	CRNA service: without medical direction by a physician[(1)]	Maximum payment is 90% of the maximum allowed for physician services.

[(1)] Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services (see Team care payment policy at the end of this chapter).

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Payment limits

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure.

Note: Patient acuity doesn't affect payment levels.

Services billed with **modifier –47** (anesthesia by surgeon) are considered bundled and aren't payable separately.

Services billed with CPT® 5-digit **modifiers** and physical status **modifiers** (**–P1** through **–P6**) aren't paid.

CRNA services are paid at a maximum of 90% of the allowed fee that would be paid to a physician.

Note: CRNA services shouldn't be reported on the same **CMS-1500** form used to report anesthesiologist services.

Links: For licensed nursing rules, see WAC 296-23-240.

For licensed nursing billing instructions, see WAC 296-23-245.

For detailed billing instructions, including examples of how to submit bills, refer to L&I's **General Provider Billing Manual** (form F248-100-000).

Payment policy: Base and time units payment method for anesthesia

How to calculate anesthesia payment paid with base and time units

Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

For services provided on or after July 1 2016, the anesthesia conversion factor is **$51.15** per 15 minutes (**$3.41** per minute).

Link: The anesthesia conversion factor is published in WAC 296-20-135.

The maximum payment for anesthesia services paid with base and time units is calculated using the:

- Base value for the procedure, *and*
- Time the anesthesia service is administered, *and*
- L&I anesthesia conversion factor.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15, *then*
2. Add the value from step 1 to the total number of whole minutes, *then*
3. Multiply the result from step 2 by **$3.41**.

   Example: CPT® code **01382** (anesthesia for knee arthroscopy) has three anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

   1. 3 base units x 15 = 45 base units,
   2. 45 base units + 60 time units (minutes) = 105 base and time units,
   3. Maximum payment for physicians = 105 x **$3.41** = **$358.05**.

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Payment policy: RBRVS payment method for anesthesia

Which services are paid using the RBRVS method

Some services commonly performed by anesthesiologists and CRNAs are paid using the RBRVS payment method, including:

- Anesthesia evaluation and management services, *and*
- Most pain management services, *and*
- Other selected services.

Injection code treatment limits

If the **injection type** is…	Then the **treatment limit** is:
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Limited** to 2 injections, same side, per date of service **Limited** to 3 injections per 6 months; 3rd requires documented improvement **Limited** to 4 injections per 365 day-period
Facet injections	**Not covered**, except in preparation for facet neurotomy. Limited to 2 joint levels bilaterally, or 3 unilaterally per day of service.
Intramuscular injections of steroids and other nonscheduled medications.	**Maximum of 6** injections per patient are allowed.
Dry needling and trigger point injections without medications	**Maximum of 6** sessions per patient per claim.

Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations, as opposed to the distant points or meridians used in acupuncture.

Note: L&I doesn't cover acupuncture services (see WAC 296-20-03002(2)).

Links: Details regarding treatment guidelines and limits for the injections listed above can also be found in WAC 296-20-03001(7) (for example, dry needling follows the same rules as trigger point injections).

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For information on billing for medications, see Chapter 16: Medication Administration and Injections.

Requirements for billing

Dry needling of trigger points should be billed using trigger point injection codes.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action.

When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed in the Units column (Field 24G on the **CMS-1500 form**).

Link: Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule, available at http://feeschedules.Lni.wa.gov.

When using **modifiers**:

- Anesthesia **modifiers –AA**, **–QK**, **–QX**, **–QY**, and **–QZ** aren't valid for services paid by the RBRVS method.

  For a complete list of modifiers and descriptions, see a current CPT® or HCPCS book.

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the provider who is performing the procedure, *or*
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service.

Link: For more information on using the **–25 modifier**, see the All E/M services payment policy section of Chapter 10: Evaluation and Management (E/M) Services chapter.

The use of E/M codes on days after the procedure is performed is subject to the global surgery policy.

Link: For more information, see the Global surgery payment policy section of Chapter 29: Surgery Services .

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Payment limits

Anesthesia teaching physicians

Teaching physicians may be paid at the personally performed rate when the physician is involved in the training of physician residents in:

- A single anesthesia case, *or*
- Two concurrent anesthesia cases involving residents, *or*
- A single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

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Payment policy: Team care (Medical direction of anesthesia)

Requirements for medical direction of anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, *and*
- Prescribe the anesthesia plan, *and*
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, *and*
- Make sure any procedures in the anesthesia plan that he/she doesn't perform are performed by a qualified individual as defined in program operating instructions, *and*
- Monitor the course of anesthesia administration at frequent intervals, *and*
- Remain physically present and available for immediate diagnosis and treatment of emergencies, *and*
- Provide indicated postanesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, *and*
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation requirements for team care

Documentation requirements for team care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician doesn't submit documentation to the insurer, but must make it available upon request.

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Requirements for billing

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate **CMS-1500** forms using their own provider account numbers,
- Anesthesiologists must use the appropriate **modifier** for medical direction or supervision (**–QK** or **–QY**),
- CRNAs should use **modifier –QX**.

How to calculate payment for team care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services (see the How to calculate anesthesia payment paid with base and time units in the payment policy for Base and time units payment method for anesthesia section of this chapter),
- The maximum payment to the physician is 50% of the maximum payment for solo physician services,
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

Additional information: How team care policies are established

L&I follows CMS's policy for team care (medical direction of anesthesia).

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for acupuncture services non-coverage	Washington Administrative Code (WAC) 296-20-03002(2): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03002
Administrative rules for anesthesia	Washington Administrative Code (WAC) 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20
Administrative rules for licensed nursing	Washington Administrative Code (WAC) 296-23-240: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-240
Administrative rules for licensed nursing billing instructions	Washington Administrative Code (WAC) 296-23-245: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-245
Administrative rules for treatment guidelines for injections	Washington Administrative Code (WAC) 296-20-03001(7): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03001
Anesthesia **conversion factor**	Washington Administrative Code (WAC) 296-20-135: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-135
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
Coverage decisions for spinal injections	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/SpinalInjections
Payment policies for **billing for medications**	Chapter 16: Medication Administration and Injections
Payment policies for **global surgery**	Chapter 29: Surgery Services
Payment policies for **using billing code modifier –25**	Chapter 10:

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	Evaluation and Management (E/M) Services
Professional Services **Fee Schedules**	L&I's website: http://feeschedules.Lni.wa.gov

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

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

Chapter 5: Audiology and Hearing Services

Effective July 1, 2016

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

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

Note: The policies and requirements in this chapter apply to all hearing aid services and devices except for CPT® codes.

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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.

- **Restocking fees:** The Washington State Department of Health statute (RCW 18.35.185) and rule (WAC 246-828-290) allow hearing instrument fitter/dispensers and licensed audiologists to retain **$150.00** or **15%** of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee sometimes is called a "restocking fee."

  Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds the purchase agreement.

  Links: For more information, see WAC 246-828-290 and RCW 18.35.185.

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Payment policy: Audiology services

Worker responsibilities

Worker responsible for devices that aren't medically necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given and wants to purchase different hearing aids, **the worker** then becomes completely responsible for the purchase of:

- The hearing aid,
- Any future repairs.

Worker responsible for some repairs, losses, damages

Workers are responsible to pay for repairs of hearing aids that aren't authorized by the insurer.

The worker is also responsible for non-work related losses or damages to their hearing aids (for example, the worker's pet eats/chews the hearing aid, etc...). In no case will the insurer cover this type of damage. In these instances, the worker will be required to buy a new hearing aid consistent with current L&I guidelines outlined in this chapter.

After the worker's purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

Services that can be billed

The insurer will only purchase hearing aids, devices, supplies, parts, and services described in the fee schedule (see Additional information: Audiology fee schedule, below.)

A physician or ARNP may be paid for a narrative assessment of work-relatedness to the hearing loss condition.

When filing a Report of Accident, Otolaryngologists should also bill 1190M if they perform a Comprehensive Hearing Loss Exam (see Chapter 12: Impairment Ratings for more information). If auditory testing is performed, bill the appropriate codes for payment.

Link: In the Attending Doctor's Handbook, refer to the table on Other Miscellaneous Codes and Descriptions.

Services that aren't covered

The insurer doesn't pay any provider or worker to fill out the:

- **Occupational Disease Employment History Hearing Loss** form (F262-013-000), *or*
- **Occupational Hearing Loss Questionnaire** (F262-016-000).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period.

The insurer won't pay for the reprogramming of hearing aids.

The insurer doesn't cover disposable shells ("ear molds" in HCPCS codes).

Links: The **Occupational Disease Employment History Hearing Loss** form is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1695.

The **Occupational Hearing Loss Questionnaire** is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1697.

Requirements for billing

Note: Also see the Documentation and record keeping requirements section of this chapter.

Hearing aid parts and supplies paid at acquisition cost

Parts and supplies must be billed and will be paid at acquisition cost including volume discounts (manufacturers' wholesale invoice).

Don't bill your usual and customary fee. (See specific billing instructions for these items in the following table.)

If you are billing for…	Then these can be:
Supply items for hearing aids, including: • Tubing, • Wax guards, *and* • Ear hooks.	Billed within the warranty period.

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If you are billing for…	Then these can be:
Parts for hearing aids, including: • Switches, • Controls, • Filters, • Battery doors, *and* • Volume control covers.	Billed as replacement parts only, but not within the warranty period.
Shells ("ear molds" in HCPCS codes)	Billed separately at acquisition cost (the insurer doesn't cover disposable shells).
Hearing aid extra parts, options, circuits, and switches (for example, T-coil and noise reduction switches)	Only billed when the manufacturer doesn't include these in the base invoice for the hearing aid.

Payment limits

Batteries

The insurer will pay the cost of battery replacement for the life of an authorized hearing aid.

Only a maximum of 60 batteries are authorized within each 90 day period. Providers must document the request for batteries by the worker and maintain proof that the worker actually received the batteries.

Wax Guards

The insurer will pay the cost of wax guards for the life of the authorized hearing aid.

Wax guards are reimbursed at $1.25 each up to a maximum 150 per calendar year. Wax guards are billed using code 5095V. This service can't be billed as part of a repair.

Tubes and Domes

Tubes and domes are used with some hearing aids. Replacement of tubes and domes is considered maintenance.

The insurer will reimburse service for replacement of tubes and domes at $25 per visit. This amount includes binaural replacement. This service:

- can be billed a maximum 18 times per calendar year,
- can be billed in conjunction with a quarterly cleaning visit,
- can't be billed as part of a repair.

Tubes and domes are billed using code 5094V.

Note: Sending workers batteries that they haven't requested and for which they don't have an immediate need violates L&I's rules and payment policies.

Additional information: Audiology fee schedule

Notes: The insurer will only purchase the hearing aids, devices, supplies, parts, and services described in the fee schedule.

Also, see definitions of **by report** and **bundled** in Definitions at the beginning of this chapter.

HCPCS code	Description	Maximum fee
V5008	Hearing screening	**$81.49**
V5010	Assessment for hearing aid	Bundled
V5011	Fitting/orientation/checking of hearing aid	Bundled
V5014	Hearing aid repair/modifying visit per ear (bill repair with code **5093V**)	**$54.33**
V5020	Conformity evaluation (1 visit allowed after the 30-day trial period)	Bundled
V5030	Hearing aid, monaural, body worn, air conduction	**Acquisition cost**
V5040	Body-worn hearing aid, bone	**Acquisition cost**
V5050	Hearing aid, monaural, in the ear	**Acquisition cost**
V5060	Hearing aid, monaural, behind the ear	**Acquisition cost**
V5070	Glasses air conduction	**Acquisition cost**

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HCPCS code	Description	Maximum fee
V5080	Glasses bone conduction	**Acquisition cost**
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	**Acquisition cost**
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	**Acquisition cost**
V5130	Binaural, in the ear	**Acquisition cost**
V5140	Binaural, behind the ear	**Acquisition cost**
V5150	Binaural, glasses	**Acquisition cost**
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$1,542.94**
V5170	Hearing aid, cros, in the ear	**Acquisition cost**
V5180	Hearing aid, cros, behind the ear	**Acquisition cost**
V5190	Hearing aid, cros, glasses	**Acquisition cost**
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$924.80**
V5210	Hearing aid, bicros, in the ear	**Acquisition cost**
V5220	Hearing aid, bicros, behind the ear	**Acquisition cost**
V5230	Hearing aid, bicros, glasses	**Acquisition cost**
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial	**$924.80**

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HCPCS code	Description	Maximum fee
	period)	
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	**$771.47**
V5242	Hearing aid, analog, monaural, CIC (completely in the ear canal)	**Acquisition cost**
V5243	Hearing aid, monaural, ITC (in the canal)	**Acquisition cost**
V5244	Hearing aid, digitally programmable analog, monaural, CIC	**Acquisition cost**
V5245	Hearing aid, digitally programmable, analog, monaural, ITC	**Acquisition cost**
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)	**Acquisition cost**
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)	**Acquisition cost**
V5248	Hearing aid, analog, binaural, CIC	**Acquisition cost**
V5249	Hearing aid, analog, binaural, ITC	**Acquisition cost**
V5250	Hearing aid, digitally programmable analog, binaural, CIC	**Acquisition cost**
V5251	Hearing aid, digitally programmable analog, binaural, ITC	**Acquisition cost**
V5252	Hearing aid, digitally programmable, binaural, ITE	**Acquisition cost**
V5253	Hearing aid, digitally programmable, binaural, BTE	**Acquisition cost**
V5254	Hearing aid, digital, monaural, CIC	**Acquisition cost**

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HCPCS code	Description	Maximum fee
V5255	Hearing aid, digital, monaural, ITC	**Acquisition cost**
V5256	Hearing aid, digital, monaural, ITE	**Acquisition cost**
V5257	Hearing aid, digital, monaural, BTE	**Acquisition cost**
V5258	Hearing aid, digital, binaural, CIC	**Acquisition cost**
V5259	Hearing aid, digital, binaural, ITC	**Acquisition cost**
V5260	Hearing aid, digital, binaural, ITE	**Acquisition cost**
V5261	Hearing aid, digital, binaural, BTE	**Acquisition cost**
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	**Acquisition cost**
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	**$0.95**
V5267	Hearing aid supply/accessory	**Acquisition cost**
5091V	Hearing aid restocking fee (the lesser of 15% of the hearing aid total purchase price or $150.00 per hearing aid)	By report
5092V	Hearing aid cleaning visit per ear (1 every 90 days, after the first year)	**$25.34**
5093V	Hearing aid repair fee. Manufacturer's invoice required	By report
5094V	Bilateral tubes/dome replacement (maximum of 18	**$25.00**

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HCPCS code	Description	Maximum fee
	times per calendar year)	
5095V	Wax guards (maximum of 150 per calendar year)	**$1.25 each**

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Payment policy: Advertising limits

False, misleading, or deceptive advertising or representations

L&I can deny a provider's application to provide services, or suspend or revoke an existing provider account if the provider participates in:

- False, misleading, or deceptive advertising, *or*
- Misrepresentations of industrial insurance benefits.

False advertising includes mailers and advertisements that:

- Suggest a worker's hearing aids are obsolete and need replacement, *or*
- Don't clearly document a specific hearing aid's failure, *or*
- Make promises of monetary gain without proof of disability or consideration of current law.

Link: For more information, see RCW 51.36.130 and WAC 296-20-015.

Payment policy: Dispensing fees

Services that can be billed

Dispensing fees cover a 30 day trial period during which all aids may be returned. Also included:

- Up to four follow up visits (ongoing checks of the aid as the wearer adjusts to it), *and*
- One hearing aid cleaning kit, *and*
- Routine cleaning during the first year, *and*
- All handling and delivery fees.

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Payment policy: Documentation and record keeping requirements

Documentation to support initial authorization

The provider must keep **all of the following** information in the worker's medical records and submit a copy of each to the insurer:

- Name and title of referring practitioner, if applicable, *and*
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual, *and*
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea, and fever, *and*
- A record of whether the worker has been treated for recent or frequent ear infections, *and*
- Results of the ear examination, *and*
- Results of all hearing and speech tests from initial examination, *and*
- Review and comment on historical hearing tests, if applicable, *and*
- All applicable manufacturers' warranties (length and coverage) plus the make, model and serial number of any hearing aid device(s) supplied to the worker as original or as a replacement, *and*
- Original or unaltered copies of manufacturers' invoices, *and*
- Copy of the **Hearing Services Worker Information** form (F245-049-000) signed by the worker and provider, *and*
- Invoices and/or records of all repairs.

Link: The **Hearing Services Worker Information** form is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032.

Documentation to support repair

The provider who arranges for repairs to hearing aid(s) authorized and purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period. Repair requests for State Fund claims must be sent to the Provider Hotline. A copy of the warranty must be on file with the insurer to ensure payment.

Documentation to support replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement:

- The name and credential of the person who inspected the hearing aid, *and*
- Serial number of the aids to be replaced, *and*
- Date of the inspection, *and*
- Observations (for example, a description of the damage, and specific reasons why the device can't be repaired).

Requirements for billing

Correspondence with the insurer

The insurer may deny payment of the provider's bill if the following information hasn't been received:

- Original or unaltered wholesale invoices from the manufacturer are required to show the acquisition cost, serial numbers, and warranty information, and must be retained in the provider's office records for a minimum of 5 years. The insurer **won't accept** invoices printed from email or the internet, *and*
- A hard copy of the original or unaltered manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part, or supply costs $150.00 or more, or upon the insurer's request.

Note: Electronic billing providers must submit a hard copy of the original or unaltered manufacturer's wholesale invoice with the make, model, and serial number for individual hearing aids within 5 days of bill submission.

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To avoid delays in processing, all correspondence to the insurer must indicate the worker's name and claim number in the upper right hand corner of each page of the document.

Providers are required to send warranty information for:

- **State Fund** claims to:

  Department of Labor and Industries
  PO Box 44291
  Olympia, WA 98504-4291

- **Self-insured** claims to the SIE/TPA. Contact list available at: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

Payment policy: Hearing aids, devices, supplies, parts, and services

General requirements

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards.

All manufacturers and assemblers must hold a valid FDA certificate.

Self-insurers with purchasing contracts for hearing aids

SIEs that have entered into contracts for purchasing hearing aid related services and devices may continue to use them.

Link: For more information, see WAC 296-23-165(1b).

SIEs that don't have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this chapter.

Types of hearing aids authorized

Types of hearing aids authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). The decision will be based on recommendations from:

- Physicians, *or*
- ARNPs, *or*
- Licensed audiologists, *or*
- Fitter/dispensers.

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The insurer covers the following types of hearing aids:

- Behind the ear (BTE),
- Digital or programmable in the ear (ITE),
- In the canal (ITC),
- Completely in the canal (CIC), *and*
- Receiver in Canal (RIC)

Any other types of hearing aids needed for medical conditions will be considered based on justifications from the physician, ARNP, licensed audiologist or fitter/dispenser.

- L&I won't purchase used or repaired equipment.
- The insurer won't purchase hearing devices intended for safety protection.

The following table indicates which services and devices are covered by provider type:

If the **provider** is a…	Then the **services or devices** that can be billed are:
Fitter/dispenser	HCPCS codes for all hearing related services and devices.
Durable medical equipment (DME) provider	• Supply codes, *and* • Battery codes.
Physician, ARNP, licensed audiologist	• HCPCS codes for hearing related services and devices, *and* • CPT® codes for hearing-related testing and office calls.

Prior authorization

Initial and subsequent hearing related services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies, and accessories.

The insurer won't pay for hearing devices provided prior to authorization.

To initiate the authorization process for:

- **State Fund** claims, call the claim manager or the State Fund's Provider Hotline at **1-800-848-0811** (in Olympia call **902-6500**).

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- **Self-insured** claims, the provider should obtain prior authorization from the SIE or its TPA.

The insurer will notify the worker in writing when the claim is accepted or denied.

Link: For more information, see WAC 296-20-03001 and WAC 296-20-1101.

Cases of special need

In cases of special need, such as when the worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted.

Special authorization for hearing aids and masking devices over $900.00 per ear

If the manufacturer's invoice cost of any hearing aid or masking device exceeds **$900.00** per ear including shipping and handling, special authorization is required from the claim manager.

Notes: The cost of ear molds doesn't count toward the **$900.00** for special authorization. Initial ear molds may be billed using **V5264** and replacements may be billed using **V5014** with **V5264**.

The cost of any external electronic device, such as a remote control or Bluetooth, counts towards the **$900.00** limit per hearing aid.

Masking devices for tinnitus

In cases of accepted tinnitus, the insurer may authorize masking devices. (Also see Requirements for billing, below.)

Required documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work related hearing loss.

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An SIE/TPA may use these or similar forms to gather information:

- **Report of Accident** (F242-130-000),
- **Occupational Disease Employment History Hearing Loss** form (F262-013-000; F262-013-111 continuation),
- **Occupational Hearing Loss Questionnaire** (F262-016-000),
- Valid audiogram,
- Medical report, *and*
- **Hearing Services Worker Information** form (F245-049-000).

Link: The forms are available on L&I's website, at: www.Lni.wa.gov/FormPub/.

Who must perform these services to qualify for payment

Authorized testing

Testing to fit a hearing aid may be done by a:

- Licensed audiologist,
- Fitter/dispenser,
- Qualified physician, *or*
- Qualified ARNP.

The provider must obtain prior authorization for subsequent testing.

Note: Fitter/ dispensers aren't reimbursed for audiograms. The provider performing the service must do the billing.

Requirements for billing

Note: Also see the Documentation and record keeping requirements section of this chapter.

All hearing aids, parts, and supplies

All hearing aids, parts, and supplies must be billed using HCPCS codes.

Hearing aids and devices are considered to be durable medical equipment (DME) and must be billed at their acquisition cost.

Link: For more details, refer to the Acquisition Cost Policy in Chapter 28: Supplies, Materials, and Bundled Services.

Binaural hearing aids

When billing the insurer for hearing aids **for both ears**, providers must indicate on the **CMS- 1500** (F245-127-000) or **Statement for Miscellaneous Services** form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left), *and*
- The appropriate HCPCS code for binaural aids.

Only bill one unit of service even though two hearing aids (binaural aids) are dispensed.

Note: Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

Link: The forms are available on L&I's website, at: www.Lni.wa.gov/FormPub/.

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Monaural hearing aids

When billing the insurer for **one hearing aid**, providers must indicate on the **CMS-1500** (F245-127-000) or **Statement for Miscellaneous Services** form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected, *and*
- The appropriate HCPCS code for monaural aid.

Only bill one unit of service.

Note: Electronic billing providers must use the appropriate field for the diagnosis code and side of body, specific to each provider's electronic billing format.

Tinnitus masking devices

Note: Also see Prior authorization, above.

If masking devices are dispensed without hearing aids, providers will bill using code **E1399**.

When dispensed as a component of a hearing aid, providers will bill using code **V5267**.

If masking devices are dispensed without hearing aids, the provider may also bill the appropriate dispensing fee code for monaural or binaural devices.

Payment limits

Authorized testing

The insurer doesn't pay for testing after a claim has closed unless related to fitting of replacement hearing aids.

The insurer will pay for hearing screening (**V5008**) only when performed and billed by an audiologist.

The insurer doesn't cover annual hearing tests.

If free initial hearing screenings are offered to the public, the insurer won't pay for these services.

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30 day trial period

A 30 day trial period is the standard established by RCW 18.35.185. During this time:

- The provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids aren't damaged),
- Follow up hearing aid adjustments are bundled into the dispensing fee, *and*
- If hearing aids are returned within the 30 day trial period, the provider must refund the hearing aid and dispensing fees.

Link: For more information, see RCW 18.35.185.

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Payment policy: Repairs and replacements

Warranties

Hearing aid industry standards provide a minimum of a one year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than one year, the manufacturer's warranty will apply.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is covered under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid according to the warranty. The worker is responsible for any charges outlined in the manufacturer's warranty.

The insurer doesn't purchase or provide additional manufacturers' or extended warranties beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer won't pay for any repairs including parts and labor within the manufacturer's warranty period. The warranty period begins:

- On the date the hearing aid is dispensed to the worker, *or*
- For repairs, when the hearing aid is returned to the worker.

Prior authorization

Repairs

Prior authorization is required for all billed repairs. The insurer will repair hearing aids and devices when needed due to normal wear and tear. Also note that:

- At its discretion, the insurer may repair hearing aids and devices under other circumstances, *and*
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased, *and*
- If the aid is damaged in a work related incident, the worker must file a new claim to repair or replace the damaged hearing aid.

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Providers must submit a written estimate of the repair cost to the State Fund Provider Hotline or the self-insured employer (SIE) claim manager to get prior authorization for:

- In office repairs, *or*
- Repairs by the manufacturer, *or*
- Repairs by an all make repair company.

Note: Tubes, domes and wax guards aren't considered repairs.

Replacements

Replacement is defined as purchasing a hearing aid for the worker according to L&I's current guidelines.

The insurer doesn't provide an automatic replacement period.

The insurer will replace hearing aids when they aren't repairable due to normal wear and tear. Also note that:

- At its discretion, the insurer may replace hearing aids in other circumstances, *and*
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer won't pay for new hearing aids when only new ear shell(s) are needed, *and*
- The insurer won't replace a hearing aid when the hearing aid is working up to the manufacturer's original specifications, *and*
- The insurer won't replace a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on the job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident, *and*
- The insurer won't replace hearing aids based solely on changes in technology, *and*
- The insurer won't pay for new hearing aids for hearing loss resulting from:
    - Noise exposure that occurs outside the workplace, *or*
    - Further coverage exposure, *or*
    - Non-work related diseases, *or*
    - The natural aging process.

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Replacement requests must be sent directly to the insurer using the Replacement Request form (F242-414-000).

State fund replacement requests are made directly to the claim manager. Request may be mailed or faxed to **360-902-6252**.

Documentation that a hearing aid isn't repairable may be submitted by:

- Licensed audiologists, *or*
- Fitter/dispensers, *or*
- All make repair companies, *or*
- FDA certified manufacturers.

The provider must submit written, logical rationale for the claim manager's consideration if:

- Only one of the binaural hearing aids isn't repairable, *and*
- In the professional's opinion, both hearing aids need to be replaced.

Note: The condition of the other hearing aid must be documented.

Who must perform these services to qualify for payment

Repairs

Audiologists and fitters/dispensers may be paid for providing authorized in office repairs.

Requirements for billing

Repairs

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Authorized in-office repairs must be billed using **V5014** and **V5267**.

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Replacements

The worker must sign and be given a copy of the **Hearing Services Worker Information** form (F245-049-000). The provider must submit a copy of the signed form with the replacement request.

The manufacturer's warranty and any additional provider warranty must be submitted in hard copy to the insurer for all hearing devices and hearing aid repairs. The warranty should include the individual hearing aids:

- Make, *and*
- Model, *and*
- Serial number.

The provider must inform the insurer of the type of hearing aid dispensed and the codes they are billing.

Link: The **Hearing Services Worker Information** form (F245-049-000) and the Hearing Aid Replacement form (F242-414-000) are available on L&I's website, at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032

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Payment policy: Replacement of linear nonprogrammable analog hearing aids

When these hearing aids may be replaced

Linear nonprogrammable analog hearing aids may be replaced with nonlinear digital or analog hearing when the worker returns a linear analog hearing aid to their dispenser or audiologist because:

- The hearing aid is inoperable, *or*
- The worker is experiencing an inability to hear, *and*
- The insurer has given prior authorization to replace the hearing aid.

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with nonlinear digital or analog hearing aid is authorized (see Prior authorization, below).

Prior authorization

Prior authorization must be obtained from the insurer **before** replacing linear analog hearing aids. The insurer **won't pay** for replacement hearing aids issued prior to authorization.

Authorization documentation and record keeping requirements

Before authorizing replacement, the insurer will require and request the following documentation from the provider:

- **Required:** A separate statement (signed by both the provider and the injured worker): *This linear analog replacement request is sent in accordance with L&I's linear analog hearing aid replacement policy*., *and*
- **Required for State Fund claims:** Completed **Hearing Services Worker Information** form (F245-049-000), available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032, *and*
- Serial number(s) of the current linear analog aid(s), if available, *and*
- Make/model of the current linear analog aid(s), if available, *and*
- Date original hearing aid(s) issued to worker, if available.

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For State Fund claims prior authorization:

- Call the claim manager, *or*
- Fax the request to the Provider Hotline at **360-902-6490**.

For self-insured claims prior authorization, contact the SIE/TPA for prior authorization.

Link: For a list of SIEs/TPAs, see:
www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/

Who must perform these services to qualify for payment

Audiologists, physicians, ARNPs, and fitter/dispensers who have current L&I provider account numbers may bill for hearing aid replacement. You may bill for the acquisition cost of the nonlinear aids and the associated professional fitting fee (dispensing fee).

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Payment policy: Restocking fees

(See definition of **restocking fees** in Definitions at the beginning of this chapter.)

Requirements for billing

The insurer must receive a **Termination of Agreement (Rescission)** form (F245-050-000) or a statement signed and dated by the provider and the worker.

Note: The form must be faxed to L&I at **360-902-6252** or forwarded to the SIE/TPA within two business days of receipt of the signatures.

Link: The form is available on L&I's website, at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2033.

The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer:

- Either for the restocking fee of **$150.00** or **15%** of the total purchase price, whichever is less, *and*
- Using billing code **5091V**.

Note: Restocking fees can't be paid until the insurer has received the refund.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules and **Washington state laws** for audiology and hearing services	Washington Administrative Code (WAC) 246-828-290: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-828-290 WAC 296-20-015: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-015 WAC 296-23-165: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-165 Revised Code of Washington (RCW) 18.35.185: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.35.185 RCW 51.36.130: http://apps.leg.wa.gov/RCW/default.aspx?cite=51.36.130
Attending Doctor's Handbook	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1669
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 professional services (including audiology)	L&I's website: http://feeschedules.Lni.wa.gov
Hearing Services Worker Information form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032
Occupational Disease Employment History Hearing Loss form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1695
Occupational Hearing Loss Questionnaire	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1697

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If you're looking for more information about…	Then go here:
Payment policies for **acquisition cost**	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services
Report of Accident form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599
Statement for Miscellaneous Services form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627
Termination of Agreement (Rescission) form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2033

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 6: Biofeedback, Electrocardiograms (EKG), Electrodiagnostic services, & Extracorporeal shockwave therapy (ESWT)

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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Payment policy: Biofeedback

Prior authorization

Biofeedback treatment requires an attending provider's order and prior authorization.

When the condition is accepted under the industrial insurance claim, the insurer will authorize biofeedback treatment for:

- Idiopathic Raynaud's disease,
- Temporomandibular joint dysfunction,
- Myofascial pain dysfunction syndrome (MPD),
- Tension headaches,
- Migraine headaches,
- Tinnitus,
- Torticollis,
- Neuromuscular reeducation as result of neurological damage in a stroke (also known as "CVA") or spinal cord injury,
- Inflammatory and/or musculoskeletal disorders causally related to the accepted condition.

Link: For more information, see WAC 296-21-280.

Twelve biofeedback treatments in a 90 day period will be authorized for the conditions listed above when an evaluation report is submitted documenting all the following:

- The basis for the worker's condition, *and*
- The condition's relationship to the industrial injury, *and*
- An evaluation of the worker's current functional measurable modalities (for example, range of motion, up time, walking tolerance, medication intake), *and*

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- An outline of the proposed treatment program, *and*
- An outline of the expected restoration goals.

No further biofeedback treatments will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (for example, range of motion, up time, walking tolerance, medication intake). Also:

- Only one additional treatment block of **12 treatments per 90 days** will be authorized, *and*
- Requests for biofeedback treatment beyond **24 treatments or 180 days** will be granted only after file review by and on the advice of the department's medical consultant.

In addition to treatment, pretreatment and periodic evaluation will be authorized. Follow-up evaluation can be authorized at one, three, six, and 12 months post treatment.

Home biofeedback device rentals are time limited and require prior authorization.

Link: Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

Who must perform these services to qualify for payment

Administration of biofeedback treatment is limited to practitioners who:

- Are certified by the Biofeedback Certification Institute of America (BCIA), *or*
- Meet the minimum education, experience, and training qualifications to be certified.

Note: Practitioners must submit a copy of their biofeedback certification or supply evidence of their qualifications to the department or self-insurer to administer biofeedback treatment to workers.

Link: For more information, see WAC 296-21-280.

Paraprofessionals who aren't independently licensed must practice under the direct supervision of a qualified, licensed practitioner:

- Whose scope of practice includes biofeedback, *and*
- Who is BCIA certified or meets the certification qualifications.

Note: Also see Requirements for billing, below, about paraprofessionals.

A qualified or certified biofeedback provider who isn't licensed as a practitioner may not receive direct payment for biofeedback services.

Links: For legal definitions of qualified biofeedback provider and certified biofeedback provider, see WAC 296-21-280. For legal definition of licensed practitioner, see WAC 296-20-01002.

Services that can be billed

CPT® codes **90875** and **90876** are payable to L&I approved biofeedback providers who are clinical psychologists or psychiatrists (MD or DO).

CPT® codes **90901** and **90911** are payable to any L&I approved biofeedback provider.

HCPCS code **E0746** is payable to DME or pharmacy providers (for rental or purchase).

Note: Also see "Payment limits," below, regarding these codes.

Requirements for billing

The supervising licensed practitioner must bill the biofeedback services for paraprofessionals.

When biofeedback is performed along with individual psychotherapy, bill using either CPT® code **90875** or **90876**.

Don't bill CPT® codes **90901** or **90911** with the individual psychotherapy codes.

Use evaluation and management codes for diagnostic evaluation services.

Payment limits

CPT® codes **90901** and **90911** aren't time limited and **only one unit of service per day** is payable, regardless of the length of the biofeedback session or number of modalities.

For HCPCS code **E0746**, use of the device in the office isn't separately payable for RBRVS providers.

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Payment policy: Electrocardiograms (EKG)

Service that can be billed

Separate payment is allowed for electrocardiograms (CPT® codes **93000**, **93010**, **93040**, and **93042**) when an interpretation and report is included. These services may be paid along with office services.

Services that aren't covered

EKG tracings without interpretation and report (CPT® codes **93005** and **93041**) aren't payable with office services.

Payment limits

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code **R0076**) is bundled into the EKG procedure and doesn't pay separately.

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Payment policy: Electrodiagnostic services

Who must perform these services to qualify for payment

Prior to performing and billing for these services, physical therapists (PTs) performing electrodiagnostic testing must provide documentation of proper Department of Health (DOH) licensure to L&I's Provider Credentialing.

PTs who meet the requirements of DOH rules may provide electroneuromyographic tests.

Links: For information on where to send proper license documentation, contact L&I's Provider Credentialing at **360-902-5140**.

To see the DOH rules, refer to WAC 246-915-370.

Services that can be billed

The department or self-insurer covers the use of electrodiagnostic testing, including nerve conduction studies and needle electromyography only when:

- Proper and necessary, *and*
- Testing meets the requirements described in L&I's Electrodiagnostic Testing policy.

Link: The policy for Electrodiagnostic Testing is available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecTest/.

Note: Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommended number of tests may be reviewed for quality and whether it is "proper and necessary." Also see "Example: Reasonable limits on units required to determine a diagnosis," below.

Qualified PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed.

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Services that aren't covered

Electrodiagnostic testing isn't covered when:

- It isn't proper and necessary (see Note and Link, below this list), *or*
- Performed in a mobile diagnostic lab in which the specialist physician isn't present to examine and test the patient, *or*
- Performed with noncovered devices, including:
  - Portable, *and*
  - Automated, *and*
  - "Virtual" devices not demonstrated equivalent to traditional lab based equipment (for example, NC-stat®, Brevio), *or*
- Determined to be outside of AANEM recommended guidelines without proper documentation supporting that the testing is proper and necessary.

Note: In general, repetitive testing isn't considered proper and necessary except if:

- Documenting ongoing nerve injury (for example, following surgery), *or*
- Required to provide an impairment rating, *or*
- Documenting significant changes in clinical condition.

Link: The legal definition of "proper and necessary" is available at WAC 296-20-01002.

Requirements for billing

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels.

Link: For the complete requirements for appropriate electrodiagnostic testing, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecTest/.

Billing of the technical and professional portions of the codes may be separated. However, the physician billing for interpretation and diagnosis (professional component) must have direct contact with the patient at the time of testing.

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Note: The department may recoup payments made to a provider, plus interest, for NCS and EMG tests paid inappropriately.

Example: Reasonable limits on units required to determine a diagnosis

The table below was developed by the AANEM and summarizes reasonable limits on units required, per diagnostic category, to determine a diagnosis 90% of the time.

Note: As mentioned under "Services that can be billed" (above), review of the quality and appropriateness (whether the test is "proper and necessary") may occur when testing repeatedly exceeds AANEM recommendations.

Recommended maximum number of studies by indication (from "AANEM Table 1"; recreated and adapted with written permission from AANEM):

	Needle EMG CPT® 95860-95864, 95867-95870	**NCS CPT® 95907-95913**	**Other EMG studies CPT® 95907-95913**		
Indication	# of tests	**Motor NCS with and without Fwave**	**Sensory NCS**	**H-Reflex**	**Neuromuscular Junction Testing** (repetitive stimulation)
Carpal tunnel (unilateral)	1	3	4	—	—
Carpal tunnel (bilateral)	2	4	6	—	—
Radiculopathy	2	3	2	2	—
Mononeuropathy	1	3	3	2	—
Poly/ mononeuropathy multiplex	3	4	4	2	—
Myopathy	2	2	2	—	2

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Indication	Needle EMG CPT® 95860-95864, 95867-95870	NCS CPT® 95907-95913	Other EMG studies CPT® 95907-95913		
	# of tests	Motor NCS with and without Fwave	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Motor neuronopathy (for example, ALS)	4	4	2	—	2
Plexopathy	2	4	6	2	—
Neuromuscular Junction	2	2	2	—	3
Tarsal tunnel (unilateral)	1	4	4	—	—
Tarsal tunnel (bilateral)	2	5	6	—	—
Weakness, fatigue, cramps, or twitching (focal)	2	3	4	—	2
Weakness, fatigue, cramps, or twitching (general)	4	4	4	—	2
Pain, numbness, or tingling (unilateral)	1	3	4	2	—
Pain, numbness or tingling (bilateral)	2	4	6	2	—

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Payment policy: Extracorporeal shockwave therapy (ESWT)

Services that aren't covered

The insurer doesn't cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature.

Link: More information is available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/ESWT.asp.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for biofeedback	Washington Administrative Code (WAC) 296-21-280: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21-280
Administrative rules for the definitions of "licensed practitioner" and "proper and necessary"	WAC 296-20-01002: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01002
Administrative rules for the policy on rental equipment	WAC 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102
Administrative rules for the requirements on who may provide electroneuromyographic tests	WAC 246-915-370: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-915-370
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
Coverage decision for extracorporeal shockwave therapy	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/ESWT.asp
Fee schedules for all healthcare professional services (including chiropractic)	L&I's website: http://feeschedules.Lni.wa.gov
Policy for **electrodiagnostic testing**	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecTest/
Sending proper license documentation to perform electrodiagnostic services	L&I's Provider Credentialing: **360-902-5140**

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 7: Chiropractic Services

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

- **Body regions:** One of the factors contributing to clinical decision-making complexity for chiropractic care visits. (See definition of **clinical decision-making complexity**, below.) Body regions include:
  - Cervical (includes atlanto-occipital joint),
  - Thoracic (includes costovertebral and costotransverse joints),
  - Lumbar
  - Sacral
  - Pelvic (includes sacroiliac joint),
  - Extra-spinal (considered one region), which includes
    - Head (includes temporomandibular joint; doesn't include atlanto-occipital), *and*
    - Upper and lower extremities, *and*
    - Rib cage (doesn't include costotransverse and costovertebral joints).

- **Chiropractic care visits:** Office or other outpatient visits involving subjective and objective assessment of patient status, management, and treatment.

- **Clinical decision-making complexity:** The primary component influencing the level of care for a chiropractic care visit. Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to clinical decision-making complexity for injured workers include:
  - The current occupational condition(s),
  - Employment and workplace factors,
  - Non-occupational conditions that may complicate care of occupational condition,
  - Chiropractic intervention(s) provided,
  - Number of body regions manipulated (see definition of **body regions**, above),
  - Care planning and patient management,
  - Response to care.

  The number of body regions being adjusted is only one of the factors that may contribute to visit complexity.

  L&I defines clinical decision-making complexity according to the definitions for medical decision-making complexity in the Evaluation and Management Services Guidelines section of the CPT® book.

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- **Complementary and preparatory services:** Interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

- **CPT® code modifiers mentioned in this chapter:**

  –22 Unusual services

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

  –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.

- **Established patient:** One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

- **New patient:** One who hasn't received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

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Payment policy: Chiropractic care visits

(See definition of **chiropractic care visits** in Definitions at the beginning of this chapter.)

Prior authorization

Prior authorization for all types of conservative care, including chiropractic, is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

Services that can be billed

Local codes **2050A**, **2051A**, and **2052A** can be billed. These codes account for both professional management (clinical complexity) and technical service (manipulation and adjustment). There are three levels of chiropractic care visits:

The primary component is **clinical decision-making.** If it is…	and the typical **number of body regions** adjusted or manipulated is…	and typical **face-to-face time** with patient or family is…	Then the **appropriate billing code** and maximum fee is…
Straightforward	Up to 2	Up to 10-15 minutes	**2050A** (Level 1) **$43.85**
Low complexity	Up to 3 or 4	Up to 15-20 minutes	**2051A** (Level 2) **$56.17**
Moderate complexity	Up to 5 or more	Up to 25-30 minutes	**2052A** (Level 3) **$68.44**

Note: See more information on **Clinical decision-making complexity** in Definitions (at the beginning of this chapter) and Examples of chiropractic care levels of complexity (below).

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Services that aren't covered

CPT® chiropractic manipulative treatment (CMT) codes (**98940** – **98943**) aren't covered.

Instead of using CMT codes, L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop the local codes that can be billed for chiropractic care visits (see Services that can be billed, above).

Requirements for billing

When billing **modifier –22** with chiropractic care visit local codes (**2050A-2052A**), submit a report detailing the nature of the unusual service and the reason it was required. The report will be reviewed individually, and payment will vary based on the review findings.

Note: See Payment limits for **modifier –22**, below.

Payment limits

Only one chiropractic care visit per day is payable.

Evaluation and management (E/M) office visit CPT® codes (**99201-99204**, **99211-99214**) are payable in addition to chiropractic care visit codes only when all of the following conditions are met:

- The E/M service is for the initial visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the chiropractic care visit), *and*
- **Modifier –25** is added to the E/M code, *and*
- Supporting documentation describing both the E/M and the chiropractic care services is in the patient's record.

Note: See the Prior authorization requirements and Payment limits under the Chiropractic evaluation and management (E/M) services section of this chapter.

Extra-spinal manipulations aren't billed separately (extremities are considered to be one body region). (See definition of **body regions** in Definitions at the beginning of this chapter.)

Modifier –22 isn't payable when used for non-covered or bundled services (for example, application of hot or cold packs).

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When a patient requires re-evaluation for an existing claim:

- An **established patient** E/M code is payable, *or*
- A chiropractic care local code (**2050A**, **2051A**, or **2052A**) is payable, *and*
- **Modifier –25** doesn't apply.

Note: See definition of **established patient** in Definitions at the beginning of this chapter.

Examples of chiropractic care levels of complexity

These examples are for illustration only and aren't clinically prescriptive:

Level 1:	**Straightforward clinical decision-making** (billing code **2050A**)
Patient	26 year old male.
Cause of injury	Lifted a box at work.
Symptoms	Mild, low back pain for several days.
Treatment	Manipulation or adjustment of the lumbar region, anterior thoracic mobilization, and lower cervical adjustment.

Level 2:	**Low complexity clinical decision-making** (billing code **2051A**)
Patient	55 year old male, follow-up visit.
Cause of injury	Slipped and fell on stairs while carrying heavy object at work.
Symptoms	Ongoing complaints of neck and low back pain. New sensation of periodic tingling in right foot. Two days off work.
Treatment	Discuss need to minimize lifting and getting assistance when carrying heavier objects. Five minutes of myofascial release prior to adjustment of the cervical, thoracic, and lumbar regions.

Level 3:	**Moderate complexity clinical decision-making** (billing code **2052A**)
Patient	38 year old female, follow-up visit.
Cause of injury	Moved heavy archive boxes at work over the course of three days.
Symptoms	Headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, pain in the sacroiliac regions, and right-sided foot drop. Obesity and borderline diabetes. Tried light-duty

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	work last week, but unable to sit for very long, went home. Tried prescribed stretching from last visit, but worker couldn't continue and didn't stretch because of pain.
Treatment	Review MRI report with the worker. 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/ adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac, and sacrococcygeal regions.

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Payment policy: Chiropractic evaluation and management (E/M) services

Prior authorization

Prior authorization is required when billing for:

- More than 20 office visits, *or*
- Visits that occur more than 60 days after the first date you treat the worker (see WAC 296-20-03001(1)).

Chiropractic consultation requires prior notification to the department or self-insurer (see WAC 296-23-195).

Who must perform these services to qualify for payment

Only an L&I-approved chiropractic consultant can perform office consultation services to qualify for payment.

Link: For more information about consultations, a list of approved chiropractic consultants, and information about becoming a chiropractic consultant, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/BySpecialty/ChiroSvcs.asp

Services that can be billed

Case management services

Codes and billing instructions for case management services telephone calls, team conferences, and secure email can be found in the Case management services section of Chapter 10: Evaluation and Management. These codes may be paid in addition to other services performed on the same day.

Chiropractic consultations

Approved consultants may bill the first four levels of CPT® office consultation codes.

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Chiropractic office visits

Chiropractic physicians may bill the first four levels of office visit codes for new and established patients.

Note: For complete code descriptions, definitions, and guidelines, refer to a CPT® book.

Link: Fees appear in the Professional Services Fee Schedule available at: http://feeschedules.Lni.wa.gov

Payment limits

A **new patient** E/M office visit code is payable only once for the initial visit. (See definitions of **new patient** and **established patient** in Definitions at the beginning of this chapter.)

An **established patient** E/M office visit code isn't payable on same day as a new patient E/M.

Modifier –22 isn't payable with E/M office visit codes for chiropractic services.

For follow-up visits, E/M office visit codes aren't payable in addition to L&I chiropractic care visit codes.

Chiropractic E/M office visits are only payable on the same date as a chiropractic care visit when all of the following are met:

- It is the first visit on a new claim, *and*
- The E/M service is a significant, separately identifiable service (it goes beyond the usual pre- and post-service work included in the chiropractic care visit), *and*
- **Modifier –25** is added to the E/M code, *and*
- The patient's record contains supporting documentation describing both the E/M and the chiropractic care services.

Note: Refer to the Chiropractic care visits section of this chapter for policies about the use of E/M office visit codes with L&I codes for chiropractic care visits.

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Additional information: Chiropractic consultations

L&I periodically publishes:

- A policy on consultation referrals, *and*
- A list of approved chiropractic consultants.

Link: For more information on this topic, including current policy, a list of approved consultants, and information on how to become an approved chiropractic consultant, go to:

www.Lni.wa.gov/ClaimsIns/Providers/AuthRef/SecondOpinion.asp.

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Payment policy: Chiropractic independent medical exams (IMEs) and impairment ratings

Prior authorization

Prior authorization is only required when an IME is scheduled. To get prior authorization for claims that are:

- **State Fund**, use L&I's secure, online Claim & Account Center to see if an IME is scheduled. To set up an account, go to: www.Lni.wa.gov/ORLI/LoGon.
- **Self-Insured**, contact the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs, go to: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.
- **Crime victims**, call **1-800-762-3716**.

Who must perform these services to qualify for payment

Only an L&I-approved IME examiner can perform chiropractic IMEs or impairment ratings to qualify for payment.

For an impairment rating, an attending chiropractic physician may:

- Perform the rating on their own patients if the physician is an approved IME examiner, *or*
- Refer to an approved IME examiner for a consultant impairment rating.

Link: For more information, see Chapter 12: Impairment Rating Services

Services that can be billed

Use the CPT® codes, local codes, and the payment policy for IMEs described in Chapter 13: Independent Medical Exams (IME).

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Additional information: Becoming an approved IME examiner

To apply for approval, chiropractic physicians must complete:

- Two years as an approved chiropractic consultant, *and*
- Impairment rating course approved by the department.

The department approved impairment rating course and the Chiropractic Consultant Seminar are offered as part of the Chiropractic Consultation Program.

Links: For more information, refer to:

- L&I's Chiropractic Consultation Program webpage, *and*
- IME and impairment rating guidelines, sample reports, and billing procedures as explained in the **Medical Examiners' Handbook** (publication F252-001-000), available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668.

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Payment policy: Chiropractic radiology services (X-rays)

Prior authorization

Required:

X-rays after the initial study require prior authorization.

Not required:

X-rays are allowed without prior authorization when:

- Medically necessary, *and*
- Performed immediately prior to and following the initial chiropractic adjustment.

Who must perform these services to qualify for payment

Chiropractic physicians in the network may bill for radiographs taken as allowed under their license. It is required that a written x-ray report of radiologic findings and impressions be included in the patient's chart.

Only chiropractic physicians on L&I's list of approved radiological consultants may bill for X-ray consultation services. A chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I to become an approved radiological consultant.

Services that can be billed

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the Requirements and Payment limits described in Chapter 26: Radiology Services.

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Payment policy: Complementary & preparatory services, and patient education or counseling

(See definition of **complementary & preparatory services** in Definitions at the beginning of this chapter.)

Payment limits

Chiropractic physicians aren't paid separately for:

- Complementary and preparatory services, *or*
- Patient education or counseling.

Example of complementary & preparatory services

The application of heat or cold is an example of a complementary and preparatory service.

Examples of patient education or counseling services

Patient education or counseling includes discussing or providing written information about:

- Lifestyle, *or*
- Diet, *or*
- Self-care and activities of daily living, *or*
- Home exercises.

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Payment policy: Physical medicine treatment

Note: Includes powered traction devices.

Services that can be billed

Use local code **1044M** for physical medicine modalities or procedures (including the use of traction devices) by attending provider not board certified/qualified in Physical Medicine and Rehabilitation (PM&R).

Link: For more information, see Chapter 25: Physical Medicine Services

Services that aren't covered

CPT® physical medicine codes (**97001** – **97799**) aren't payable to chiropractic physicians.

Requirements for billing

Documentation of the visit must support billing for local code **1044M**.

Payment limits

Local code **1044M** is limited to six units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.

After six units, the patient must be referred to a licensed physical or occupational therapist, or physiatrist for such treatment except when the attending provider practices in a remote location. (Refer to WAC 296-21-290 for more information.)

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

The insurer won't pay any additional cost when powered traction devices are used. This policy applies to all FDA-approved powered traction devices.

Note: Published literature hasn't substantially shown that powered traction devices are more effective than other forms of traction, other conservative treatments, or surgery. Powered traction devices are covered as a physical medicine modality under existing physical medicine payment policy. When powered traction is a

proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider.

Link: For additional information, see powered traction therapy in Chapter 25: Physical Medicine Services.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for physical medicine	Washington Administrative Code (WAC) 296-21-290: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21-290
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
Chiropractic Services including Industrial Insurance Chiropractic Advisory Committee, practice, training, consultation resources	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/BySpecialty/ChiroSvcs.asp
Fee schedules for all healthcare professional services (including chiropractic)	L&I's website: http://feeschedules.Lni.wa.gov
Payment policies for **case management services**	Chapter 10: Evaluation and Management Services
Payment policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **IMEs**	Chapter 13: Independent Medical Exams (IMEs)
Payment policies for **impairment ratings**	Chapter 12: Impairment Rating Services
Payment policies for **physical medicine treatment** or **powered traction therapy**	Chapter 25: Physical Medicine Services
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 8: Dental Services

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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All dental services 8-2

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Related topics.....8-9

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Payment policy: All dental services

Note: This policy pertains to bills submitted for dental services.

Prior authorization

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers‘ compensation claims and Crime Victims Compensation (CVC) claims, *or*
- Self-insured employer or their third party administrator.

Only claim managers can authorize dental services for State Fund workers‘ compensation claims and CVC claims.

For self-insured workers‘ compensation claims, contact the insurer directly for prior authorization procedure details.

Link: For a list of self-insured employers’ contact information, see www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

Prior authorization review of treatment plan

Claim services requiring prior authorization require a treatment plan. Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

Note: See Treatment plan requirements later in this section.

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to:

- Restorative,
- Endodontic,

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- Prosthodontic,
- Prosthetic,
- Implant,
- Orthodontics,
- Surgery, *and*
- Anesthesia procedures.

In cases presenting complication, controversy or diagnostic/therapeutic problems, the claim manager may request consultation by another dentist to support authorization for procedures.

Who must perform these services to qualify for payment

Dental providers licensed in the state in which they practice may be paid for performing dental services, including:

- Dentists,
- Oral and Maxillofacial surgeons,
- Orthodontists,
- Denturists,
- Hospitals, *and*
- Dental clinics.

Dentists must be enrolled in the provider network in order to treat injured workers beyond the initial visit.

Note: Also see information about the Medical Provider Network in Chapter 2: Information for All Providers - Becoming a provider. Network requirements do not apply to Crime Victim services.

Links: You can find more information about dental services in WAC 296-20-110, WAC 296-23-160, and WAC 296-20-015, and about becoming an L&I provider at www.Lni.wa.gov/ClaimsIns/Providers/Becoming/.

For self-insured workers' compensation claims, contact the insurer directly for provider account number requirements.

Link: For a list of self-insured employers' contact information, see www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/ .

Services that aren't covered

Pre-existing conditions

Pre-existing conditions aren't payable unless medically justified as related to the injury. Preauthorization is required for treatment.

Underlying conditions

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker. It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that won't be covered.

Periodontal disease

Periodontal disease is an underlying condition that isn't covered because it isn't related to industrial injuries.

Link: For more information, see WAC 296-20-110.

Requirements for billing

Bills must be submitted within one year from the date the service is rendered.

Link: For more information, see WAC 296-20-125.

To bill:

- All workers' compensation dental claims should be billed using the ADA American Dental Association Dental Claim form (© 2012 American Dental Association J430D), or L&I's **Statement for Miscellaneous Services** form (F245-072-000).
- For Crime Victims Compensation (CVC) claims, dentists should use the ADA American Dental Association Dental Claim form (© 2012 American Dental

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Association J430D), or CVC's **Statement for Crime Victims Miscellaneous Services** form (F800-076-000).

Note: Failure to use the most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the:

- Full billing code,
- Materials used, *and*
- Injured tooth number(s).

Note: When using Current Dental Terminology (CDT®) codes, please include the **D** in front of the code billed to avoid delays in claim/bill processing.

Link: The HCPCS fee schedule, which includes the dental billing codes, is available at http://feeschedules.Lni.wa.gov.

Treatment plan requirements

Before authorization can be granted, the treatment plan and/or alternative treatment plan must be completed and submitted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

The dentist should outline the extent of the dental injury and the treatment plan. To **obtain authorization** for a treatment plan, all of the following are **required**:

- Causal relationship of injury to condition of the mouth and teeth,
- Extent of injury,
- Alternate treatment plan,
- Time frame for completion, *and*
- Medical history and risk level for success.

Please include:

- Procedure code,
- Tooth number,
- Tooth surface, *and*
- Charge amount.

Notes: To avoid delays in treatment, please exclude information regarding treatment that isn't directly related to the injury. The ADA American Dental Association Dental Claim form (© 2012 American Dental Association J430D) may be attached to treatment plan. Select Request for Predetermination/Preauthorization in section 1 of the ADA form.

In addition, to **avoid delays in authorization** of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number, *and*
- State the condition of the mouth and involved teeth including:
  - Missing teeth, existing caries and restorations, *and*
  - Condition of involved teeth prior to the injury (caries, periodontal status).

Link: For more information, see WAC 296-20-110.

Where to submit a treatment plan

State Fund treatment plans (not billing info) may be sent to:

- Faxed to: **360-902-4567,** *or*
- Mail **State Fund** treatment plans to:

  Department of Labor & Industries
  PO Box 44291
  Olympia, Washington 98504-4291

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Crime Victims Compensation (CVC) treatment plans (not billing info) may be sent to:

- Faxed to: **360-902-5333**, *or*
- Mail **CVC** claim treatment plans to:

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

Mail **self-insured** treatment plans to the Self-insured employer (SIE) or third party administrator (TPA).

Link: For a list of self-insured employers' contact information, see www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/ .

Documentation and recordkeeping requirements

Acceptance of a claim

If you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. To initiate the State Fund claim or CVC claim for your patient, send L&I a **Report of Industrial Injury or Occupational Disease** form (F242-130-000) (also known as Accident Report or Report Of Accident (ROA) Workplace Injury, Or Occupational Disease).

Links: You can order copies of the **Report Of Accident (ROA) Workplace Injury, Accident or Occupational Disease**(F242-130-000) at www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599 or by calling **1-800-LISTENS** or **1-360-902-4300**.

To request a supply of the **Provider's Initial Report** (**PIR**) form used for workers of self-insured employers (F207-028-000), go to www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467, or call **1-360-902-6898**.

Chart notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service. Legible copies of office notes are required for all initial and follow up visits.

Links: For more information, see WAC 296-20-010 and WAC 296-20-06101.

Attending provider

If dental treatment is the only treatment the injured worker requires and you are directing the care, you will be the attending provider (AP).

Your responsibility as the AP includes documenting employment issues in the injured worker‘s chart notes, including:

- A record of the worker‘s physical and medical ability to work,
- Information regarding any rehabilitation that the worker may need to undergo,
- Restrictions to recovery,
- Any temporary or permanent physical limitations, *and*
- Any unrelated condition(s) that may delay recovery must also be documented.

For ongoing treatment, use the **SOAP-ER** (Subjective, Objective, Assessment, Plan and progress, Employment issues, Restrictions to recovery) format.

Link: Information on the Charting format can be found in Chapter 2: Information for All Providers.

Additional information: L&I’s periodic review of dental services

L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but aren‘t limited to, review of the injured worker‘s dental records.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules Medical Aid	Washington Administrative Code (WAC) 296-20-110: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-110 WAC 296-20-015: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-015 WAC 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125 WAC 296-20-06101: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-06101
Administrative rules dental services, general information and instructions	WAC 296-23-160: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-160
Attending Doctor's Handbook	www.Lni.wa.gov/FormPub/Detail.asp?DocID=1669
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
Charting format (SOAP-ER) instructions	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including dental)	L&I's website: http://feeschedules.Lni.wa.gov
Payment policies for **diagnostic X-ray services**	Chapter 26: Radiology Services
Provider's Initial Report (PIR) form for all State Fund and crime victims claims	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467

If you're looking for more information about…	Then go here:
Report Of Accident (ROA) Workplace Injury, Accident or Occupational Disease form for all State Fund and crime victims claims	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599
Statement for Crime Victims Miscellaneous Services form for all crime victims claims	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1976
Statement for Miscellaneous Services form for all worker's compensation claims	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627

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

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Washington State Department of
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Workers' Compensation Services

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

Chapter 9: Durable Medical Equipment (DME)

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.

  Pharmacy and DME providers can bill HCPCS codes listed as bundled on the fee schedules because, for these provider types, there's not an office visit or a procedure into which supplies and/or equipment can be bundled.

  Link: For the legal definition of **Bundled codes**, see WAC 296-20-01002.

- **Note: 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.

- **Durable medical equipment (DME):** DME means equipment that:
  - Can withstand repeated use, *and*
  - Is primarily and customarily used to serve a medical purpose, *and*
  - Generally isn't useful to a person in the absence of illness or injury, *and*
  - Is appropriate for use in the client's place of residence.

- **HCPCS code modifiers mentioned in this chapter:**

  –NU New purchased DME

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

  –RR Rented DME

  Use the **–RR** modifier when DME is to be rented.

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–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.

–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.

- **Portable oxygen systems:** Portable oxygen systems, sometimes referred to as ambulatory systems, are lightweight (less than 10 pounds) and can be carried by most patients. These systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.
  - **Small gas cylinders** are available as portable systems. Some are available that weigh less than five pounds.
  - **Portable liquid oxygen systems** that can be filled from the liquid oxygen reservoir are available in various weights.
- **Stationary oxygen systems:** Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems, and oxygen concentrators.
  - **Oxygen gas cylinders** contain oxygen gas stored under pressure in tanks or cylinders.
  - **Liquid oxygen systems** store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas, but takes up less space and can be transferred more easily to a portable tank.
  - **Oxygen concentrators** are electric devices that extract oxygen from ambient air and deliver up to 4 liters of oxygen per minute for 85% or greater concentration. A backup oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

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Payment policy: Hot or cold therapy DME

Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for DME providers only and is **bundled** for all other provider types.

Services that aren't covered

Hot water bottles, heat and/or cold wraps aren't covered.

Hot or cold therapy DME isn't covered.

> **Examples** include heat devices for home use, including heating pads. These devices either aren't covered or are **bundled**.

Note: Cryotherapy DME with or without compression used in a clinical setting aren't payable separately. These modalities are considered to be **bundled** into existing physical medicine services billable under CPT® **97010** and **1044M**. HCPCS code **E1399** isn't appropriate for cryotherapy DME in any setting.

Link: For more information, see WAC 296-20-1102.

Payment limits

Application of hot or cold packs (CPT® code **97010**) is **bundled** for all providers.

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

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Payment policy: Oxygen and oxygen equipment

Requirements for billing

Pharmacies and DME providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes.

Delivery charges, shipping and handling, tax, and fitting fees aren't payable separately. Include these charges in the total charge for the supply.

Link: For more information on purchasing or renting DME, see WAC 296-20-1102.

Services that can be billed

To bill for oxygen, if the worker owns a:

- **Portable oxygen system**, bill using either **E0443** (gaseous contents) or **E0444** (liquid contents), *or*
- **Stationary oxygen system**, bill using either **E0441** (gaseous contents) or **E0442** (liquid contents).

Note: See definitions of **Portable oxygen system** and **Stationary oxygen system** in Definitions at the beginning of this chapter.

Payment limits

The insurer primarily pays for rental of oxygen equipment and no longer rents to purchase.

If the worker **rents** the oxygen system:

- One monthly fee is paid for oxygen equipment. This fee includes payment for the equipment, contents, necessary maintenance, and accessories furnished during a rental month, *and*
- Oxygen accessories are included in the payment for rented systems. The supplier must provide any accessory ordered by the physician. (See Examples of oxygen accessories, below.)

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If the worker **owns** the oxygen system:

- The fee for oxygen contents must be billed once a month, not daily or weekly. One unit of service equals one month of rental, *and*
- Oxygen accessories are payable separately only when they are used with a patient owned system.

Examples of oxygen accessories

Oxygen accessories include but aren't limited to:

- Cannulas (**A4615**),
- Humidifiers (**E0555**),
- Masks (**A4620**, **A7525**),
- Mouthpieces (**A4617**),
- Regulators (**E1353**),
- Nebulizer for humidification (**E0580**),
- Stand/rack (**E1355**),
- Transtracheal catheters (**A4608**),
- Tubing (**A4616**).

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Payment policy: Prosthetic and orthotic services

Prior authorization

Required

Prior authorization is required for:

- Prosthetics, surgical appliances, and other special equipment described in WAC 296-20-03001, *and*
- Replacement of specific items on closed claims as described in WAC 296-20-124.

Note: If DME or orthotics requires prior authorization and it isn't obtained, then bills may be denied. For prior authorization for:

- **State fund claims**, contact the Provider Hotline at **1-800-848-0811**.

- **Use the Fee Look-up tool**
  http://feeschedules.Lni.wa.gov

  - **Self-insured claims**, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims. See www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/default.asp

Link: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization; the fee schedule is available at http://feeschedules.Lni.wa.gov

Not required

Providers aren't required to obtain prior authorization for orthotics or DME when:

- The provider verifies that the claim is open/allowed on the date of service, *and*
- The orthotic/DME is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, *and*The fee schedule prior authorization indicator field is blank (see link to the fee schedule, above).

Who qualifies for payment for custom made devices

The insurer will only pay for custom made (sometimes called "custom fabricated") prosthetic and orthotic devices manufactured by these providers specifically licensed to produce them:

- Prosthetists,
- Orthotists,
- Occupational therapists,
- Certified hand specialists,
- Podiatrists.

Link: To determine if a prosthetic or orthotic device is in this category, see the "license required" field in the fee schedule; the fee schedule is available at http://feeschedules.Lni.wa.gov

Requirements for billing

For covered prosthetics that pay **By report**, providers must bill their usual and customary fees.

Notes: Also see Payment limits for **By report** prosthetics, below. See definition of **By report** in Definitions at the beginning of this chapter.

Links: For more information on billing usual and customary fees, see WAC 296-20-010 (2).

To find out which codes pay **By report**, see the HCPCS section of the Professional Services Fee Schedule, available at http://feeschedules.Lni.wa.gov

Payment limits

For **by report** prosthetic items, the insurer will pay **80%** of the billed charge.

Note: Also see Requirements for billing for **By report** prosthetics, above.

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Payment policy: Purchasing or renting DME

General policies on purchased or rented DME

Purchased DME

Purchased DME belongs to the worker.

State fund and Crime Victims Compensation Program won't purchase used DME.

Self-insured employers may purchase used DME.

Rented DME

During the authorized rental period, the DME belongs to the provider.

When the DME is no longer authorized:

- It will be returned to the provider.
- If unauthorized DME isn't returned to the provider within 30 days, the provider can bill the worker for charges related to DME rental, purchase, and supplies that accrue after the insurer denies authorization for the DME.

Link: For more information on purchasing or renting DME, see WAC 296-20-1102.

Prior authorization

Required

If prior authorization is required but isn't obtained, then bills may be denied. Prior authorization is required for:

- Prosthetics, surgical appliances, and other special equipment (see WAC 296-20-03001).
- Replacement of specific items on closed claims (see WAC 296-20-124).

Link: The HCPCS section of the Professional Services Fee Schedule has a column designating which codes require prior authorization; these codes include the HCPCS E codes and the HCPCS K codes. The fee schedule is available at http://feeschedules.Lni.wa.gov

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Note: For prior authorization for:

- **State fund claims**, contact the Provider Hotline at **1-800-848-0811**.
- **Self-insured claims**, contact the self-insured employer or their third party administrator for prior authorization on self-insured claims. See www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/default.asp

Not required

Providers aren't required to obtain prior authorization for orthotics or DME when:

- The provider verifies that the claim is open/allowed on the date of service, *and*
- The orthotic/DME is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, *and*
- The fee schedule prior authorization indicator field is blank.

Requirements for billing

Pharmacies and DME providers must bill their usual and customary charge for supplies and equipment with appropriate HCPCS and local codes.

Delivery charges, shipping and handling, tax, and fitting fees aren't payable separately. Include these charges in the total charge for the supply.

If the DME is rented for:

- One day, use the same date for the first and last dates of service.
- More than one day, use the actual first and last dates of service.

Note: Errors will result in suspension and/or denial of payment.

Always include a modifier with a DME HCPCS code. The HCPCS/CPT® code column of the Professional Services Fee Schedule specifies which DME items can be:

- Only purchased (use modifier **–NU**), *or*
- Only rented (use modifier **–RR**), *or*
- Either purchased (use modifier **–NU**) or rented (use modifier **–RR**).

  Example: E0117-NU (Underarm spring-assist crutch) is only purchased (there isn't an **–RR** modifier for that code).

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Note: **Exceptions:** Repair codes **K0739** and **K0740** don't require modifiers.

Bills submitted without the correct modifier will be denied payment.

Providers may continue to use other modifiers, for example **–LT** or **–RT**, in conjunction with the mandatory modifiers if appropriate (up to four modifiers may be used with any one HCPCS code).

Payment limits

Rented DME

The maximum allowable rental fee is based on a per month period. Rental of one month or less is equal to one unit of service.

Rental payments won't exceed 12 months:

- At six months:
  - The insurer may review rental payments and decide to purchase the equipment at that time, *and*
  - If purchased, the DME belongs to the worker.
- At the 12th month of rental, the worker owns the equipment.

Note: For more details on equipment rented for less than 12 months and permanently required by the worker, see DME purchase after rental period of less than 12 months, below.

Note: **Exceptions:**

- **Continuous passive motion exercise devices**, **E0935** (for use on knee only) and **E0936** (for use other than knee), are rented on a per diem basis up to 14 days, with 1 unit of service = 1 day.
- **Extension/flexion devices** (**E1800-E1818**, **E1825-E1840**) are rented for one month. If needed beyond one month, the insurer's authorization is required.
- **Wound Therapy devices** **(E2402)** are rented per day. 1 unit of service = 1 day.

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Negative Pressure Wound Therapy (NPWT) is covered when the wound is related to an injury or illness allowed on the claim. Prior authorization is required before starting NPWT, and every 30 days thereafter. See the Department's coverage decision on the requirements for authorization.

Link: For more information go to www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/WoundVAC.asp

Equipment limits for **E2402**: Patients are allowed one NPWT pump per episode (a pump may be used for more than one wound at the same time). Supplies should be limited to 15 dressing kits (**A6550**) per wound per month, and 10 canister sets (**A7000**) per month.

Miscellaneous DME (**E1399**) will be paid by report:

- The miscellaneous item must be appropriate relative to the injury or type of treatment received by the worker.
- **E1399** is payable only for DME that doesn't have a valid HCPCS code.
- All bills for **E1399** items must have either the modifier **–NU** (for purchased) or **–RR** (for rented).
- A description must be on the paper bill or in the remarks section of the electronic bill.

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

DME purchase after rental period of less than 12 months

For equipment rented for less than 12 months and permanently required by the worker:

- For **State fund claims**, the provider will retrieve the rental equipment and replace it with the new DME item.
  - The provider should bill the usual and customary charge for the new replacement DME item. The billed HCPCS code requires a **–NU modifier**.
  - L&I will pay the provider the new purchase price for the replacement DME item up to no more than the maximum fee in the DME fee schedule.
- For **self-insured claims**, self-insurers may purchase the equipment and receive rental credit toward the purchase.

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Payment policy: Repairs and non-routine services, and warranties

Requirements for billing

Repairs and non-routine services

DME repair codes (**K0739**, **K0740**) must be billed per each 15 minutes. One unit of service in the Units field equals 15 minutes.

> **Example:** 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with 3 units of service.

Submitting a warranty to the insurer

A copy of the original warranty is required on each repair service completed and must be submitted to the insurer. **Payment will be denied** if no warranty is received or if the item is still under warranty.

Note: Repair, non-routine service, and maintenance on purchased equipment that is out of warranty will be paid **by report** (see definition of **By report** in Definitions at the beginning of this chapter).

When submitting the warranty to the insurer, write the claim number in the upper right hand corner of the warranty document, and send a copy for:

- **State fund claims** to:

  Department of Labor and Industries
  PO Box 44291
  Olympia, WA 98504-4291

- **Self-insured claims** to the SIE/TPA. A SIE/TPA contact list is available at www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/

Link: For more information on miscellaneous services and appliances, see WAC 296-23-165.

Payment limits

Purchased equipment repair

Repair or replacement of DME is the responsibility of the worker when the item is:

- Damaged due to worker abuse, neglect, misuse, *or*
- Lost or stolen.

Rented equipment repair

Repair, non-routine service, and maintenance are included as part of the monthly rental fee on DME. No additional payment will be provided. This doesn't include disposable and nonreusable supplies. (See **required warranty coverage** in table below.)

Warranty coverage requirements

If the **DME item type** is…	Then the **required warranty coverage** is:
DME purchased new (excluding disposable and nonreusable supplies)	Limited to the manufacturer's warranty
Rented DME	Complete repair and maintenance coverage is provided as part of the monthly rental fee
Power operated vehicle (**E1230**: 3-wheel or 4-wheel non-highway Scooter)	Minimum of one year or manufacturer's warranty, whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	
Wheelchair codes **K0004**, **K0005**, and **E1161**	Lifetime warranty on side frames and cross braces

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules (Washington state laws) for purchasing or renting DME	Washington Administrative Code (WAC) 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102
Administrative rules for miscellaneous services and appliances	WAC 296-23-165: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-165
Administrative rules for payments for rejected and closed claims	WAC 296-20-124: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-124
Administrative rules for treatments requiring authorization	WAC 296-20-03001: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03001
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
Negative Pressure Wound Therapy coverage and treatment	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/WoundVAC.asp
Professional Services **Fee Schedules**	L&I's website: http://feeschedules.Lni.wa.gov

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 10: Evaluation and Management (E/M) Services

Effective July 1, 2016

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

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

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Definitions

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

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

  Used to indicate an E/M 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.

  –GT Interactive telecommunication

  Teleconsultations via interactive audio and video telecommunication systems.

- **Established patient:** One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

- **New patient:** One who hasn't received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

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Payment policy: All E/M services

Requirements for billing

All E/M services

Chart notes must contain documentation that justifies the level of service billed. (See Documentation guidelines, below.)

Determining level of visit: New or established patient

If a patient presents with a work related condition and meets the definition in a provider's practice as:

- A **new patient**, then a new patient E/M should be billed, *or*
- An **established patient**, then an established patient E/M service should be billed, even if the provider is treating a new work related condition for the first time.

Note: L&I uses the CPT® definitions of **new patient** and **established patient**. Also, see definitions of both terms in Definitions at the beginning of this chapter.

Using CPT® billing code modifier –25

Modifier –25 must be appended to an E/M code when reported with another procedure on the same date of service.

The E/M visit and the procedure must be documented separately.

To be paid, **modifier –25** must be reported in the following circumstances:

- Same patient, same day encounter, *and*
- Same or separate visit, *and*
- Same provider, *and*
- Patient condition required a **significant separately identifiable E/M service above and beyond the usual pre and post care** related to the procedure or service.

Scheduling back-to-back appointments doesn't meet the criteria for using **modifier –25**.

Documentation guidelines

The key components in determining the level of E/M service are:

- The history,
- The examination, *and*
- Decision making.

Note: Office visits that consist predominately (more than 50 percent of the visit) of counseling and/or coordination of care activities are the exception. For these visits, time is the key or controlling factor for selecting the level of evaluation and management service. If the level of service is reported based on counseling and/or coordination of care, the chart note must have the total length of the visit documented, as well as what portion of the time was spent counseling and/or coordinating care. The chart note must also describe the counseling and/or the activities to coordinate care.

To determine the appropriate level of service, providers must use one of the following guidelines in conjunction with Evaluation and Management (E/M) Services Guidelines noted in CPT®:

- The "1995 Documentation Guidelines for Evaluation & Management Services," *or*
- The "1997 Documentation Guidelines for Evaluation and Management Services."

Links: Both guidelines are available on Medicare's website. The 1995 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

The 1997 version is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Examples of using billing code modifier –25

Example 1

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A worker goes to an osteopathic physician's office to be treated for back pain.

The physician:

- Reviews the history,
- Conducts a review of body systems, *and*
- Performs a clinical examination.

The physician then advises the worker that osteopathic manipulation is a therapeutic option for treatment for the condition. The physician performs the manipulation during the office visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

How to bill for this scenario

For this office visit, the physician may bill the appropriate:

- CPT® code for the manipulation, *and*
- E/M code with the **–25 modifier**.

Example 2

A worker goes to a physician's office for a scheduled follow up visit for a work related injury.

During the examination, the physician determines that the worker's condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection wasn't scheduled previously as part of the E/M visit. The physician gives the injection during the visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

How to bill for this scenario

For the same time and date of service, the physician may bill the appropriate:

- CPT® code for the injection, *and*
- E/M code with the **–25 modifier**.

Example 3

A worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury.

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That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen. The provider sees the patient for a second office visit.

How to bill for this scenario

Since the 2 visits were completely separate, both E/M services may be billed:

- The scheduled visit would be billed with the E/M code alone, *and*
- The unscheduled visit would be billed with the E/M code with the **–25 modifier**.

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Payment policy: Care plan oversight

Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

Services that can be billed

The insurer allows separate payment for care plan oversight services (CPT® codes **99375**, **99378**, and **99380**).

Requirements for billing

Payment for care plan oversight to a provider providing post surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery, *and*
- **Modifier –24** is used.

The medical record must document the medical necessity as well as the level of service.

Payment limits

Payment is limited to one:

- Per attending provider,
- Per patient,
- Per 30 day period.

Care plan services (CPT® codes **99374**, **99377**, and **99379**) of less than 30 minutes within a 30 day period are considered part of E/M services and aren't separately payable.

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Payment policy: Case management services – Team conferences

Prior authorization

Physical and occupational therapists (PT and OT), and speech language pathologists

PTs, OTs, and speech language pathologists may be paid for attendance at a team conference only when the Medical Director/Associate Medical Director at L&I or the SIE/TPA authorizes the conference in advance.

To be authorized all of the following criteria must be met:

- There is a moderate to high probability of severe, prolonged functional impairment. This may be addressed with the development of a multidisciplinary approach to the plan of care, *and*
- The need for a conference exceeds the expected routine correspondence/communication among healthcare/vocational providers, *and*
- The worker isn't participating in a program in which payment for conference is already included in the program payment (For example, head injury program, pain clinic, work hardening), *and*
- 3 or more disciplines/specialties need to participate, including PT, OT, or speech.

Who must perform team conferences to qualify for payment

Team conferences may be payable when the **attending provider**, **consultant**, or **psychologist** meets with one or more of the following:

- An interdisciplinary team of health professionals,
- L&I staff,
- Vocational rehabilitation counselors,
- Nurse case managers,
- L&I medical consultants,
- SIEs/TPAs, *or*
- PTs, OTs, and speech language pathologists.

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Requirements for billing

Using correct CPT® billing codes

If the **patient status** is…	And you are a **physician,** then bill CPT® code:	And you are a **non-physician,** then bill CPT® code:
Patient present	Appropriate level E&M	**99366**
Patient not present	**99367**	**99368**

For conferences **exceeding 30 minutes**, multiple units of **99366**, **99367**, and **99368** may be billed. If the duration of the conference is:

- 1-30 minutes, then bill 1 unit, *or*
- 31-60 minutes, then bill 2 units.

Documentation requirements

Each provider must submit their own conference report; joint reports aren't allowed. Each conference report must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the visit, *and*
- The nature of the visit, *and*
- All medical, vocational or return to work decisions made.

In addition to the documentation requirements noted above, team conference documentation must also include a goal oriented, time limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, *or*
- Objective measures of function.

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function.

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PTs and OTs

To be paid for the conference the therapists must:

- Bill using CPT® code **99366** if the patient is present or **99368** if the patient isn't present.
- Bill on a **CMS-1500** form (F245-127-000)
- Submit a separate report of the conference; joint reports aren't allowed. The conference report must include:
  - Evaluation of the effectiveness of the previous therapy plan, *and*
  - New goal oriented, time limited treatment plan, *or*
  - Objective measures of function that address the return to work process, *and*
  - The duration of the conference

Providers in a hospital setting

Providers in a hospital setting may only be paid if the services are billed on a **CMS-1500** with an individual provider account number.

Psychiatrists and clinical psychologists

Psychiatrists and clinical psychologists may only bill for these services when also providing consultation or evaluation services.

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Payment policy: Case management services – Telephone calls

Who must perform these services to qualify for payment

Telephone calls are payable to the attending provider, consultant, psychologist, or other provider only when they personally participate in the call.

Services that can be billed

These services are payable when discussing or coordinating care or treatment with:

- The worker,
- L&I staff,
- Attending Provider
- Vocational rehabilitation counselors,
- Nurse case managers,
- Health services coordinators (COHE),
- L&I medical consultants,
- Other physicians,
- Other providers,
- TPAs, *or*
- Employers.

Note: The insurer will pay for telephone calls if the provider leaves a detailed message for the recipient and meets all of the documentation requirements.

Telephone calls are payable regardless of when the previous or next office visit occurs.

Note: L&I doesn't adhere to the CPT® limits for telephone calls.

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Services that aren't covered

Telephone calls aren't payable if they are for:

- Authorization, *or*
- Resolution of billing issues, *or*
- Ordering prescriptions.

Requirements for billing

Using correct CPT® billing codes

If the **duration** of the telephone call is…	And you are a **physician,** then bill CPT® code:	And you are a **non-physician** (see Note below table), then bill CPT® code:
1-10 minutes	**99441**	**98966**
11-20 minutes	**99442**	**98967**
21-30 minutes	**99443**	**98968**

Note: ARNPs, PAs, psychologists, PTs, and OTs must bill using non-physician codes.

Documentation requirements

Each provider must submit documentation for the telephone call that must include:

- The date, *and*
- The participants and their titles, *and*
- The length of the call, *and*
- The nature of the call *and*
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists

Psychiatrists and clinical psychologists may only bill for these services when mental health services are authorized.

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Payment policy: Case management services – Online communications and consultations

Requirements for online communications

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association,
- The Federation of State Medical Boards, *and*
- The eRisk Working Group for Healthcare.

Who must perform these services to qualify for payment

Electronic online communications (email) with the worker are payable only when personally made by the:

- Attending provider, *or*
- Consultant, *or*
- Psychologist, *or*
- Physical or occupational therapist, *and*
- Who has an existing relationship with the worker.

Services that can be billed

Services that are payable for communications with workers include:

- Follow up care resulting from a face to face visit that doesn't require a return to the office,
- Non-urgent consultations regarding an accepted condition when the equivalent service provided in person would have resulted in a charge,
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications, *and*
- Discussions of return to work activities with workers and employers.

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Note: L&I doesn't follow the CPT® limits for online communications.

Electronic communications are also payable when discussing or coordinating care, treatment, or return to work activities with:

- L&I staff,
- Vocational rehabilitation counselors,
- Case managers,
- L&I medical consultants,
- TPAs, *or*
- Employers.

Services that aren't covered

Services that aren't payable include:

- Routine requests for appointments,
- Test results that are informational only,
- Requests for prescription refills, *and*
- Consultations that result in an office visit.

Requirements for billing

Using correct CPT® billing codes

As a **provider**, if you are a…	Then bill **CPT® code**:	And the **non-facility maximum fee** is:	Or the **facility maximum fee** is:
Physician	**99444**	**$46.04**	**$43.62**
Non-physician	**98969**	**$46.04**	**$43.62**

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Documentation Requirements

Documentation for electronic communications must include:

- The date, *and*
- The participants and their titles, *and*
- The nature of the communication, *and*
- All medical, vocational or return to work decisions made.

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Payment policy: End stage renal disease (ESRD)

Note: L&I follows CMS's policy regarding the use of E/M services along with dialysis services.

Services that can be billed

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes **99221-99223**),
- An initial inpatient consultation (CPT® codes **99251-99255**), *or*
- A hospital discharge service (CPT® code **99238** or **99239**).

Payment limits

E/M services (CPT® codes **99231-99233** and **99307-99310**) aren't payable on the same date as hospital inpatient dialysis (CPT® codes **90935**, **90937**, **90945**, and **90947**). These E/M services are bundled in the dialysis service.

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Payment policy: Medical care in the home or nursing home

Note: L&I allows attending providers to charge for E/M services in:

- Nursing facilities,
- Domiciliary, boarding home, or custodial care settings, *and*
- The home.

Who must perform these services to qualify for payment

The attending provider (not staff) must perform these services.

Requirements for billing

The medical record must document the medical necessity as well as the level of service.

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Payment policy: Prolonged E/M

Requirements for billing

A report is required when billing for prolonged evaluation and management services. The provider must document in the medical record that they personally furnished the direct face-to-face time with the worker.

Use the following CMS payment criteria:

If you are billing for this **CPT® code**…	Then you **must also bill this (or these) other CPT® code(s)** on the **same date of service:**
99354	**99201-99205, 99212-99215, 99241-99245 or 99324-99350**
99355	**99354** and 1 of the E/M codes required for **99354**
99356	**99221-99223, 99231-99233, 99251-99255, 99304-99310**
99357	**99356** and 1 of the E/M codes required for **99356**

Payment limits

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient.

Prolonged E/M service codes are payable only when another E/M code is billed on the same day.

The time counted toward payment for prolonged E/M services includes only direct face to face contact between the provider and the patient (whether the service was continuous or not).

Prolonged physician services without direct contact are bundled and aren't payable in addition to other E/M codes.

Links: For more information on E/M services, refer to either the:

"1995 Documentation Guidelines for Evaluation & Management Services," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

or

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"1997 Documentation Guidelines for Evaluation and Management Services," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

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.

If evaluation and treatment of the two injuries increases the complexity of the visit:

- A higher level E/M code might be billed, *and*
- If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed.

For State Fund claims, when submitting:

- **Paper bills** to L&I, list all workers' compensation claims treated in Box 11 of the **CMS-1500** form (F245-127-000) or
- **Electronic claims**, list all workers' compensation claims treated in the remarks section of the **CMS-1500** form.

Note: L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition:

- Providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit, *and*
- In this case, separate chart notes for the accepted condition should be sent to the insurer.

Note: Employers don't have the right to see information about an unrelated condition.

Payment limits

A physician would only be paid for more than one evaluation and management visit if there were two separate and distinct visits on the same day (see Example 3, below).

Scheduling back-to-back appointments doesn't meet the criteria for using the **–25 modifier**.

Note: See more about Using billing code **modifier –25** in the All E/M services payment policy section of this chapter.

Examples of split billing

Example 1

A worker goes to a provider to be treated for a work related shoulder injury and a separate work related knee injury. The provider treats both work related injuries.

How to bill for this scenario

For State Fund claims, the provider bills for one visit listing both workers' compensation claims in Box 11 of the **CMS-1500** form (F245-127-000).

L&I will divide charges equally to the claims.

Note: For self-insured claims, contact the SIE or their TPA for billing instructions.

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Example 2

A worker goes to a provider's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident.

How to bill for this scenario

The provider would bill:

- 50% of his usual and customary fee to L&I or the SIE, *and*
- 50% to the insurance company paying for the motor vehicle accident.

L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

Example 3

In the morning, a worker arrives at a physician's office for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit.

How to bill for this scenario

Since the two visits were completely separate, both E/M services may be billed as follows:

- The scheduled visit would be billed with the E/M code alone, *and*
- The unscheduled visit would be billed with the E/M code with the **–25 modifier**.

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Payment policy: Standby services

Requirements for billing

A report is required when billing for standby services.

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service, *and*
- The standby service involves prolonged provider attendance without direct face-to-face patient contact, *and*
- The standby provider isn't concurrently providing care or service to other patients during this period, *and*
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package," *and*
- Standby services of 30 minutes or more are provided.

Payment limits

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported.

Note: Round all fractions of a 30 minute period downward.

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Payment policy: Teleconsultations and other telehealth services

System requirements

Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real time consultation between the patient and consultant. Providers are responsible for ensuring the complete confidentiality and privacy of the worker is protected at all times.

Note: L&I adopted a modified version of CMS's policy on teleconsultations and other telehealth services.

Coverage of teleconsultations

Teleconsultations are covered in the same manner as face-to-face consultations, but in addition, all of the following conditions must be met:

- The **consultant** must be a:
  - Doctor as described in WAC 296-20-01002, or
  - ARNP, *or*
  - PhD Clinical Psychologist, *or*
  - Consulting DC who is an approved consultant with L&I, *and*
- The **referring provider** must be one of the following:
  - MD, *or*
  - DO, *or*
  - ND, *or*
  - DPM, *or*
  - OD, *or*
  - DMD, *or*
  - DDS, *or*

  - DC, *or*
  - ARNP, *or*
  - PA, *or*
  - PhD Clinical Psychologist, *and*
- The patient must be present at the time of the consultation, *and*
- The exam of the patient must be under the control of the consultant, *and*
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant, *and*
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer, *and*
- A referring provider who isn't the attending must consult with the attending provider before making the referral.

Links: For more information about coverage of these services, see WAC 296-20-045 and WAC 296-20-051. Also, see WAC 296-20-01002.

Services that can be billed

Originating facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment.

Providers

Providers (acting within their scope of practice) may bill for these services:

- Consultation codes,
- Office or other outpatient visits,
- Follow up visits after the initial consultation,
- Psychiatric intake and assessment,
- Individual psychotherapy,
- Pharmacologic management,

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- End stage renal disease (ESRD) services, *and*
- Team conferences.

Services that aren't covered

Telemedicine procedures and services that aren't covered include:

- "Store and Forward" technology, asynchronous transmission of medical information to be reviewed by the consultant at a later time,
- Facsimile transmissions,
- Purchase, rental, installation, or maintenance of telecommunication equipment or systems,
- Telerehabilitation services,
- Home health monitoring, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Requirements for billing

Originating facility

For the use of the telecommunications equipment, bill HCPCS code **Q3014,** which has a maximum fee of **$36.40** (effective July 1, 2016).

Documentation must be identified clearly and separately in the medical record.

Providers

Providers must append a **–GT modifier** to one of the appropriate services (see the list of services under Services that can be billed, above).

Payment limits

No separate payment will be made for the:

- Review and interpretation of the patient's medical records, *or*
- Required report that must be submitted to the referring provider and to the insurer.

The insurer will only pay for a professional service by the referring provider if it is:

- A separately identifiable service, *and*

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- Provided on the same day as the telehealth service.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for E/M services	Washington Administrative Code (WAC) 296-20-045: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-045 WAC 296-20-051: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-051 WAC 296-20-01002: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01002
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services (including chiropractic)	L&I's website: http://feeschedules.Lni.wa.gov
The 1995 Documentation Guidelines for Evaluation & Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
The 1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

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

Chapter 11: Home Health Services

Effective July 1, 2016

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

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

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Definitions

- **Attendant care services:** Attendant care services provide assistance in the home for **personal care** and activities of daily living. (See definition of **Personal care**, below.)

- **Bundled:** A bundled procedure code isn't payable separately because its value is accounted for and included in the payment for other services. Bundled codes are identified in the fee schedules.

  Link: For the legal definition of **Bundled**, 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.

- **Chore services aren't authorized:** Examples of **chore services** are:

  - Childcare,
  - Laundry and other housekeeping activities,
  - Meal planning and preparation,
  - Other everyday environmental needs unrelated to the medical care of the worker,
  - Recreational activities,
  - Shopping and running errands for the worker,
  - Transportation of the worker,
  - Yard work,
  - Work associated activities.

- **Home health services:** Home health services are for intermittent or short-term treatment or therapy for a medical condition, and include attendant care, home health, home care, infusion therapy, and hospice.

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Note: In this chapter, payment policies for Attendant care services, Home infusion services, and In-home hospice services are detailed in distinct payment policy sections.

- **Home infusion services:** Home health services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home.

- **Personal care:** Personal care may include, but isn't limited to:

  - Administration of medication,
  - Bathing,
  - Personal hygiene and skin care,
  - Bowel and bladder incontinence,
  - Feeding assistance,
  - Mobility assistance,
  - Turning and positioning,
  - Transfers or walking,
  - Supervision due to cognitive impairment, behavior, or blindness,
  - Range of motion exercises, *or*
  - Ostomy care.

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Payment policy: Attendant care services

(See definition of **Attendant care services** in Definitions at the beginning of this chapter.)

Prior authorization

All attendant care

All attendant care services require prior authorization.

The insurer will determine the maximum hours and type of authorized attendant care based on the nursing assessment of the worker's **personal care** needs that are proper and necessary and related to the worker's industrial injury.

Note: For a definition of **Personal care**, see Definitions at the beginning of this chapter.

Attendant care services may be **terminated or not authorized** if:

- Behavior of worker or others at the place of residence is threatening or abusive,
- Worker is engaged in criminal or illegal activities,
- Worker doesn't have the cognitive ability to supervise attendant and there isn't an adult family member or guardian available to supervise the attendant,
- Residence is unsafe or unsanitary and places the attendant or worker at risk, *or*
- Worker is left unattended during approved service hours by the approved provider.

The insurer will notify the provider in writing if current approved hours are modified or changed.

Wound care

When attendant care agencies are providing care to a worker with an infectious wound, prior authorization and prescription from the treating physician is required.

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Worker travel

Workers who qualify for attendant care and are planning a long-distance trip must inform the insurer of the plans and request specific authorization for coverage during the trip.

Temporary or respite care

Temporary or respite care requires prior authorization. The agency providing respite care must meet L&I criteria as a provider of home health services.

The insurer can approve short-term agency attendant care services for a spouse or family member who provides either paid or unpaid attendant care when respite (relief) is required.

Note: Spouses won't be paid for respite care.

If a current nursing assessment is unavailable, a nursing evaluation will be conducted to determine the level of care and the maximum hours of service required. (Also see Independent nurse evaluation reports under Services that can be billed, below.)

If in-home attendant care can't be arranged with an agency, the insurer can approve a temporary stay in a residential care facility.

The insurer will notify the agency in writing when services are approved.

The insurer will notify the provider in writing if current approved hours are modified or changed.

Who must perform these services to qualify for payment

Attendant care agency requirements

Attendant care services must be provided by an agency that is licensed, certified, or registered to provide home health or home care services. Attendant care agencies must have registered nurse (RN) supervision of caregivers providing care to a worker.

The agency providing services must be able to provide the type of attendant care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

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Attendant requirements

Workers must not be left unattended during approved service hours.

Attendants for workers may be:

- Registered aides,
- Certified nurse's aides,
- Licensed practical nurses, *or*
- RNs.

Respite care

The agency providing respite care must meet L&I criteria as a provider of home health services.

Spouse attendant care

Spouses may continue to bill for spouse attendant care if they:

- Aren't employed by an agency,
- Provided insurer approved attendant services to the worker prior to October 1, 2001, *and*
- Met criteria in the year 2002.

Note: Also, see Payment limits for spouse attendant care, below.

Link: For more information on laws about spouse attendant care, see WAC 296-23-246.

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Services that can be billed

Attendant services

HCPCS code	Description	Max fee
S9122	Attendant in the home provided by a home health aide certified or certified nurse assistant per hour	**$27.69**
S9123	Attendant in the home provided by a registered nurse per hour	**$60.23**
S9124	Attendant in the home provided by licensed practical nurse per hour	**$43.95**

Agency care services

The agency can bill workers for hours that aren't approved by the insurer if the worker is notified in advance that they are responsible for payment.

Independent nurse evaluation reports

An independent nurse evaluation requested by the insurer, may be billed under Nurse Case Manager or Home Health Agency RN codes, using their respective codes. (See more information about these reports under Requirements for billing, below.)

Wound care and medical treatment supplies

Attendant care agencies may bill for wound care and medical treatment supplies.

Covered HCPCS codes listed as **bundled** in the fee schedule are separately payable to home attendant care service providers for supplies used in the worker's home.

Note: See legal definition of **Bundled** in Definitions at the beginning of this chapter.

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Spouse attendant care

HCPCS code	Description	Max fee
8901H	Spouse attendant in the home per hour	**$13.59**

Services that aren't covered

Chore services

Chore services and other services that are only needed to meet the worker's environmental needs aren't covered.

Social work and **chore services** aren't covered, except as part of home hospice care.

Notes: See definition of **Chore services** in Definitions at the beginning of this chapter.

Attendant care services in hospitals or nursing facilities

Attendant care services won't be covered when a worker is in the hospital or a nursing facility **unless**:

- The worker's industrial injury causes a special need that the hospital or nursing facility can't provide, *and*
- Attendant care is authorized specifically to be provided in the hospital or nursing facility.

Travel that isn't related to medical care

The insurer won't cover travel expenses of the attendant or authorized additional care hours.

Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

(Also see Requirements for billing, below.)

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Requirements for billing

Agency care services

In addition to prior authorization, attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services.

Independent nurse evaluation reports

All RN evaluation reports must be submitted to the insurer:

- Within 15 days of the initial evaluation, *and then*
- Annually, *or*
- When the worker's condition changes and necessitates a new evaluation.

Daily chart notes

Documentation to support daily billing must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift,
- Name, initials, and title of each caregiver, *and*
- Specific care provided and who provided the care.

Wound care

In addition to prior authorization, when caregivers are providing wound care a prescription from the treating provider is required to bill for infection control supplies (HCPCS code **S8301**).

An invoice for the supplies must be submitted with the bill.

Travel that isn't related to medical care

A worker who qualifies for attendant care and is planning a long distance trip, must inform the insurer of the plans and request specific authorization for coverage during the trip.

The worker must coordinate the trip with the appropriate attendant care agencies. (Also see Services that aren't covered, above.)

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Payment limits

Attendant services

RN supervision services aren't paid separately and are included in the hourly fee as business overhead.

Attendant care providers can't bill for services the attendant performs in the home while the worker is away from the home.

Agency care services

- The agency will not bill for more than 12 hours per day for any one caregiver.
- The agency will not bill for care during the time the caregiver is sleeping.

Spouse attendant care

Spouse attendants may bill up to 70 hours per week. Also:

- Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation, which must be performed yearly, *and*
- If the worker requires more than 70 hours per week of attendant care the insurer can approve a qualified agency to provide the additional hours of care, *and*
- The insurer will determine the maximum amount of additional care based on an RN evaluation.

Spouse attendants won't be paid during sleeping time.

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Payment policy: Home health services

(See definition of **Home health services** in Definitions at the beginning of this chapter.)

Links: For additional information on home health services, see WAC 296-20-03001(8) and WAC 296-23-246.

Prior authorization

Home health services

All home health services require prior authorization and must be requested by a physician. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

When services become proper and necessary to treat a worker's accepted condition, the insurer will pay for aide, RN, physical therapy (PT), occupational therapy (OT), and speech therapy services provided by a licensed home health agency.

Home health services may be **terminated or denied** when the worker's medical condition and situation allows for outpatient treatment.

Durable medical equipment (DME)

Durable medical equipment may require specific authorization prior to purchase. Covered HCPCS codes listed as **bundled** in the fee schedule are separately payable to home health and home care providers for supplies used during the home health visit.

Link: To see which codes require prior authorization, see the HCPCS fee schedule at http://feeschedules.Lni.wa.gov/

Codes that require prior authorization are noted with a **Y** in the "PRIOR AUTH" column.

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

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Worker responsibilities

The worker is expected to be present and ready for the home health nurse or therapist treatment.

Noncooperation can result in termination of services.

Who must perform these services to qualify for payment

Aide, RN, LPN, physical therapy (PT), occupational therapy (OT), and speech therapy services are provided by a licensed home health agency.

Services that can be billed

Home health services

HCPCS code	Description and notes	Max fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day	**$39.72**
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day	**$41.19**
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day	**$41.19**
G0156	Services of home health aide in the home 15 min units. Maximum of 96 units per day	**$6.91**
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units	**$41.19**
G0299	Services of skilled nurse RN in the home. 15 min units	**$41.19**
G0300	Services of skilled nurse LPN in the home. 15 min units	**$37.71**

Wound care and medical treatment supplies

Home health and home infusion services may bill appropriate HCPCS codes for wound care and medical treatment supplies.

Covered HCPCS codes listed as **bundled** in the fee schedule are separately payable to home health and home care providers for supplies used during the home health visit.

Note: See legal definition of **Bundled** in Definitions at the beginning of this chapter.

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Requirements for billing

Documentation

The following documentation is required to be submitted by the home health care provider within 15 days of beginning the services:

- Attending provider's treatment plan and/or orders by the attending provider,
- An initial evaluation by the RN or PT/OT, *and*
- A home care treatment plan.

Updated plans must be submitted every 30 days thereafter.

Providers must submit documentation to the insurer to support daily billing that includes:

- Begin and end time of each caregiver's shift,
- Name, initials, and title of each caregiver, *and*
- Specific care provided and who provided the care.

Continued treatment

Payment for continued treatment requires:

- Documentation of the worker's needs and progress, *and*
- Renewed authorization at the end of an approved treatment period.

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Payment policy: Home infusion services

(See definition of **Home infusion services** in Definitions at the beginning of this chapter.)

Links: For additional information on home infusion services, see WAC 296-20-1102.

Prior authorization

Regardless of who is providing services, prior authorization is required for:

- **Home infusion nurse services**,
- **Drugs**, *and*
- Any **supplies**.

The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Home infusion services can be authorized independently or in conjunction with home health services.

Home infusion skilled nurse services will only be authorized when **infusion therapy** is approved as treatment for the worker's allowed industrial condition.

Who must perform these services to qualify for payment

Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy, as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

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Note: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.

Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for Home infusion services in this chapter for more information.

Services that can be billed

Home infusion nurse services and drugs

These home infusion CPT® codes may be billed for initial establishment of nutritional therapy for the worker when services have been authorized:

CPT® code	Description and notes	Max fee
99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit	**$158.95**
99602	Skilled RN visit for each additional hour per visit	**$66.84**

Wound care and medical treatment supplies

Home health and home infusion services may bill appropriate HCPCS codes for wound care and medical treatment supplies.

Covered HCPCS codes listed as **bundled** in the fee schedule are separately payable to home health and home care providers for supplies used during the home health visit.

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

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Requirements for billing

Home infusion nurse services

For administering home injections or nutritional parenteral solutions only, use the RN visit code **G0154** (Services of skilled nurse in home health setting, each 15 minutes).

Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.

Supplies

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes.

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Payment policy: In-home hospice services

Link: For payment policies for hospice services performed in a facility, see Chapter 36: Nursing Home and Other Residential Care Services.

Prior authorization

In-home hospice services must be preauthorized and may include chore services. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Services that can be billed

HCPCS code	Description and notes	Max fee
Q5001	Hospice care, in the home, per diem. Applies to in-home hospice care.	**By report**

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

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for home health services	Washington Administrative Code (WAC) 296-20-03001(8): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03001 WAC 296-20-1102: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-1102 WAC 296-23-246: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-246
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 professional services (including home health)	L&I's website: http://feeschedules.Lni.wa.gov
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **hospice services performed in a facility**	Chapter 36: Nursing Home and Other Residential Care Services
Payment policies for **physical therapy and occupational therapy**	Chapter 24: Physical Medicine Services
Payment policies for **supplies**	Chapter 28: Supplies, Materials, and Bundled Services

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 12: Impairment Rating Services

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

- **Body areas:** For rating impairment, the following **body areas** are recognized:
  - Head, including the face,
  - Neck,
  - Chest, including breasts and axilla,
  - Genitalia, groin, buttock,
  - Back,
  - Abdomen, *and*
  - Each extremity.

  Note: Each extremity is counted **once per extremity examined**, when determining standard, or complex codes.

- **Organ systems:** For rating impairment, the following **organ systems** are recognized:
  - Eyes,
  - Ears, nose, mouth, and throat,
  - Cardiovascular,
  - Gastrointestinal,
  - Respiratory,
  - Genitourinary,
  - Musculoskeletal,
  - Skin,
  - Neurologic,
  - Psychiatric, *and*
  - Hematologic/ lymphatic/ immunologic.

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Payment policy: Impairment ratings

Prior authorization

Prior authorization is only required when:

- A psychiatric impairment rating is needed, *or*
- An IME is scheduled.

Local billing code **1198M** must be requested and authorized by the claim manager.

When and how to perform an impairment rating

When to rate impairment

When the worker has reached maximum medical improvement (MMI) or when requested by the insurer. Impairment rating should occur during the closing exam.

Rate impairment only for medical conditions accepted under the claim.

Body areas and organ systems

The definitions of **body areas** and **organ systems** from Current Procedural Terminology (CPT®) book must be used to distinguish between standard, and complex impairment rating.

Note: See definitions of **body areas** and **organ systems** in Definitions at the beginning of this chapter.

How to rate impairment

Use the appropriate rating system.

Link: For an overview of systems for rating impairment, see the **Medical Examiners' Handbook** (F252-001-000).

Include the objective findings to support the impairment rating. The objective medical information will also be needed if a worker requests the claim be reopened.

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Impairment rating reports must include all of the following elements:

- **MMI**: Statement that the patient has reached maximum medical improvement (MMI) and that no further curative or rehabilitative treatment is recommended, *and*
- **Examination**: Pertinent details of the physical examination performed (both positive and negative findings). The report must include pertinent measurements (e.g. range of motion) even if they are within normal limits. This is important to document for comparison with potential reopening applications., *and*
- **Diagnostic tests**: Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam, *and*
- **Rating**: An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example:
    - The AMA Guidelines to the Evaluation of Permanent Impairment Fifth Edition, *or*
    - The Washington State Category Rating System.

Links: Refer to WAC 296-20-19000 through WAC 296-20-19030 and WAC 296-20-200 through WAC 296-20-690, and for amputations refer to RCW 51.32.080.

- **Rationale**: The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

Note: If there isn't an impairment, document that in your report.

Who must perform these services to qualify for payment

Attending providers (APs) who are permitted to rate their own patients don't need an IME provider account number and may use their existing provider account number.

Qualified APs may rate impairment of their own patients.

Providers may only give ratings for areas of the body or conditions within their scopes of practice.

If the AP is unable or unwilling to perform the rating examination, the AP can ask a consultant to perform the rating examination.

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Psychologists may not be an attending provider (except for Crime Victim's claims) and may not rate impairment for injured workers but may rate impairment for victims of crime.

To determine if you are qualified to provide this service, see table below:

If your provider type **that you're** currently licensed in **is…**	**Then are you** able to rate impairment as AP or consultant?
Medicine and surgery	Yes
Osteopathic medicine and surgery	Yes
Podiatric medicine and surgery	Yes
Dentistry	Yes
Chiropractic	Yes, if L&I approved IME examiner
Naturopathy	No
Optometry	No
Physicians' Assistant	No
Advanced Registered Nurse Practitioners (ARNP), including Psychiatric ARNPs	No

Links: To see how these qualifications are set in state law, see WAC 296-20-2010.

For more details on the topic of impairment ratings, refer to the **Medical Examiners' Handbook** (F252-001-000), available online at www.Lni.wa.gov/IPUB/252-001-000.pdf, and to the **Attending Doctor's Handbook** (F252-004-000), available online at www.Lni.wa.gov/IPUB/252-004-000.pdf.

Services that can be billed

The impairment rating exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the local billing code based on the number of **body areas** or **organ systems** that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related (see fee schedule, below).

Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

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Impairment rating fee schedule, effective July 1, 2016:

Note: See definitions of **body areas** and **organ systems** in Definitions at the beginning of this chapter.

Local billing code	Description	Maximum fee
1190M	**Comprehensive Hearing loss exam** Use this code for comprehensive examination of the hearing system. The hearing system is comprised of two organ systems that need to be thoroughly examined for evaluation of the contended or accepted condition(s). Included in this code are the following requirements: This specialty exam is directed only toward the affected body area or organ system. Familiarity with the history of the industrial injury, exposure or condition through patient interview and medical and work records if available. Diagnostic tests needed including audiograms are ordered and interpreted by the physician. The degree of impairment is based on the audiogram and is interpreted by a physician. The report must contain the required elements noted in the Medical Examiners' Handbook. The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or conditions(s). Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	**$525.42**
1191M	**Impairment rating by attending physician, standard, 1-3 body areas or organ systems**. Use this code if there are 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: Familiarity with the history of the industrial injury or condition. Physical exam is directed only toward the affected body area or organ system.	**$525.42**

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Local billing code	Description	Maximum fee
	Diagnostic tests needed are ordered and interpreted. Impairment rating is performed. Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	
1192M	**Impairment rating by attending physician, complex, 4 or more body areas, or organ systems**. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: Familiarity with the history of the industrial injury or condition. Physical exam is directed only toward the affected body area or organ system. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed. Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	**$656.75**
1194M	**Impairment rating by consultant, standard, 1-3 body areas or organ systems**. Use this code if there are 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: Records are reviewed. Physical exam is directed only toward the affected areas or organ systems of the body. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed. Impairment rating report must contain the required elements noted	**$525.42**

Local billing code	Description	Maximum fee
	in the Medical Examiners' Handbook. The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	
1195M	**Impairment rating by consultant, complex, 4 or more body areas or organ systems**. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: Records are reviewed. Physical exam is directed only toward the affected areas or organ systems of the body. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed. Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	**$656.75**
1198M	**Impairment rating, addendum report**. Must be requested and authorized by the claim manager. Addendum report for additional information which necessitates review of new records. Payable to attending physician or consultant. This code isn't billable when the impairment rating report didn't contain all the required elements. (See the Medical Examiners' Handbook for the required elements.)	**$120.72**

Requirements for billing

APs use billing codes **1191M** and **1192M**.

Consultants use billing codes **1194M** and **1195M**.

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Code **1198M** must be requested and authorized by the claim manager.

Additional information: How to find out if an impairment rating is scheduled

Links: To see if an IME is scheduled, for a claim that is:

- State Fund, use our secure, online Claim & Account Center. To set up an account go to www.Claiminfo.Lni.wa.gov, *or*
- Self-insured, contact the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs, go to: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/, *or*
- Crime Victims, call **1-800-762-3716**.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules and other Washington state laws for impairment ratings	Washington Administrative Code (WAC) 296-20-19000: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-19000 WAC 296-20-19030: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-19030 WAC 296-20-200: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-200 WAC 296-20-2010: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-2010 WAC 296-20-690: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-690 Revised Code of Washington (RCW) 51.32.080: http://apps.leg.wa.gov/RCW/default.aspx?cite=51.32.080
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 (including impairment ratings)	L&I's website: http://feeschedules.Lni.wa.gov
How to perform an impairment rating	L&I's website: **Attending Doctor's Handbook**: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1669 **Medical Examiner's Handbook**: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 13: Independent Medical Exams (IME)

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

- **Body areas:** For IMEs, the following **body areas** are recognized:
  - Head, including the face,
  - Neck,
  - Chest, including breasts and axilla,
  - Abdomen,
  - Genitalia, groin, buttock,
  - Back, *and*
  - Each extremity.

  Note: Each extremity is counted **once per extremity examined**, when determining standard or complex codes.

- **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.

- **Local code modifier mentioned in this chapter:**

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

  When X-rays, laboratory, neuropsychological testing and other diagnostic tests are requested for the IME, identify the service(s) by adding the **modifier – 7N** to the usual procedure number.

  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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- **Organ systems:** For IMEs, the following **organ systems** are recognized:
  - Eyes,
  - Ears, nose, mouth, and throat,
  - Cardiovascular,
  - Gastrointestinal,
  - Genitourinary,
  - Respiratory,
  - Musculoskeletal,
  - Skin,
  - Neurologic,
  - Psychiatric, *and*
  - Hematologic/ Lymphatic/ Immunologic.

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Payment policy: Independent medical exams (IMEs)

Who must perform an IME to qualify for payment

Only **department approved** IME Providers with an IME provider account number can bill IME codes.

Links: To obtain an **application** go to

www.Lni.wa.gov/FormPub/Detail.asp?DocID=1620, *or*

For more information on **becoming an approved IME provider** or to perform impairment ratings:

- See the **Medical Examiners' Handbook** (F252-001-000) at www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668, *or*
- Go to www.Lni.wa.gov/ClaimsIns/Providers/Becoming/IME/ .

To receive email updates on IMEs, subscribe to the ListServ at: www.Lni.wa.gov/Main/Listservs/IME.asp.

Services that can be billed

IME unique billing codes

Local billing code	Description and notes	Maximum fee
1104M	**IME, addendum report. Requested and authorized by claim manager**. Addendum report for information that isn't requested in original assignment, which necessitates review of records. Isn't to be used for review of job analysis or review of diagnostic testing or study results ordered by the examiner.	**$120.72**
1105M	**IME Physical Capacities Estimate**. Form (F242-387-000) Must be requested by the insurer. Bill under one examiner's provider account number for multi-examiner exams. (Bill once per exam.)	**$32.22**

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Local billing code	Description and notes	Maximum fee
1108M	**IME, standard exam – 1-3 body areas or organ systems** Use this code if there are only 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient. Use of this code requires: • Records to be reviewed and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests ordered and interpreted. • Impairment rating performed if requested. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions addressing how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note:** Additional examiners use **1112M**.	**$525.42**
1109M	**IME, complex exam – 4 or more body areas or organ systems** Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the patient. Use of this code requires: • Records to be reviewed and a report included with detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam directed only toward the affected body areas or organ systems. • Appropriate diagnostic tests ordered and interpreted. • Impairment rating performed if requested. • The IME report containing the required elements noted in the Medical Examiners' Handbook. • Report conclusions addressing how the examined body	**$656.75**

Local billing code	Description and notes	Maximum fee
	areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Review of up to 2 job analyses. **Note:** Additional examiners use **1112M**.	
1111M	**IME, no-show fee, per examiner**. Bill only if worker fails to show and appointment time can't be filled. Isn't payable for no-shows of IME related services (for example, neuropsychological evaluations see billing code **1139M**, and Functional Capacity Evaluations (FCE) see billing code **1140M**). For more information, see: WAC 296-20-010.	**$223.58**
1134M	**IME late cancellation fee, per examiner** Bill only if worker fails to show and appointment time can't be filled and cancellation is within 3 business days of exam. (Business days are Monday thru Friday.) Isn't payable for no shows of IME related services (for example, neuropsychological evaluations).	**$223.58**
1112M	**IME, additional examiner for IME** Use where input from more than 1 examiner is combined into 1 report. Includes: • Record review, • Exam, *and* • Contribution to combined report. L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient. **Note**: One examiner on IMEs with a combined report should bill a standard or complex exam code (**1108M** or **1109M**).	**$525.42**
1118M	**IME by psychiatrist** Psychiatric diagnostic interview with or without direct observation of a physical exam. L&I expects these exams will typically involve at least 60 minutes of face-to-face time with the patients. Includes: • Review of records, other specialist's exam results, if any. • Consultation with other examiners and submission of a joint report if scheduled as part of a panel. • Report with a detailed chronology of the injury or condition,	**$950.80**

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Local billing code	Description and notes	Maximum fee
	as described in the Medical Examiners' Handbook. Also includes impairment rating, if applicable.	
1120M	**IME, no-show fee, psychiatrist** Bill only if worker fails to show and appointment time can't be filled Isn't payable for no shows of IME related services (for example, neuropsychological evaluations see billing code 1139M). For more information, see: WAC 296-20-010.	**$346.57**
1135M	**IME late cancellation fee, psychiatrist** Bill only if worker fails to show and appointment time can't be filled and cancellation is within 3 business days *of exam*. (Business days are Monday thru Friday.) Isn't payable for late cancellation of IME related services (for example, neuropsychological evaluations).	**$346.57**
1122M	**Impairment rating by an approved pain program** Program must be approved by insurer Impairment rating must be requested by the insurer. Must be performed by a doctor currently licensed in medicine and surgery (including osteopathic and podiatric physicians), dentistry, or L&I approved chiropractic examiners. (For more information, see: WAC 296-20-2010). The rating report must include at least the following elements as described in the Medical Examiners' Handbook: • MMI (maximum medical improvement), • Physical exam, • Diagnostic tests, • Rating, *and* • Rationale.	**$525.42**
1123M	**IME, communication issues** Exam was unusually difficult due to expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report. If interpreter needed, verify and record name of interpreter in report. Bill once per examiner per exam. Isn't payable with a no show fee (**1111M** or **1120M**).	**$211.29**

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Local billing code	Description and notes	Maximum fee
1124M	**IME, other, by report** Requires preauthorization and prepay review: • For State Fund claims, call Credentialing and Compliance at **360-902-6818**, *or* • For self-insured claims contact the self-insured employer or third party administrator.	**By report**
1125M	**Physician travel per mile** Allowed when roundtrip exceeds 14 miles. Code usage is limited to extremely rare circumstances. Requires preauthorization and prepay review: • For State Fund claims, call Credentialing and Compliance at **360-902-6818**, *or* • For self-insured claims contact the self-insured employer or third party administrator.	**$5.17**
1128M	**Occupational disease report**. (Doctor's Assessment of Work Relatedness for Occupational Diseases) Must be requested by insurer. Examples of conditions which L&I considers occupational diseases are: • Occupational carpal tunnel syndrome, • Noise-induced hearing loss, • Occupational dermatitis, *and* • Occupational asthma. The legal standard is different for occupational diseases than for occupational injuries. This is a detailed assessment of work relatedness, with the exact content presented in the Medical Examiners' Handbook. A doctor may bill this code **only once for each patient**.	**$195.40**

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Local billing code	Description and notes	Maximum fee
1129M	**IME, extensive file review by examiner** Units of service are based on the number of hardcopy pages reviewed by the IME examiner on microfiche, paper, Claim and Account Center, or other medium. Review of the **first 550 hardcopy pages** is included in the base exam fee (**1108M**, **1109M**, **1118M**, or **1130M**). Bill for each additional page reviewed beyond the first 550 hardcopy pages. Isn't payable with **1111M** or **1120M**. Only the following document categories will be paid for **unless** the authorizing letter requests a review of **all** documents: • Medical files, • History, • Report of Accident, • Reopen Application, *and* • Other documents specified by claim manager or requestor. Bill per examiner. Bill for unique documents not duplicates. Payment won't be made for review of duplicate documents. **Note**: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook.	**$1.07**
1130M	**IME, terminated exam** Bill for exam ended prior to completion. Requires file review, partial exam by the examiner and report (including reasons for early termination of exam). **Note**: A partial exam is face-to-face time between the examiner and the worker where, at a minimum, the worker's history is obtained.	**$374.29**
1132M	**Document printing of electronic medical records per page**. Payable only once per IME referral. Charges must be based on printing the following electronic records unless the authorizing letter requests a review of **all** documents: • Report of Accident, • Reopen application, • History,	**$0.07 per printed page**

Local billing code	Description and notes	Maximum fee
	• Medical files, • Other documents specified by claim manager or requestor. **Note**: This fee isn't payable if paper copies of records are provided.	
1133M	**IME, document processing fee.** Payable only once per IME referral. **Note**: This fee includes the preparation of documents for examiner review. The preparation of documents includes duplicate document removal.	**$62.62**
1139M	**No show fee for missed neuropsychological testing**. Must be scheduled or approved by department or self-insurer as part of an independent medical examination. (For more information, see: WAC 296-20-010(5).) This code is payable only once per independent medical examination assignment. Must notify department or self-insurer of no-show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$939.52**
1140M	**No show fee for missed Functional Capacity Evaluation (FCE)**. Must be scheduled or approved by department or self-insurer as part of an independent medical examination. (For more information, see: WAC 296-20-010(5).) This code is payable only once per independent medical examination assignment. Must notify department or self-insurer of no show as soon as possible. Bill only if worker fails to show and appointment can't be filled.	**$300.54**
Modifier -7N	**X-rays and laboratory services in conjunction with an IME**. When X-rays, laboratory, neuropsychological testing and other diagnostic tests are provided with an exam, identify the service(s) by adding the **modifier – 7N** to the usual procedure number. **Link:** Procedure codes are listed in the L&I Professional Services Fee Schedules, Radiology and Laboratory Sections, or the other payment policies available at: http://feeschedules.Lni.wa.gov.	n/a

Note: See definition of **Bundled codes** in Definitions at the beginning of this chapter.

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Multiple claim codes

Local billing code	Description and notes	Maximum fee
1136M	**IME, two claims included in evaluation**. Medical examination includes second claim to be evaluated by the medical examiner. This code is used in addition to the primary IME exam code (**1108M**, **1109M**, **1112M**, **1118M**, or **1130M**) only. This shouldn't be reported as a stand-alone code. Bill once per examiner. **Note:** This must be preauthorized by State Fund claim manager or self-insured employer/third party administrator**.**	**$106.46**
1137M	**IME, three claims included in evaluation**. Medical examination includes second and third claims to be evaluated by the medical examiner. This code is used in addition to the primary IME exam code (**1108M**, **1109M**, **1112M**, **1118M**, or **1130M**) only. This shouldn't be reported as a stand-alone code. Bill once per examiner. **Note:** This must be preauthorized by State Fund claim manager or self-insured employer/third party administrator.	**$212.90**
1138M	**IME, four or more claims included in evaluation**. Medical examination includes second, third, and four or more claims to be evaluated by the medical examiner. This code is used in addition to the primary IME exam code (**1108M**, **1109M**, **1112M**, **1118M**, or **1130M**) only. This shouldn't be reported as a stand-alone code. Bill once per examiner. **Note:** This must be preauthorized by State Fund claim manager or self-insured employer/third party administrator.	**$319.36**

Requirements for billing

State Fund (L&I) provider account number requirements for IMEs

For IMEs, examiners need one IME provider account number for each payee they wish to designate.

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An IME examiner who isn't working through any IME firms will need just one IME number, which will also serve as their payee number.

Billing for IME's

Use only the IME examiner's provider account number/NPI for these CPT® or local billing codes (see code description above for more details):			The following codes may be billed by the IME firm or the IME examiner, depending on who renders the service. (see code description above for more details)
1104M	**1120M**	**1135M**	**1124M**
1105M	**1123M**	**1136M**	**1132M**
1108M	**1125M**	**1137M**	**1133M**
1109M	**1128M**	**1138M**	
1111M	**1129M**	**1028M**	
1112M	**1130M**	**1038M**	
1118M	**1134M**	**1066M**	
		99441-99443	

Bills for testing or other services performed in conjunction with an IME must be submitted by the provider who rendered the service (WAC 296-20-125(3)(o)). These services include:

- X-ray, diagnostic laboratory tests in conjunction with IME (append modifier 7N).
- Neuropsychological evaluations and testing CPT® codes – **90791**, **96101**, **96102**, **96118**, **96119**. (For more detailed information on neuropsychological services refer to Chapter 17: Mental Health Services.
- Functional Capacity Evaluations (FCE) – **1045M**

Standard and complex coding

The exam should be sufficient to achieve the purpose and reason the exam was requested.

Choose the code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related.

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Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of **body areas** and **organ systems** from the Current Procedural Terminology (CPT®) book must be used to distinguish between standard and complex IMEs.

Note: See definitions of **Body areas** and **organ systems** in Definitions at the beginning of this chapter.

Payment limits

Limit on total scheduled exams per day

L&I has placed a limit of 12 independent medical examinations scheduled per examiner per day. For psychiatrist examiners, the limit is 8 per day. A psychiatric examiner must spend at least 60 minutes of face to face time with the worker. This limit is inclusive of IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- **1108M** IME, standard exam – 1-3 body areas or organ systems,
- **1109M** IME, complex exam – 4 or more body areas or organ systems,
- **1111M** IME, no show fee, per examiner,
- **1112M** IME, additional examiner for IME,
- **1118M** IME by psychiatrist,
- **1120M** IME, no show fee, psychiatrist,
- **1122M** Impairment rating by an approved pain program,
- **1130M** IME, terminated exam,
- **1134M**, late cancellation fee,
- **1135M**, late cancellation fee, psychiatrist,
- **1136M**, IME, two claims included in evaluation,
- **1137M**, IME, three claims included in evaluation, *and*
- **1138M**, IME four or more claims included in evaluation.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for Billing procedures	Washington Administrative Code (WAC 296-20-125): http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-125
Administrative rules for IME no shows	Washington Administrative Code (WAC) 296-20-010: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-010
Administrative rules and other Washington state laws for impairment ratings	Washington Administrative Code (WAC) 296-20-19000 through WAC 296-20-690 available in WAC 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20 Revised Code of Washington (RCW) 51.32.080: http://apps.leg.wa.gov/RCW/default.aspx?cite=51.32.080
Application to become an IME provider	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1620
Becoming an L&I IME provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/IME/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare professional services	L&I's website: http://feeschedules.Lni.wa.gov
Mental Health Services	Chapter 17: Mental Health Services
Receiving **email updates on IMEs**	Subscribe to L&I's ListServ: www.Lni.wa.gov/Main/Listservs/IME.asp
Performing **impairment ratings**	Medical Examiner's Handbook: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 14: Interpretive Services

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

- **Certified interpreter:** Interpreter who holds credentials in good standing from one or more of the following:

If the **agency or organization** is…	Then the **credential** is a:
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate
Washington State Administrative Office for the Courts (AOC)	Certificate
RID-NAD National Interpreter Certification (NIC)	• Certified Advanced (Level 2), *or* • Certified Expert (Level 3)
Registry of Interpreters for the Deaf (RID)	• Comprehensive Skills Certificate (CSC), *or* • Master Comprehensive Skills Certificate (MSC), *or* • Certified Deaf Interpreter (CID), *or* • Specialist Certificate: Legal (SC:L), *or* • Certificate of Interpretation and Certificate of Transliteration (CI/CT)
National Association for the Deaf (NAD)	Level 4 or Level 5
National Board of Certification for Medical Interpreter	Certified Medical Interpreter (CMI)
Certification Commission for Healthcare Interpreters (CCHI)	Certified Healthcare Interpreter
Federal Court Interpreter Certification Test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate

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- **Certified translator:** Translator who holds credentials in good standing from one or more of the following:

If the **agency or organization** is…	Then the **credential** is a:
DSHS	Translator Certificate
Translators and Interpreters Guild	Certificate
American Translators Association	Certificate

- **Client:** A worker, an individual or a group of people that uses the professional services of an interpreter.

- **Family members:** For the purposes of the interpreter payment policy, **family members** are persons related to each other either biologically or legally. This includes but isn't limited to:

  - Spouse, *or*
  - Registered domestic partner, *or*
  - Parents, *or*
  - Grandparents, *or*
  - Children, *or*
  - Grandchildren, *or*
  - Brothers, *or*
  - Sisters, *or*
  - Mother-in-law , *or*
  - Father-in-law, *or*
  - Brothers-in-law , *or*
  - Sisters-in-law, *or*
  - Daughters-in-law , *or*
  - Sons-in-law, *or*
  - Uncles , *or*
  - Aunts, *or*
  - Cousins, *or*

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- Nieces, *or*
- Nephews, *or*
- Adopted members, *or*
- Half members, *or*
- Step members.

- **Independent medical examination (IME):** An objective medical legal examination requested (by the department or self-insurer) to establish medical facts about a worker's physical condition. These examinations may only be conducted by department approved examiners.

Link: For more information, see: WAC 296-23-302.

- **Qualified interpreter:** Interpreter who holds credentials in good standing from one or more of the following:

If the **agency or organization** is…	Then the **credential** is a:
Translators and Interpreters Guild	Certificate
Washington State Department of Social and Health Services (DSHS)	Letter of authorization as a qualified social and/or medical services interpreter
Federal Court Interpreter Certification Examination (FCICE)	Letter of designation or authorization

- **Qualified translator:** Translator who holds credentials in good standing from one or more of the following:

If the **agency or organization** is…	Then the **credential** is a:
• A state or federal agency, • A state or federal court system, • Other organization including language agencies, *and/or* • An accredited academic institution of higher education.	Certificate or other verification showing: • Successful completion of an examination or test of written language fluency in both English and in the other tested language(s), *and* • A minimum of 2 years experience in document translation.

- **Wait time:** The time period between the scheduled start time and the actual start time of an appointment. No other covered services are performed during this time.

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Payment policy: All interpretive services

What are interpretive services?

Workers or crime victims who have limited English proficiency or sensory impairments may need interpretive services to effectively communicate with providers.

For example, when a procedure requires informed consent, a credentialed interpreter should help the provider explain the information.

Healthcare and vocational services provider responsibilities

Healthcare and vocational services providers should note in their records that an interpreter was used at the appointment.

Whom does this policy apply to?

This policy **applies to** interpretive services provided:

- For healthcare, independent medical examinations (IMEs), and vocational services,
- In all geographic locations,
- To workers and crime victims having limited English proficiency or sensory impairment, and receiving benefits from:
  - The State Fund, *or*
  - Self-insured employers, *or*
  - The Crime Victims Compensation Program.

This policy **doesn't apply to:**

- Document translation unless requested or authorized by the insurer
- Interpretive services for workers or crime victims for legal purposes, including but not limited to:
  - Attorney appointments, *or*
  - Legal conferences, *or*
  - Testimony at the Board of Industrial Insurance Appeals or any court, *or*
  - Depositions at any level.

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Note: In these circumstances, payment is the responsibility of the attorney or other requesting party. Don't bill L&I or the self-insured employer for these services.

Who chooses both the interpretive services provider and when the services are needed

Under the Civil Rights Act of 1964, the healthcare or vocational provider will determine whether effective communication is occurring.

If **assistance is needed**, the healthcare or vocational provider:

- Selects an interpreter to facilitate communication, *and*
- Determines if an interpreter (whether paid or unpaid) accompanying the worker meets the communication needs.

If healthcare or vocational provider determines **a different interpreter is needed**:

- The worker may be consulted in the selection process,
- Sensitivity to the worker's cultural background and gender is encouraged when selecting an interpreter, *and*
- The ultimate decision on who does the interpreting rests with healthcare or vocational provider.

Either **paid or unpaid interpreters** may assist with communications. In all cases:

- A paid interpreter must meet L&I's credentialing standards (see "Standards and responsibilities for interpretive services provider conduct" listed later in this "Payment policy" section), *and*
- Persons identified as ineligible to provide services in this policy may not be used even if they are unpaid, *and*
- Persons under age 18 may not interpret for workers or crime victims.

Note: Also, see other payment policy sections in this chapter related to eligible and ineligible interpretive services providers, including content under these titles:

- Requirements for credentials,
- Who must perform these services to qualify for payment,
- Who can't perform these services, *and*

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- Who can perform these services but won't be paid.

Interpreter Lookup Service (ILS)

Face-to-face interpreters with an active L&I provider account number are listed on the searchable, online ILS database, unless they request not to be included.

Link: ILS is available at: Interpreter Lookup Service.

Prior authorization

Required

Document translation services require prior authorization and must be requested by the insurer.

Not required

Direct interpretive services (either group or individual) and mileage don't require prior authorization on open claims.

Note: Prior to service delivery, providers should check claim status with the insurer.

Who must perform these services to qualify for payment

Note: See unique requirements in other "Payment policy" sections of this chapter for:

- IME interpretive and translation services, *and*
- Telephone interpretive services, *and*
- Video interpretive services.

Who can't perform these services

Note: See unique requirements in other "Payment policy" sections of this chapter for:

- Document translation services,
- Face to face services,

- IME interpretive and translation services, Telephone interpretive services, *and*
- Video interpretive services.

Who can perform these services but won't be paid

Other persons on occasion may assist the worker or crime victim with language or communication limitations. These persons may include but aren't limited to:

- **Family members**, *or*
- Friends or acquaintances, *or*
- The healthcare or vocational provider, *or*
- Employee(s) of the healthcare or vocational provider whose primary job isn't interpretation, *or*
- Employee(s) of the healthcare or vocational provider whose primary job is interpretation but who isn't a credentialed interpreter or translator, *or*
- Interpreters/translators who don't comply with all applicable state and/or federal licensing or certification requirements, including but not limited to, business licenses as they apply to the specific provider's practice or business.

These persons (listed above) don't require provider account numbers, but also **won't be paid** for interpretive services

Note: See the definition of **Family members** in Definitions at the beginning of this chapter.

Services that are covered

Services that may be payable are:

- Except for the initial visit, services prior to claim allowance aren't payable. If the claim is allowed later, the insurer will determine which services rendered prior to claim allowance are payable, *and*
- Only services to assist in completing the reopening application and for insurer requested IMEs are payable unless or until a decision is made. If a claim is reopened, the insurer will determine which other services are payable.

These services are covered and may be billed to the insurer:

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- Interpretive services which facilitate language communication between the worker and a healthcare or vocational provider, *and*
- Time spent waiting for an appointment that doesn't begin at time scheduled (when no other covered services are being delivered during the wait time), *and*
- Assisting the worker to complete forms required by the insurer and/or healthcare or vocational provider, *and*
- A flat fee for an insurer requested IME appointment plus mileage when the worker doesn't attend, *and*
- Translation of document(s) at the insurer's request, *and*
- Miles driven from a point of origin to a destination point and return in a privately-owned vehicle.

Note: Payment is dependent upon service limits and L&I policy.

Interpretive services fee schedule, effective July 1, 2016

Code	Description	L&I limit and authorization information	1 unit of service equals…	Maximum fee
9988M	**Group interpretation** Direct services time between more than one client and healthcare or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute.	Limited to 480 minutes (8 hours) per day per interpreter. Doesn't require prior authorization.	1 minute	**$0.85per minute**
9989M	**Individual interpretation** Direct services time between worker and healthcare or vocational provider, includes wait and form completion time, per minute.	Limited to 480 minutes (8 hours) per day per interpreter. Doesn't require prior authorization.	1 minute	**$0.85per minute**
9986M	**Mileage**, per mile, in a Privately Owned Vehicle (POV)	Mileage billed over 200 miles per claim per day will be reviewed. Doesn't require prior	1 mile	**State rate**

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Code	Description	L&I limit and authorization information	1 unit of service equals…	Maximum fee
		authorization.		
9996M	**Interpreter "IME no show"** Wait time when worker doesn't attend the insurer requested IME, flat fee.	Only 1 no show per worker per day. Payment requires prior authorization. Contact Central Scheduling Unit at **206-515-2799** or the SIE/TPA after no show occurs.	1 worker no show at IME	**Flat fee** **$56.15** Mileage to and from appointment will also be paid
9997M	**Document translation, at insurer request**	Over $500.00 per claim will be reviewed. Authorization will be documented on translation request packet.	1 page	**By report**

Services that aren't covered

The insurer won't pay for the following:

- Interpretive services exceeding **480 minutes** (8 hours) per day per interpreter, *and*
- Interpretation for services that aren't covered by the insurer (see WAC 296-20-03002), *and*
- Interpretive services provided for a denied or closed claim (except services associated with the initial visit, or the visit for the worker's application to reopen a claim, or for a worker receiving a pension with a treatment order), *and*
- No show for any service other than an insurer requested IME (for example, physical therapy visits), *and*
- Mileage for no shows for any service other than an insurer requested IME (for example, physical therapy visits), *and*
- Personal assistance on behalf of the worker (for example, scheduling appointments, translating correspondence or making phone calls), *and*
- Document translation requested by anyone other than the insurer, including the worker, *and*

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- Interpretive services provided for communication between the worker and an attorney or lay worker representative, *and*
- Interpretive services provided for communication not related to the worker's communications with healthcare or vocational providers, *and*
- Travel time and travel related expenses (for example, meals, parking, lodging), *and*
- Overhead costs (for example, phone calls, photocopying, and preparation of bills).

Requirements for billing

Submitting a new bill vs. a billing adjustment for State Fund claims

When the whole bill is denied, then a **new bill** must be submitted to be paid.

When part of the bill is paid, then submit **an adjustment** for the services that weren't paid.

Note: If the time or mileage needs to be corrected, you should submit an adjustment for the **last paid** bill.

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

Documentation requirements:

For paid interpreters, healthcare or vocational providers or their staff must verify services on the **Interpretive Services Appointment Record (ISAR)** (F245-056-000) which the interpreter will present at the end of the appointment. Also see Common Errors on the Interpretive Services Appointment Record (ISAR) at http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2816 for assistance in completing the form.

If the appointment involves multiple claims, a separate ISAR must be submitted for each claim and the healthcare or vocational providers or their staff must verify services on each ISAR.

Note: If corrections to the ISAR form are necessary, see "Changes to medical records" in Chapter 2: Information for All Providers for information on how to appropriately make corrections. (See definition of **Medical records** in Definitions at the beginning of Chapter 2.)

Note: When multiple claims are involved, the billable minutes and the mileage must be prorated between the claims. The "Total Billable Minutes" and the "Total Billable Mileage" on each ISAR submitted must match the amounts billed for that claim.

Interpretive service appointment and mileage documentation must be submitted to the insurer when services are billed. Fax State Fund documentation to **360-902-4567**.

Don't staple documentation to bill forms.

Send **documentation separately from bills** for State Fund or Crime Victims Compensation Program claims, and:

- **Send State Fund bills to:**

  Department of Labor & Industries
  PO Box 44269
  Olympia, WA 98504-4269
  or call **360-902-6500** or **1-800-848-0811**

- **Send Crime Victims Compensation Program bills to:**

  Department of Labor & Industries
  PO Box 44520
  Olympia, WA 98504-4520
  or call **360-902-5377** or **1-800-762-3716**

- **For self-insurer bills:**

  To determine insurer, see the SIE/TPA list at:
  www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/
  or call **360-902-6901**

Additional requirements of hospitals and other facilities

Hospitals, freestanding surgery and emergency centers, nursing homes, and other facilities may have additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider isn't a contractor or a facility employee.

The facility is responsible for notifying the interpretive services provider of their additional requirements and managing compliance with the facilities' requirements.

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Standards and responsibilities for interpretive services provider conduct

L&I is responsible for assuring workers and crime victims receive proper and necessary services. The following requirements set forth the insurer's expectations for quality interpretive services:

Interpreter responsibilities regarding the worker and the healthcare or vocational provider

The interpreter must ensure that all parties understand the interpreter's role and obligations. The interpreter must:

- Inform all parties that everything said during the appointment will be interpreted and they shouldn't say anything they don't want interpreted, *and*
- Inform all parties the interpreter will respect the confidentiality of the worker, *and*
- Inform all parties the interpreter is required to remain neutral, *and*
- Disclose any relationship to any party that may influence or someone could perceive to influence the interpreter's impartiality, *and*
- Accurately and completely represent their credentials, training and experiences to all parties.

Standards for interpreter accuracy and completeness

Interpreters must:

- Always communicate the source language message in a thorough and accurate manner, *and*
- Give consideration to linguistic differences in the source and target languages and preserve the tone and spirit of the source language, *and*
- Not change, omit, or add information during the interpretation assignment, even if asked by the worker or another party, *and*
- Not filter communications, advocate, mediate, speak on behalf of any party, or in any way interfere with the right of individuals to make their own decisions.

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Standards for interpreter confidentiality

The interpreter must not discuss any information about an interpretation job without specific permission from all parties or unless required by law. This includes content of the assignment, such as:

- Time or place,
- Identity of persons involved,
- Content of discussions, *and*
- Purpose of appointment.

Standards for interpreter impartiality

The interpreter must:

- Not discuss, counsel, refer, advise, or give personal opinions or reactions to any of the parties, *and*
- Turn down the assignment if he or she has a vested interest in the outcome or when any situation, factor, or belief exists that represents a real or potential conflict of interest.

Standards for interpreter competency

Interpreters must meet L&I's credentialing standards and be:

- Fluent in English, *and*
- Fluent in the worker's language, *and*
- Fluent in medical terminology in both languages, *and*
- Willing to decline assignments requiring knowledge or skills beyond their competence.

Standards for interpreter maintaining role boundaries

Interpreters must not engage in any other activities that may be thought of as a service other than interpreting, such as:

- Driving the worker to and from appointments, *or*
- Suggesting that the worker receive care from certain providers, *or*
- Advocating for the worker.

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Prohibited conduct

In addition, interpreters can't:

- Market their services to workers or crime victims, *or*
- Arrange appointments in order to:
  - Create business of any kind, *or*
  - Fit into the interpreter's schedule including canceling and rescheduling a worker's medical appointment, *or*
- Contact the worker other than at the request of the insurer or healthcare or vocational provider, *or*
- Provide transportation for the worker to and from healthcare or vocational appointments, *or*
- Require the worker to use the interpreter provider's services exclusive of other approved L&I interpreters, *or*
- Accept any compensation from workers or crime victims or anyone else other than the insurer, *or*
- Bill for someone else's services with your individual (not language agency group) provider account number.

Additional information: Tips for interpretive services providers

Here are some things to keep in mind when working as an interpreter on workers' compensation or crime victims' claims:

- Arrive on time, *and*
- Always provide identification to the worker and providers, *and*
- Introduce yourself to the worker and provider, *and*
- Don't sit with the worker in the waiting room unless assisting him or her with form completion, *and*
- Acknowledge language limitations when they arise and always ask for clarification, *and*
- Don't give your home (nonbusiness) telephone number to the worker or providers, *and*
- Sign up to get L&I provider news and updates at: www.Lni.wa.gov/Main/Listservs/Provider.asp, *and*

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- Send to the insurer the completed Interpreter Services Appointment Record (ISAR) and mileage documentation as required in the Payment Policy: Face-to-face services, Requirements for billing, section of this chapter.

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Payment policy: Document translation services

Requirements for credentials

Note: Requirements for credentials is identical for Face-to-face services (see next Payment policy section of this chapter).

Credentials required for L&I provider account number

An Interpreter or translator must have an active L&I provider account.

To obtain an L&I interpretive services provider account number, an interpreter or translator must submit credentials using the **Submission of Provider Credentials for Interpretive Services** form (F245-055-000). Also note that:

- Credentials accepted include those listed under definitions for **certified translator** and **qualified translator** (see Definitions at the beginning of this chapter), *and*
- Provisional certification isn't accepted.

Note: Interpreters and translators can only be paid for services in the languages for which they have provided credentials.

Interpreters and translators located outside of Washington State must submit credentials from their:

- State Medicaid programs, *or*
- State or national court systems, *or*
- Other nationally recognized programs.

For interpretive services providers in any geographic location, credentials submitted from agencies or organizations other than those listed in the definitions may be accepted if the testing criteria can be verified as meeting the minimum standards listed in the following table.

Note: At the beginning of this chapter, see Definitions of **Certified translator** and **qualified translator**.

Interpreter test(s) consists of, at minimum:	**Document translation test(s)** consists of, at minimum:
A verbal test of sight translation in both English and other tested language(s); ***and***	A written test in English and in the other language(s) tested; ***or***
A written test in English; ***and***	A written test and work samples demonstrating the ability to accurately translate from one specific source language to another specific target language.
A verbal test of consecutive interpretation in both languages; ***and***	—
For those providing services in a legal setting, a verbal test of simultaneous interpretation in both languages.	—

Maintaining credentials

Interpretive services providers are responsible for maintaining their credentials as required by the credentialing agency or organization.

If the interpretive services provider's credentials expire or are removed for any reason, the provider must immediately notify the insurer.

Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers are eligible to receive payment for interpretive services under the following circumstances:

- The individual's sole responsibility is to assist patients or clients with language or sensory limitations, *and*
- The individual is a credentialed interpreter or translator, *and*
- The individual has an L&I provider account number for interpretive services.

Prior authorization

Document translation services are only paid when performed at the insurer's request.

Services will be authorized before the request packet is sent to the translators.

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Who can't perform these services

Note: Who can't perform these services is identical for Face-to-face services (see next Payment policy section of this chapter).

Some persons **may not provide interpretation or translation services** for workers or crime victims during healthcare or vocational services delivered for their claims. These persons are:

- Persons under age 18, *and*
- The legal or lay representative (or any employee of the legal or lay representative) of the:
  - Worker, *or*
  - Crime victim, *or*
  - Employer.

Note: Workers or crime victims using children for interpretation purposes must be told that an adult (a person at least 18 years old) must provide these services.

Services that can be billed

Document translation is an insurer requested service only. Therefore:

- Payment for document translation will be made only if the service was requested by the insurer, *and*
- If anyone other than the insurer requests document translation, the insurer must be contacted before services can be approved for payment.

Requirements for billing

Documentation for translation services must include:

- Date of service, *and*
- Description of document translated (letter, order and notice, medical records), *and*
- Total number of pages translated, *and*

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- Total words translated, *and*
- Target language and source language.

Note: Also see the Interpretive services fee schedule, effective July 1, 2016 in the All interpretive services payment policy section, earlier in this chapter.

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Payment policy: Face-to-face services

Requirements for credentials

Note: Requirements for credentials is identical for Document translation services (see previous Payment policy section of this chapter).

Credentials required for L&I provider account number

An Interpreter or translator must have an active L&I provider account.

To obtain an L&I interpretive services provider account number, an interpreter or translator must submit credentials using the **Submission of Provider Credentials for Interpretive Services** form (F245-055-000). Also note that:

- Credentials accepted include those listed under definitions for certified translator and qualified translator (see Definitions at the beginning of this chapter), *and*
- Provisional certification isn't accepted.

Note: Interpreters and translators can only be paid for services in the languages for which they have provided credentials.

Interpreters and translators located outside of Washington State must submit credentials from their:

- State Medicaid programs, *or*
- State or national court systems, *or*
- Other nationally recognized programs.

For interpretive services providers in any geographic location, credentials submitted from agencies or organizations other than those listed in the definitions may be accepted if the testing criteria can be verified as meeting the minimum standards listed in the following table.

Note: At the beginning of this chapter, see Definitions of **Certified translator** and **qualified translator**.

Interpreter test(s) consists of, at minimum:	**Document translation test(s)** consists of, at minimum:
A verbal test of sight translation in both English and other tested language(s); ***and***	A written test in English and in the other language(s) tested; ***or***
A written test in English; ***and***	A written test and work samples demonstrating the ability to accurately translate from one specific source language to another specific target language.
A verbal test of consecutive interpretation in both languages; ***and***	—
For those providing services in a legal setting, a verbal test of simultaneous interpretation in both languages.	—

Maintaining credentials

Interpretive services providers are responsible for maintaining their credentials as required by the credentialing agency or organization.

If the interpretive services provider's credentials expire or are removed for any reason, the provider must immediately notify the insurer.

Credentialed employees of healthcare and vocational providers

Credentialed employees of healthcare and vocational providers are eligible to receive payment for interpretive services under the following circumstances:

- The individual's sole responsibility is to assist patients or clients with language or sensory limitations, *and*
- The individual is a credentialed interpreter or translator, *and*
- The individual has an L&I provider account number for interpretive services.

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Who can't perform these services

Note: Who can't perform these services is identical for Document translation services (see previous Payment policy section of this chapter).

Some persons **may not provide interpretation or translation services** for workers or crime victims during healthcare or vocational services delivered for their claims. These persons are:

- Persons under age 18, *and*
- The legal or lay representative (or any employee of the legal or lay representative) of the:
  - Worker, *or*
  - Crime victim, *or*
  - Employer.

Note: Workers or crime victims using children for interpretation purposes must be told that an adult (a person at least 18 years old) must provide these services.

Services that can be billed

Mileage and travel

Interpretive service providers may bill for actual POV miles driven to perform interpretation services for an individual worker or group of clients. (Also see Requirements for billing, below.)

Requirements for billing

All face-to-face interpretive services

Interpretive services providers must use the miscellaneous bill form and billing instructions.

Before payment is made:

- All **Interpretive Services Appointment Record** (**ISAR**) forms must be signed by the healthcare or vocational provider or the provider's staff to verify services including the need for mileage for IME no shows, *and*
- All **ISAR** forms must be in the claim file.

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- If the appointment involves multiple claims, a separate ISAR must be submitted for each claim and the healthcare or vocational providers or their staff must verify services on each ISAR.

Note: If corrections to the ISAR form are necessary, see "Changes to medical records" in Chapter 2: Information for All Providers for information on how to appropriately make corrections. (See definition of Medical records in Definitions at the beginning of Chapter 2.)

Note: When multiple claims are involved, the billable minutes and the mileage must be prorated between the claims. The "Total Billable Minutes" and the "Total Billable Mileage" on each ISAR submitted must match the amounts billed for that claim.

Links: The **ISAR** form (F245-056-000) is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625, or a supply of forms can be ordered from the warehouse. Also see Common Errors on the Interpretive Services Appointment Record (ISAR) at http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2816 for assistance in completing the form.

See more information about the **ISAR** form under Appointment documentation,-" below.

To avoid bill denial (a bill that won't be paid):

- All services provided to a worker on the same date must be billed on one bill form, *and*
- POV Mileage verification and an **ISAR** form (see Links below) must be in the claim file at the same time you bill the insurer, *and*
- You must send a completed **ISAR** form, including the healthcare or vocational provider's signature, and the mileage verification by the time your bill is processed.

Links: For more information about billing, see the:

- Examples of how to bill for individual and group interpretive services (later in this payment policy section),
- **General Provider Billing Manual** (F248-100-000).

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Mileage and travel

For mileage documentation:

When billing for mileage, you must submit documentation that supports the reported number of miles between appointments. Documentation must include the:

- Name of software program used, and
- Complete physical address for each appointment location (Street address, City, State, and Zip Code).

When billing for actual miles driven to perform interpretation services for an individual worker or group of clients:

- The interpreter must split the mileage between the worker and the next client if this isn't the first or last appointment of the day, *and*
- When mileage is for services to more than one person (regardless of whether all are workers and/or crime victims), the mileage must be prorated between all the persons served.
- Mileage is reimbursed only in **whole miles**. Calculate mileage from point to point, rounding each trip up to the nearest whole mile.

See examples at the end of this section. Send mileage verification to each worker's claim file at the same time you bill the insurer or **your bill may not be paid**.

Appointment documentation

For appointment documentation direct interpretive services must be recorded on the ISAR form.

Note: If corrections to the ISAR form are necessary, see "Changes to medical records" in Chapter 2: Information for All Providers for information on how to appropriately make corrections. (See definition of **Medical records** in Definitions at the beginning of Chapter 2.)

Note: If a group appointment, include on the form the total number of clients (not healthcare or vocational providers) participating in the appointment.

- Actual mileage information including: actual miles from starting location (including street address) to appointment, actual miles (not prorated) from appointment to next appointment or return to starting location (include street address), actual total miles, *and*
- Verification of appointment by healthcare or vocational provider (printed name and signature of person verifying services), *and*
- Date signed.

Individual face-to-face interpretive services

Services delivered for a single injured worker may include:

- Interpretation performed with the worker and a healthcare or vocational provider, *and*
- Form completion, *and*
- **Wait time** (when no other covered services are being delivered).

Note: See definition of **Wait time** in Definitions at the beginning of this chapter.

When billing for individual interpretation services:

- Only the time actually spent delivering those services may be billed, *and*
- To avoid bill denial, you must bill all services for the same worker, for the same date of service, on one bill form, *and*
- Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end, *and*
- **Exception:** If the appointment starts early, time is counted from when the appointment actually begins. For example, the appointment is scheduled to start at 8:30 a.m. but interpreter arrives at 8:00 a.m. and appointment starts early at 8:15 a.m. Time is counted from 8:15 a.m. when the appointment actually started.
- Time spent travelling between places where interpretive services are performed must be deducted from the total time billed.

Group face-to-face interpretive services

When interpretive services are delivered for more than one person (regardless of whether all are workers and/or crime victims), the time spent must be prorated between the participants. Send a separate bill, with prorated amounts, for each person.

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For example, if three persons are receiving a one-hour group physical therapy session at different stations and the interpretive services provider is assisting the physical therapist with all three persons:

- The interpretive services provider must bill only 20 minutes per person, *and*
- The time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end.

Note: Also see the Interpretive services fee schedule, effective July 1, 2016 in the All interpretive services payment policy section, earlier in this chapter.

Payment limits

Daily time limit

The combined total of both individual and group services is limited to **480 minutes** (8 hours) per day per interpreter.

Mileage and travel

POV Mileage is payable for no show appointments for IMEs only.

Mileage is reimbursed only in **whole miles**. Calculate mileage from point to point, rounding each trip up to the nearest whole mile.

Before being paid, mileage over 200 miles per day will be reviewed for necessity.

Insurers won't pay interpretive service providers' travel time or for travel expenses such as hotel, meals, and parking.

Note: See more details about the payment policy for IME interpretive and translation services in the next section of this chapter.

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Example of how to bill for individual interpretive services

If **you are an interpreter** and during one day you…	Then the **type of service** you will bill for is:	And the **relevant data** to note is:	And the appropriate **units of service and code to bill** are:
Drive 8 miles from your place of business to the location of an appointment for a worker.	Mileage	8 miles	**8 units** of **9986M**
Next, the worker has an 8:45 a.m. appointment. You and the worker enter the exam room at 9:00 a.m. The exam takes 20 minutes. The healthcare provider leaves the room for 5 minutes and returns with a prescription and an order for X-rays for the worker. The appointment ends at 9:30 a.m.	Individual interpretive services	8:45 a.m. to 9:30 a.m. (45 minutes)	**45 units** of **9989M**
Next, you drive 4 miles to the X-ray service provider and meet the worker there.	Mileage	4 miles	**4 units** of **9986M**
Next, you and the worker arrive at the radiology facility at 9:45 a.m. and wait 15 minutes for X-rays, which takes 15 minutes. You both wait 10 minutes to verify X-rays don't need to be repeated.	Individual interpretive services	9:45 a.m. to 10:25 a.m. (40 minutes)	**40 units** of **9989M**
Next, you drive 2 miles to the pharmacy and meet the worker.	Mileage	2 miles	**2 units** of **9986M**
Next, you and the worker arrive at the pharmacy at 10:35 a.m. and wait 15 minutes at the pharmacy for prescription. You explain the directions to the worker, which takes 10 minutes.	Individual interpretive services	10:35 a.m. to 11:00 a.m. (25 minutes)	**25 units** of **9989M**
Finally, after completing the services, you drive 10 miles to your next interpretive services appointment. Since this isn't your last appointment of the day, when you bill you will split the mileage between the worker and the next client.	Mileage	5 miles	**5 units** of **9986M**

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Example of how to bill for group interpretive services

If **you are an interpreter** and during one day you…	Then the **type of service** you will bill for is:	And the **relevant data** to note is:	And the appropriate **units of service and code to bill** are:
Drive 9 miles from your place of business to the location of an appointment for 3 clients. 2 are insured by the State Fund.	Mileage	9 miles, 3 workers (9 divided by 3 = 3)	**3 units** of **9986M** to each State Fund claim
Next, the 3 clients begin a physical therapy appointment at 9:00 a.m. You circulate between the 3 clients during the appointment which ends at 10:00 a.m.	Group interpretive services	9:00 a.m. to 10:00 a.m., 3 workers (60 minutes divided by 3 = 20)	**20 units** of **9988M** to each State Fund claim
Finally, after completing the appointment, you drive 12 miles to your next appointment location. Since this isn't your last appointment of the day, when you bill you will split the mileage between the 3 clients and the next client.	Mileage	12 miles, 2 appointments, 3 workers at first appointment (12 divided by 2 = 6; 6 divided by 3 = 2)	**2 units** of **9986M** to each State Fund claim

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Example of how to bill for interpretive services for 1 client with appointment involving multiple open claims

If **you are an interpreter** and during one day you…	Then the **type of service** you will bill for is:	And the **relevant data** to note is:	And the appropriate **units of service and code to bill** are:
Drive 10 miles from your place of business to the location of a medical appointment for client A with 2 open State Fund claims.	Mileage	10 miles, 1 worker, 2 open claims (10 divided by 2 = 5)	**5 units** of **9986M** to each State Fund claim
Next, client A begins the medical appointment at 9:00 a.m. The appointment ends at 10:00 a.m.	Individual interpretive services	9:00 a.m. to 10:00 a.m., 1 worker, 2 open claims (60 minutes divided by 2 = 30)	**30 units** of **9989M** to each State Fund claim
Finally, after completing the medical appointment, you drive 12 miles to your next appointment location. Since this isn't your last appointment of the day, when you bill you will split the mileage between the 2 claims of client A and the 1 state fund claim of client B.	Mileage	12 divided by 2 clients= 6 units per client; Client A with 2 claims = 3 units per claim (6 divided by 2 = 3 units) Client B = 6 units.	**3 units** of **9986M** to each of client A's State Fund claims **6 units** of **9986M** to the client B's claim

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Payment policy: Independent medical examination (IME) interpretive and translation services

Prior authorization

IME interpretation services

Prior authorization isn't required. Also note that:

- When an IME is scheduled, the insurer or IME provider will arrange for the interpretive services, *and*
- The worker may ask the insurer to use a specific interpreter, however, only the interpreter scheduled by the insurer or the IME provider will be paid, *and*
- Interpreters who accompany the worker, without insurer approval, won't be paid or allowed to interpret at the IME.

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

IME no shows

Authorization is required prior to payment for an IME no show.

Note: After occurrence of IME no show, for:

- State Fund claims, contact the Central Scheduling Unit supervisor at **206-515-2799**, *or*
- Self-insured claims, contact the SIE/TPA.

Link: For more information, see: WAC 296-20-010(5) which states, "L&I or self-insurers will not pay for a missed appointment unless the appointment is for an examination arranged by the department or self-insurer."

Who must perform these services to qualify for payment

Credentialed interpreters who have an active L&I account number can perform these services.

Who can't perform these services

Persons (including interpreter/translator providers with account numbers) who can't provide interpretation or translation services at IMEs for workers or crime victims are:

- Those related to the worker or crime victim, *or*
- Those with an existing personal relationship with the worker or crime victim, *or*
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative, *or*
- The employer's legal or lay representative or employees of the legal or lay representative, *or*
- Any person who couldn't be an impartial and independent witness, *or*
- Persons under age 18.

Link: Also see: WAC 296-23-362(3), which states, "The worker may not bring an interpreter to the examination. If interpretive services are needed, the insurer will provide an interpreter."

Services that can be billed

IME no shows

Only services related to no shows for insurer requested IMEs will be paid.

The insurer will pay a flat fee for an IME no show.

Mileage to and from the IME appointment will also be paid.

Link: For more information, see: WAC 296-20-010(5).

Mileage and travel

Interpretive service providers may bill for actual POV miles driven to perform interpretation services for an individual worker or group of clients. (Also see Requirements for billing, below.)

Mileage is reimbursed only in **whole miles**. Calculate mileage from point to point, rounding each trip up to the nearest whole mile.

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Requirements for billing

Multiple Claims

If the IME appointment involves multiple claims, a separate ISAR must be submitted for each claim and the healthcare or vocational providers or their staff must verify services on each ISAR. See information in Face-to-face Services section.

Mileage and travel

When billing for actual miles driven to perform interpretation services for an individual worker or group of clients:

- The interpreter must split the mileage between the worker and the next client if this isn't the last appointment of the day, *and*
- When mileage is for services to more than one person (regardless of whether all are workers and/or crime victims), the mileage must be prorated between all the persons served.

Send mileage verification to each worker's claim file at the same time you bill the insurer or **your bill may not be paid**.

Payment limits

Mileage and travel

POV Mileage is payable for no show appointments for IMEs only.

Before being paid, mileage over 200 miles per day will be reviewed for necessity.

Insurers won't pay interpretive service providers' travel time or for travel expenses such as hotel, meals, and parking.

Links: For more information about billing, see the:

- Examples of how to bill for individual and group interpretive services (at the end of the Face-to-face services payment policy section, earlier in this chapter),
- **General Provider Billing Manual** (F248-100-000).

Note: Also see the Interpretive services fee schedule, effective July 1, 2016 in the All interpretive services payment policy section, earlier in this chapter.

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Payment policy: Telephone interpretive services

Note: Telephone interpretive services are payable only to providers that are part of Washington's Western States Contracting Alliance (WSCA) – National Association of State Procurement Officials (NASPO) Telephone Based Interpreter Services Contract.

Link: The WSCA-NASPO Telephone Based Interpreter Services contract is available to view at: https://fortress.wa.gov/ga/apps/ContractSearch/ContractSummary.aspx?c=05614.

Prior authorization

Telephone interpretive services don't require prior authorization on open claims.

Note: Providers should check claim status with the insurer prior to requesting interpretive services.

Who must perform these services to qualify for payment

Only department preapproved vendors listed in the WSCA-NASPO contract may provide and be paid for telephone interpretive services.

Providers, both in and out of state, who use telephone interpretive services, must use this preapproved WSCA-NASPO contracted vendor:

CTS Language Link	
911 Main St., Suite 10 Vancouver, WA 98660 Toll free number: **877-626-0678** Website: www.ctslanguagelink.com	

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Note: For credentialing, vendor's telephonic interpreter tests will consist of, at minimum:

- Oral fluency in English and other language, *and*
- Verbal test of consecutive interpretation in both languages.

Services that are covered

Telephone interpretive services are covered when:

- There is face-to-face contact between the provider and the worker, *and*
- Requested by healthcare providers and vocational counselors through the WSCA-NASPO contract.

Billing code **9999M** ("Telephone Interpretation Direct service time between worker(s) and healthcare vocational provider, per minute") is payable only to the L&I preapproved WSCA-NASPO contractor.

Requirements for billing

When billing for telephone interpretive services, use billing code **9999M**. For this code:

- One minute equals 1 unit of service, *and*
- The maximum fee is per WSCA-NASPO contract only. For:
  - **CTS Language Link**, the fee is **$0.62 per minute** for all languages.

Bills for telephone interpretive services must be submitted to the appropriate insurer. For:

- State Fund, bill State Fund claims electronically.
- Self-Insurance, bill the self-insured employer (SIE) or their third party administrator (TPA).

Link: To determine SIE/TPA:

- See the self-insurer list at: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/ *or*
- Call **360-902-6901**.

- Crime Victims claims:
  - Bill for services using the **Statement for Crime Victim Miscellaneous Services** form (see Link below) or the **CMS 1500** form (F245-127-000), *and*
  - Mail Crime Victims bills to:

    Crime Victims Compensation Program
    PO Box 44520
    Olympia, WA 98504-4520

  - Call the Crime Victims Program Hotline with questions: **800-762-3716**.

Link: The **Statement for Crime Victim Miscellaneous Services** form (F800-076-000) is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1976.

Note: State Fund claims 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 begin with an **S, T,** or **W** followed by six digits, or **double alpha letters** (example SA) followed by five digits. Department of Energy (DOE) claims are now self-insured.

Crime Victims claims begin with a **V** followed by six digits, or double alpha letters (example **VA)** followed by five digits.

Contracted WSCA-NASPO vendors

Each vendor must have an active department assigned provider account number.

Documentation

Documentation for telephone interpretive services must include all of the following:

- Claim number, *and*
- Worker's/victim's full name, *and*
- Date of injury, *and*
- Interpreter name and ID number, *and*

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- Language, *and*
- Vendor name, *and*
- Healthcare or vocational provider name, *and*
- Appointment address, *and*
- Appointment date, *and*
- Appointment start time, *and*
- Appointment completion time.

Payment limits

Telephone interpretive services are payable only when the healthcare or vocational provider has direct (face-to-face) contact with the worker or crime victim.

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Payment policy: Video interpretive services

Note: Video interpretive services are payable only to providers who are participating in L&I's Video Based Interpreter Services Contract.

Requirements for credentials

Requirements for credentials is identical to those required for Face-to-face services.

Prior authorization

Video interpretive services don't require prior authorization on open claims.

Note: Providers should check claim status with the insurer prior to requesting interpretive services.

Who must perform these services to qualify for payment

Vendors must have an active L&I provider account.

Only department preapproved vendors listed in the L&I contract may provide and be paid for video interpretive services.

Providers, both in and out of state, who use video interpretive services, must use one of the preapproved L&I contracted vendors.

Services that are covered

Video interpretive services are covered when:

- There is face-to-face contact between the provider and the worker, *and*
- Requested by healthcare providers or vocational counselors from a L&I contracted vendor.

Billing codes **9970M, 9971M, and 9972M** (Video Interpretation Direct service time between worker(s) and healthcare vocational provider, per minute) are payable only to the L&I contractors.

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Video Interpretive services fee schedule, effective January 1, 2016

Code	Description	L&I limit and authorization information	1 unit of service equals…	Maximum fee
9970M	**Video interpreting services - Spanish** Direct services time between worker and healthcare or vocational provider, includes form completion time, per minute.	Payable to L&I pre-approved contracted vendors only. Doesn't require prior authorization.	1 minute	**$1.59 per minute**
9971M	**Video interpreting services – Other language than Spanish** Direct services time between worker and healthcare or vocational provider, includes form completion time, per minute.	Payable to L&I pre-approved contracted vendors only. Doesn't require prior authorization.	1 minute	**$2.05 per minute**
9972M	**Video interpreting services – American Sign Language** Direct services time between worker and healthcare or vocational provider, includes form completion time, per minute.	Payable to L&I pre-approved contracted vendors only. Doesn't require prior authorization.	1 minute	**$3.19 per minute**

Requirements for billing

Bills for video interpretive services must be submitted to the appropriate insurer. For:

- State Fund, bill State Fund claims electronically.
- Self-Insurance, bill the self-insured employer (SIE) or their third party administrator (TPA).

Link: To determine SIE/TPA:

- See the self-insurer list at: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/ *or*
- Call **360-902-6901**.

- Crime Victims claims:
  - Bill for services using the **Statement for Crime Victim Miscellaneous Services** form (see Link below) or the **CMS 1500** form (F245-127-000), *and*
  - Mail Crime Victims bills to:

    Crime Victims Compensation Program
    PO Box 44520
    Olympia, WA 98504-4520

  - Call the Crime Victims Program Hotline with questions: **800-762-3716**.

Link: The **Statement for Crime Victim Miscellaneous Services** form (F800-076-000) is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1976.

Note: State Fund claims 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 begin with an **S, T,** or **W** followed by six digits, or **double alpha letters** (example SA) followed by five digits. Department of Energy (DOE) claims are now self-insured.

Crime Victims claims begin with a **V** followed by six digits, or double alpha letters (example **VA)** followed by five digits.

Contracted L&I vendors

Each vendor must have an active department assigned provider account number.

Documentation

Documentation for video interpretive services must include all of the following:

- Claim number, *and*
- Worker's/victim's full name, *and*
- Date of injury, *and*
- Interpreter name and ID number, *and*

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- Source Language, *and*
- Vendor name, *and*
- Healthcare or vocational provider name, *and*
- Appointment address, *and*
- Appointment date, *and*
- Appointment start time, *and*
- Appointment completion time.

It is prohibited to retain the video interpretive session.

Payment limits

Video interpretive services are payable only when the healthcare or vocational provider has direct (face-to-face) contact with the worker or crime victim.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for interpretive services	Washington Administrative Code (WAC) 296-20-010(5): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-010 WAC 296-23-362(3): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-362 WAC 296-23-302 http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-302
Administrative rules for missed appointments	WAC 296-20-010(5): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-010
Becoming an L&I interpreter provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/Interpreters/
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp
Billing adjustments	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/
Billing instructions and forms	Chapter 2: Information for All Providers
Common Errors on the Interpretive Services Appointment Record (ISAR)	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2816
CTS Language Link (WSCA-NASPO contracted vendor)	CTS Language Link website: www.ctslanguagelink.com
Federal laws relevant to interpretive services	Civil Rights Act of 1964, available online at: www.eeoc.gov/laws/statutes/titlevii.cfm
Fee schedules for all healthcare professional services (including	L&I's website: http://feeschedules.Lni.wa.gov

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If you're looking for more information about…	Then go here:
interpretive services)	
Interpretive Services Website	L&I's website: www.Interpreters.Lni.wa.gov/
Interpretive Services Appointment Record (**ISAR**) form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625
L&I's **General Provider Billing Manual**	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2148
Place to sign up for **L&I provider news and updates**	L&I's website: www.Lni.wa.gov/Main/Listservs/Provider.asp
Statement for Crime Victim Miscellaneous Services form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1976
WSCA-NASPO Telephone Based Interpreter Services contract	Washington State Government General Administration website: https://fortress.wa.gov/ga/apps/ContractSearch/ContractSummary.aspx?c=05614

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

Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 15: Medical Testimony

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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Medical testimony and depositions **15-2**

More info:

Related topics **15-6**

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Payment policy: Medical testimony and depositions

Who arranges testimonies and depositions

The Office of the Attorney General or the self-insured employer SIE makes arrangements with expert witnesses to provide testimony or deposition.

Responsibilities of providers

Any provider having examined or treated a worker must:

- Abide by the fee schedule, *and*
- Testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General or the self-insurer.

Link: For more information, see: RCW 51.04.050.

Reasonable availability

The Office of the Attorney General or the self-insurer and the provider must schedule a reasonable time for the provider's testimony during business hours.

Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeals.

Cancellation fees

If the **cancellation notice** for the testimony or deposition is…	Then the Attorney General/SIE:
3 working days or less than 3 working days before a hearing or deposition	**Will pay a cancellation fee** for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days before a hearing or deposition	**Won't pay** a cancellation fee.

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Services that can be billed

The Office of the Attorney General provides a medical provider testimony fee schedule when testimony is scheduled. The medical witness fee schedule (see below) is set by the Attorney General's Office and not by the Department.

Note: In the fee schedule below, 1 unit equals 15 minutes of actual time spent.

Fee schedule for testimony and related fees, effective July 1, 2016:

If the service provided by a **doctor, attending ARNP or psychologist** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	$100.00/unit* (maximum of 17 units)
Record review	$100.00/unit* (maximum of 25 units)
Conferences (live or by telephone)	$100.00/unit* (maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$100.00/unit* (maximum of 17 units)

If the service provided by **all other healthcare providers** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	$23.00/unit* (maximum of 17 units)
Record review	$23.00/unit* (maximum of 25 units)
Conferences (live or by telephone)	$23.00/unit* (maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$23.00/unit* (maximum of 17 units)

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If the service provided by a **vocational provider** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition), regular vocational services Medical testimony (live or by deposition), forensic vocational services	$23.00/unit* $27.50/unit* (maximum of 17 units)
Record review, regular vocational services Record review, regular vocational services, forensic vocational services	$23.00/unit* $27.50/unit* (maximum of 25 units)
Conferences (live or by telephone), regular vocational services Conferences (live or by telephone), forensic vocational services	$23.00/unit* $27.50/unit* (maximum of 9 units)
Travel, regular vocational services Travel, forensic vocational services (Paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$23.00/unit* $27.50/unit* (maximum of 17 units)

If the service provided by an **out of state doctor** is…	Then the **maximum fee** is:
Medical testimony (live or by deposition)	$125.00/unit* (maximum of 17 units)
Record review	$125.00/unit* (maximum of 25 units)
Conferences (live or by telephone)	$125.00/unit* (maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$125.00/unit* (maximum of 17 units)

Link: For legal definitions of **Doctor or attending doctor** see: WAC 296-20-01002.

Services that aren't covered

Requests for a nonrefundable amount will be denied.

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Requirements for billing

For **State Fund claims**:

- Providers shouldn't use the CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the Office of the Attorney General.

Note: State Fund uses a separate voucher **A19** form, which will be provided to you by the Office of the Attorney General.

For **self-insured employer claims**:

- SIEs must allow providers to use CPT® code **99075** to bill for these services, *and*
- Bills for these services should be submitted directly to the SIE/TPA.

Payment limits

Pre-payment

L&I can't provide pre-payment for any of these services.

Calculating timed fees

Travel fees are calculated:

- On a portal to portal time basis (from the time you leave your office until you return), *and*
- Don't include side trips.

The time calculation for testimony, deposition, or related work performed in the provider's office or by phone is based upon the actual time used for the testimony or deposition.

Interpretive services

The party requesting interpretive services for depositions or testimony is responsible for payment.

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Out of state testimony

Payment for medical testimony for an independent medical examination at the out of state rate will only be made if the examination was conducted out of state. Payment isn't based on the physical address of the examiner.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for definitions	Washington Administrative Code (WAC) 296-20-01002: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-01002
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: http://feeschedules.Lni.wa.gov
Legal statute (Washington State law) for physician or licensed advanced registered nurse practitioner's **testimony not privileged**	Revised Code of Washington (RCW) 51.04.050: http://apps.leg.wa.gov/RCW/default.aspx?cite=51.04.050

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 16: Medication Administration and Injections

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.

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

  –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.

  –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.

  –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.

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Payment policy: Botulinum toxin (BTX)

Prior authorization

The insurer covers a maximum of two courses of botulinum toxin injections per worker (except for catastrophic injuries) for FDA indications with prior authorization.

Note: Catastrophic injuries, in which significant recovery of physical function isn't expected, are exempt from the two course limit and the requirement of meaningful improvement in function. A maximum of four courses of injections may be authorized per year.

Link: For prior authorization criteria and coverage decision information, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/botulinumtoxin.asp.

Requirements for billing

Billing codes

If the **injection** is…	Then the appropriate **HCPCS billing code** is:	Which has a **maximum fee** of:
Onabotulinumtoxin A, 1 unit (Botox® or Botox Cosmetic®)	**J0585**	**$6.03**
Abobotulinumtoxin A, 5 units (Dysport®)	**J0586**	**$7.97**
Rimabotulinumtoxin B, 100 units (Myobloc®)	**J0587**	**$12.18**
Incobotulinumtoxin A, 1 unit (Xeomin®)	**J0588**	**$4.75**

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Services that aren't covered

The insurer won't authorize payment for BTX injections for off label indications.

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Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk nonpayment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any noncommercially available preparations.

Link: For more information, see the department's coverage policy on compound drugs, available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/SpecCovDec/Compounded.asp.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't **covered.** There are many commercially available, FDA approved alternatives, on the Outpatient Drug Formulary such as:

- Oral generic nonsteroidal anti-inflammatory drugs,
- Muscle relaxants,
- Tricyclic antidepressants,
- Gabapentin, *and*
- Topical salicylate and capsaicin creams.

Link: More information on the Outpatient Drug Formulary is available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/OutpatientDrug.asp .

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient.

Payment limits

No separate payment will be made for **99070** (Supplies and materials).

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Payment policy: Hyaluronic acid for osteoarthritis of the knee

Prior authorization

Hyaluronic acid injections are **only allowed** for osteoarthritis of the knee. Other uses are considered experimental, and therefore will not be paid.

Link: For more information about treatments that aren't authorized, see: WAC 296-20-03002(6).

For authorization, the correct side of body HCPCS billing code modifier (**–RT** or **–LT**) is required. If bilateral procedures are required, both modifiers must be authorized.

Requirements for billing

CPT® code **20610** must be billed for hyaluronic acid injections along with and the appropriate HCPCS code:

If the **injection** is…	Then the appropriate **HCPCS billing code** is:	Which has a **maximum fee** of:
Hyalgan or Supartz	**J7321**	**$205.20**
Euflexxa	**J7323**	**$332.98**
Orthovisc	**J7324**	**$350.75**
Synvisc or Synvisc-1	**J7325**	**$25.03** per mg
Gel-One	**J7326**	**$1,053.00**
Monovisc	**J7327**	**$1,053.00**
Gel-Syn	**J7328**	**By Report**

The correct side of body HCPCS code billing modifier (**–RT** or **–LT**) is required for billing. If bilateral procedures are authorized, both modifiers must be billed as a separate line item.

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Additional information: Hyaluronic acid injections

Link: For more information about hyaluronic acid injections, see:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/HyalVisco.asp

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Payment policy: Immunizations

Prior authorization

Immunization materials are payable when authorized.

Services that can be billed

CPT® codes **90471** and **90472 are payable**, in addition to the immunization materials code(s).

For each additional immunization given, add on CPT® code **90472** may be billed.

Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a **–25 modifier**.

Additional information: Bloodborne pathogens and infectious diseases

Link: For more information on bloodborne pathogens, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/PEP/ For more information about work related exposure to an infectious disease, see: WAC 296-20-03005.

Payment policy: Immunotherapy

Services that aren't covered

Complete service codes aren’t paid.

Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- One of the injection codes, *and*
- One of the antigen/antigen preparation codes.

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Payment policy: Infusion therapy services and supplies for RBRVS providers

Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

Note: An exception is **outpatient services**, which are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. (See Services that can be billed, below.)

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, baclofen).

Services that can be billed

Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

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Supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782 – E0783**, *and*
- **E0785 – E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered with the following exceptions for accepted conditions:

- To treat pain caused by cancer or other end-stage diseases, or
- To administer anti-spasticity drugs when spinal cord injury is an accepted condition.

Link: For more information, see: WAC 296-20-03002.

Requirements for billing

Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for Home infusion services in Chapter 11: Home Health Services for more information.

Link: For information on home infusion therapy in general, see the Home infusion services section of Chapter 11: Home Health Services .

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Note: Billing instructions for non-pharmacy providers are detailed in the Payment policy for “Injectable medications (the next section of this chapter).

Drugs

Drugs for outpatient use must be billed by pharmacy providers, either electronically through the point of service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

Payment limits

E/M office visits

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the code definitions.

Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren’t covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term postoperative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

Link: For more information, see: WAC 296-20-03014.

Equipment and supplies

Infusion therapy supplies and related DME, such as infusion pumps, aren’t separately payable for RBRVS providers. Payment for these items is **bundled** into the fee for the professional service).

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

Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373 and 96374,** won't be paid separately in conjunction with the IV infusion codes.

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Payment policy: Injectable medications

Requirements for billing

Providers must use the HCPCS **J** codes for injectable drugs that are administered during an E/M office visit or other procedure.

Note: The HCPCS **J** codes aren't intended for self-administered medications.

When billing for a nonspecific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, **providers must bill their acquisition cost for the drugs**. To get the total billable units, divide the:

- Total strength of the injected drug, *by*
- The strength listed in the manual.

For **example**:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

Payment limits

Payment is made according to the published fee schedule amount, or the acquisition cost for the covered drug(s), whichever is less.

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Payment policy: Medical foods and co-packs

Services that aren't covered

Medical food products and their convenience packs or "co-packs" aren't covered.

Examples of medical food products include:

- Deplin® (L-methylfolate), *and*
- Theramine® (arginine, glutamine, 5-hydroxytryptophan, and choline).

Examples of "co-packs" include:

- Theraproxen® (Theramine and naproxen), *and*
- Gaboxetine® (Gabadone and fluoxetine).

Link: For more information, see the department's coverage policy on Medical foods and co-packs, available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/SpecCovDec/MedicalFood.asp.

Payment limits

Medical foods and co-packs administered or dispensed during office procedures are considered **bundled** in the office visit.

No separate payment will be made for **99070** (Supplies and materials), which is a **bundled** code.

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

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Payment policy: Non-injectable medications

Services that can be billed

Providers may use distinct HCPCS **J** codes that describe specific non-injectable medication administered during office procedures.

- Separate payment will be made for medications with distinct J codes.

Note: The HCPCS **J** codes aren't intended for self-administered medications.

Services that aren't covered

No payment will be made for:

- Pharmaceutical samples,
- Repackaged drugs.

Requirements for billing

Providers must bill their acquisition cost for these drugs.

The name, NDC, strength, dosage, and quantity of the drug administered must be documented in the medical record and noted on the bill.

Link: For more information, see the payment policy for Acquisition cost in Chapter 28: Supplies, Materials, and Bundled Services.

Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Noninhalation drug for DME), *or*

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- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*
- **J8499** (Oral prescript drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

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

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Payment policy: Spinal injections

Payment methods

Physician or CRNA/ARNP

The payment methods for physician or CRNA/ARNP are:

- Injection procedure: **—26** component of Professional Services Fee Schedule, *and*
- Radiology procedure: **—26** component of Professional Services Fee Schedule

Note: A separate payment for the injection **won't be made** when computed tomography is used for imaging unless documentation demonstrating medical necessity is provided.

Radiology facility payment methods

The payment methods for radiology facilities are:

- Injection procedure: No facility payment, *and*
- Radiology procedure: **—TC** component of Professional Services Fee Schedule.

Hospital payment methods

The payment methods for hospitals are:

- Injection procedure: APC or POAC (payment method depends on the payer and/or the hospital's classification), *and*
- Radiology procedure: APC, POAC or **—TC** component of Professional Services Fee Schedule.

Note: Radiology codes may be packaged with the injection procedure.

Link: See the Professional Services Fee Schedule at: http://feeschedules.Lni.wa.gov.

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Payment policy: Therapeutic or diagnostic injections

Prior authorization

Required

These services require prior authorization:

- Trigger point injections and **dry needling** (refer to guideline for limits), and
- Sympathetic nerve blocks (refer to the CRPS guideline).

Note: See the definition of **dry needling** in Definitions at the beginning of this chapter.

Links: For guidelines on trigger point and dry needling injections, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Dryneedling.asp.

For CRPS guidelines, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ComplexRegionalPain.asp.

Required along with utilization review

These services require both prior authorization and utilization review:

- Therapeutic epidural and spinal injections for chronic pain,
- Therapeutic sacroiliac joint injections for chronic pain,
- Diagnostic facet and medial branch block injections (refer to neurotomy guideline).

Links: For the coverage decision and guidelines on spinal injections, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/SpinalInjections.asp.

For the neurotomy guidelines, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/facetneurotomy.asp.

For the coverage decision on discography, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Discography.asp.

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Services that can be billed

These services can be billed without prior authorization:

- E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable,
- Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS **J** code for the drug,
- Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360, 96361, 96365-96368**), *and*
- Spinal injections that don't require fluoroscopy or CT guidance:
  - CPT® code **62270** – diagnostic lumbar puncture,
  - CPT® code **62272** – therapeutic spinal puncture for drainage of CSF, *and*
  - CPT® code **62273** – epidural injection of blood or clot patch.

Services that aren't covered

CPT® code **99211** won't be paid separately.

Note: If billed with the injection code, providers will be paid only the E/M service and the appropriate HCPCS **J** code for the drug.

The insurer doesn't cover acupuncture services.

Links: For more information about the coverage decision for acupuncture services, see: WAC 296-20-03002(2) and: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Acupuncture.asp.

The insurer doesn't cover:

- Therapeutic medial branch nerve block injections, *or*
- Therapeutic or diagnostic intradiscal injections, *or*
- Therapeutic facet injections, *or*

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- Diagnostic sacroiliac joint injections.

Links: For more information about these injections, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/SpinalInjections.asp.

Requirements for billing

Dry needling

Dry needling of trigger points must be billed using CPT® codes **20552** and **20553**.

The coverage decision for dry needling can be found at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Dryneedling.asp

Spinal injections that require fluoroscopy

For spinal injection procedures that require fluoroscopy:

- One fluoroscopy code must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied, *and*
- Only one fluoroscopy code may be billed for each injection (see table below).

Only one of these **CPT® fluoroscopy codes** may be billed for each injection …	… and it must be billed along with this underlying **CPT® code**:
77002, **77012**, **76942**	**62268**
77002, **77012**, **76942**	**62269**
77003, **72275**	**62281**
77003, **72275**	**62282**
77003, **77012**, **76942**, **72240**, **72255**, **72265**, **72270**	**62284**
72295	**62290**
72285	**62291**
72295	**62292**

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Only one of these **CPT® fluoroscopy codes** may be billed for each injection …	… and it must be billed along with this underlying **CPT® code**:
77002, **77003**, **77012**, **75705**	**62294**
77003, **72275**	**62310**
77003, **72275**	**62311**
77003, **72275**	**62318**
77003, **72275**	**62319**

Spinal injection procedures that include fluoroscopy, ultrasound, or CT in the code description

Paravertebral facet joint injections now include fluoroscopic, ultrasound, or CT guidance as part of the description. This includes these CPT® codes:

- **64479-64480**, *and*
- **64483-64484**, *and*
- **64490-64495**, *and*
- **0213T-0218T**, *and*
- **0228T-0231T**.

Note: Fluoroscopic, ultrasound, or CT guidance can't be billed separately.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for drug limitations (such as opiates)	Washington Administrative Code (WAC) 296-20-03014: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03014
Administrative rules for treatment authorization	WAC 296-20-03002: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03002
Administrative rules for work related exposure to an infectious disease	WAC 296-20-03005: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03005
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
Bloodborne pathogens	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/PEP/
Botulinum toxin (BTX) injections	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/botulinumtoxin.asp.
Complex Regional Pain Syndrome (CRPS) guidelines	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ComplexRegionalPain.asp
Compound drugs coverage decision	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/SpecCovDec/Compounded.asp
Discography guidelines	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Discography.asp
Dry needling and trigger point injections guidelines	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Dryneedling.asp
Fee schedules for all healthcare	L&I's website:

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If you're looking for more information about…	Then go here:
professional services (including medication administration)	http://feeschedules.Lni.wa.gov
Hyaluronic acid injections	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/hyalVisco.asp
Medical coverage decision for **acupuncture**	WAC 296-20-03002(2) and L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Acupuncture.asp
Medical foods and co-packs coverage decision	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/SpecCovDec/MedicalFood.asp
Neurotomy guidelines	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/facetneurotomy.asp
Payment policies for **acquisition cost policy**	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for **home infusion therapy**	Chapter 11: Home Health Services
Spinal injections coverage decision and guidelines	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/SpinalInjections.asp

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 17: Mental Health Services

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.

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Payment policy: All mental health services

Who the policies in this chapter apply to

The mental health services payment policies in this chapter apply to workers covered by the State Fund and self-insured employers.

The policies in this chapter don't apply to crime victims.

Links: For more information on **mental health services** for State Fund and self-insured claims, see WAC 296-21-270. (Also, see Authorization and Reporting Requirements for Mental Health Specialists, below.)

For information about psychiatric services' policies for the Crime Victims' Compensation Program, see: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/ *and* WAC 296-31.

Who can be an attending provider and who can't

Can be attending provider: Psychiatrists and psychiatric ARNPs

A psychiatrist or psychiatric ARNP can be a worker's attending provider only when:

- The insurer has accepted a psychiatric condition, *and*
- It is the only condition being treated.

A psychiatrist or psychiatric ARNP may certify a worker's time loss from work if:

- A psychiatric condition has been allowed, *and*
- The psychiatric condition is the only condition still being treated.

A psychiatrist may also rate mental health permanent partial disability.

A psychiatric ARNP can't rate permanent partial disability.

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Can't be attending provider: Psychologists

Psychologists can't be attending providers and can't certify time loss from work or rate permanent partial disability.

Link: For more information on who can be an attending provider, see WAC 296-20-01002.

Payment rates for specific provider types

Licensed clinical psychologists and psychiatrists

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

Psychiatric ARNPs

Psychiatric ARNPs are paid at **90%** of the values listed in L&I's Professional Services Fee Schedule.

Link: The fee schedule is available at: http://feeschedules.Lni.wa.gov.

Social workers and other master's level counselors

Mental health evaluation and treatment services provided by social workers and other master's level counselors aren't covered even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

Who must perform these services to qualify for payment

Authorized mental health services must be performed by a:

- Psychiatrist (MD or DO), *or*
- Psychiatric Advanced Registered Nurse Practitioner (ARNP), *or*
- Licensed clinical PhD or PsyD psychologist.

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Psychological testing

Staff supervised by a psychiatrist, psychiatric ARNPs, or licensed clinical psychologist may administer psychological testing; however, the psychiatrist, or licensed clinical psychologist must:

- Interpret the testing, *and*
- Prepare the reports.

Services that aren't covered

These services (CPT® billing codes) aren't covered*:*

- **90845**,
- **90846**,
- **90849**, *and*
- **90863**

Psychologists can't bill the E/M codes for office visits.

Payment limits

These services (CPT® billing codes) are **bundled** and aren't payable separately:

- **90885**,
- **90887**, *and*
- **90889**.

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

Psychiatrists and psychiatric ARNPs may only bill the E/M codes for office visits on the same day psychotherapy is provided if it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized.

Note: The provider must submit documentation of the event and request a review before payment can be made.

Additional information: Authorization and Reporting Requirements for Mental Health Specialists

Link:

http://www.Lni.wa.gov/ClaimsIns/Files/OMD/091715FINALMHSpecialistsAuthorizationReportingRequirements.pdf

This document provides guidance for mental health specialists on the following:

1. Coverage of Mental Health Conditions
    a. Conditions caused or aggravated by an industrial injury or occupational disease
    b. Pre-existing or unrelated conditions delaying recovery
    c. Services that mental health specialists provide
2. Authorization Requirements
    a. Initial evaluation and treatment
    b. Ongoing treatment
3. Reporting Requirements
    a. Diagnosis of a mental health condition
    b. Return to work considerations
    c. Identification of barriers to recovery from an industrial injury
    d. Documenting a treatment plan with special emphasis on functional recovery
    e. Assessment of functional status during treatment
4. Billing Codes

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Payment policy: Case management services

Payment limits

Psychiatrists, psychiatric ARNPs, and clinical psychologists may only bill for case management services (telephone calls, team conferences, and secure e-mail) when mental health services are authorized.

Link: For more information about payment criteria and documentation requirements for these services, see the payment policy for Case management services in Chapter 10: Evaluation and Management.

Payment policy: Individual and group insight-oriented psychotherapy

Prior authorization

Group psychotherapy

Group psychotherapy treatment is authorized on a case by case basis only.

If authorized, the worker may participate in group therapy as part of the individual treatment plan.

Requirements for billing

Individual psychotherapy services

To report individual psychotherapy:

- Don't bill more than one unit per day, *and*
- Use the following timeframes for billing the psychotherapy codes:
  - 16-37 minutes for 90832 and 90833.
  - 38-52 minutes for 90834 and 90836.
  - 53 or more minutes for 90837 and 90838.

Note: Coverage of these services is different for psychiatrists and psychiatric ARNPs than it is for clinical psychologists (see below).

Psychiatrists and psychiatric ARNPs

Psychotherapy performed with an E/M service may be billed by psychiatrists and psychiatric ARNPs when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation, *or*
- Drug management, *or*
- Writing physician orders, *or*
- Interpreting laboratory or other medical tests.

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Psychiatrists and psychiatric ARNPs may bill the following individual insight-oriented psychotherapy CPT® billing codes without an E/M service:

- **90832**,
- **90834**, *and*
- **90837**.

Psychiatrists and psychiatric ARNPs may bill the following codes when performing an evaluation and management service on the same day:

- **90833**,
- **90836**, *and*
- **90838**.

Psychiatrists and psychiatric ARNPs bill these codes in addition to the code for evaluation and management services.

Clinical psychologists

Clinical psychologists may bill only the individual insight-oriented psychotherapy codes without an E/M component 90832, 90834, and 90837. They can't bill psychotherapy codes 90833, 90836, or 90838 in conjunction with an E/M component because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license in Washington.

Prolonged Services

Use the appropriate prolonged services code (99354, 99355, 99356, 99357) with 90837 for psychotherapy services of 90 minutes or longer, face to face with the patient, not performed with E/M service.

Group psychotherapy services

If group psychotherapy is authorized and performed on the same day as individual insight-oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

Note: The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.

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Payment policy: Narcosynthesis and electroconvulsive therapy

Prior authorization

Narcosynthesis and electroconvulsive therapy require prior authorization.

Who must perform these services to qualify for payment

Authorized services are payable only to psychiatrists.

Services that can be billed

Use CPT® codes **90865** (narcosynthesis) and **90870** (electroconvulsive therapy).

Link: More information about electroconvulsive therapy is available on line at: http://www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/NonPharmTreatments.aspwww.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/NonPharmTreatments.asp

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Payment policy: Neuropsychological testing

What's included in neuropsychological testing

Test data includes:

- The injured worker's test results,
- Raw test data,
- Records,
- Written/computer-generated reports,
- Global scores or individual's scale scores, *and*
- Test materials such as:
  - Test protocols,
  - Manuals,
  - Test items,
  - Scoring keys or algorithms, *and*
  - Any other materials considered secure by the test developer or publisher.

The term **test data** also refers to:

- Raw and scaled scores,
- Patient responses to test questions or stimuli, *and*
- Psychologists' notes and recordings concerning patient statements and behavior during an examination.

Note: The psychologist is responsible for releasing test data to the insurer.

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Services that can be billed

The following billing codes may be used when performing neuropsychological evaluation:

If the **CPT® code** is…	Then it **may be billed**:
90791 or 90792	Once every 6 months per patient per provider.
96101 or **96102**	Up to a combined 4 hour maximum. In addition to CPT® codes **96118** and **96119**.
96118 or **96119**	Per hour, up to a combined 12 hour maximum.

Note: Reviewing records and/or writing/submitting a report is included in these codes and can't be billed separately.

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Payment policy: Pharmacological evaluation and management

Who must perform these services to qualify for payment

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs.

Requirements for billing

Services conducted on the same day

When a pharmacological evaluation is conducted on the same day as psychotherapy, the psychiatrist or psychiatric ARNP:

- Can bill one of the add on psychotherapy codes **90833**, **90836**, or **90838** *and*
- Can bill a separate code for E/M services (CPT® codes **99201-99215**) at the same time.

Note: Also see Requirements for billing, above (in this same payment policy) as well as Requirements for billing under the payment policy for Individual and group insight-oriented psychotherapy earlier in this chapter.

Services not conducted on the same day

When a pharmacological evaluation is the only service conducted on a given day, the provider must bill the appropriate E/M code.

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Payment policy: Mental health consultations and evaluations

Links: For more information on consultations and consultation requirements, see WAC 296-20-045 and WAC 296-20-051.

Prior authorization

Prior authorization is required for all mental health care referrals. This requirement includes referrals for mental health consultations and evaluations.

Services that can be billed

When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the:

- Psychiatric diagnostic evaluation code **90791**, *or*
- Psychiatric diagnostic evaluation with medical services code **90792**.

When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code **90791** (Psychiatric diagnostic evaluation).

Services that aren't covered

Telephone psychology services aren't covered.

Links: For more information, see the payment policy for Teleconsultation and other telehealth services in Chapter 10: Evaluation and Management (E/M) Services.

Payment limits

CPT® codes **90791 or 90792** are limited to one occurrence every six months, per patient, per provider.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for attending providers	Washington Administrative Code (WAC) 296-20-01002: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-01002
Administrative rules for consultations and consultation requirements	WAC 296-20-045: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-045 WAC 296-20-051: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-051
Administrative rules for mental health services	WAC 296-21-270: http://apps.leg.wa.gov/wac/default.aspx?cite=296-21-270 WAC 296-14-300: http://app.leg.wa.gov/wac/default.aspx?cite=296-14-300
Authorization and Reporting Requirements for Mental Health Specialists	L&I's website: www.Lni.wa.gov/ClaimsIns/Files/OMD/091715FINALMHSpecialistsAuthorizationReportingRequirements.pdf
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	L&I's website: http://feeschedules.Lni.wa.gov
Mental health services website	L&I's website: www.Lni.wa.gov/mentalhealth
Payment policies for **case management services**	Chapter 10: Evaluation and Management (E/M) Services
Payment policies for **teleconsultations and other telehealth services**	Chapter 10: Evaluation and Management (E/M) Services

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If you're looking for more information about…	Then go here:
Psychiatric services payment **policies for crime victims**	L&I's website: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/ WAC 296-31: http://apps.leg.wa.gov/wac/default.aspx?cite=296-31

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 18: Modifications: Home, Job, and Vehicle

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

- **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 modifications:** Job modifications are adjustments or alterations made to the way a job is performed to accommodate the restrictions imposed by an industrial injury or occupational disease. The purpose of job modification benefits is to encourage employers to modify jobs to retain or hire injured workers. Job modifications are used when an employer/employee relationship exists, and they may include worksite adjustment; job restructuring; and/or tools, equipment or appliances.

  Link: For more information, see: WAC 296-19A-010(9).

- **Pre-job accommodations:** Pre-job are adjustments or alterations made to the way a job is performed to accommodate the restrictions imposed by an industrial injury or occupational disease. The purpose of pre-job accommodation benefits is to make it possible for the worker to perform the essential functions of a job. Accommodations are used when an industrially injured or ill worker is engaged in a vocational rehabilitation plan or in a job search, and they may include tools, equipment or appliances.

  Link: For more information, see: WAC 296-19A-010(10).

- **Residence (home) modification:** A residence or home modification is a permanent change to an existing residence or a repair of a modification previously approved and paid for by the department or self-insured employer, or a modification made when constructing a new residence.

  Link: For more information, see: WAC 296-14-6200.

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Payment policy: Home modifications

(See definition of **Home modification** in Definitions at the beginning of this chapter.)

Prior authorization

A **consultation** for a:

- State Fund claimant must be pre-authorized by claim manager, *and*
- Self-insured employer claimant, you must contact the employer or their claim management representative for pre-authorization.

Construction and design work done for a:

- State Fund claimant must be preauthorized by the Assistant Director for the Insurance Services Program (AD), *and*
- Self-insured employer claimant can't be denied without L&I's AD's approval.

Who must perform these services to qualify for payment

The home modification consultant must:

- Be a licensed nurse, occupational therapist, or physical therapist, *and*
- Have training or experience in both rehabilitation of catastrophic injuries and modifying homes.

Note: See more information about who can bill for specific services in the Home modifications fee schedule below.

Services that can be billed

Home modifications fee schedule, effective July 1, 2016:

For this **HCPCS or local billing code**…	The **provider that can bill** is a:	And the **insurer pays for:**	With a **maximum fee** of:
8914H Home modification **construction and design**.	• Contractor, • Architect, • Construction material supplier, *and* • Worker.	• **Construction materials**, • **Labor & tax**, • **Permits and inspections**, *and* • **Architect plans**. If the worker pays for inspections, predesign, or planning services, the worker may be reimbursed if the modification request is approved.	Each bill pays **by report** (as billed) up to the maximum amount authorized for the home modification.
8916H Home modification **evaluation and consultation**.	Home modification consultant.	**Time spent** doing: • Onsite home evaluation, • Consultation, *or* • Required reports.	**By report**.
8917H Home modification **mileage, lodging, bridge and ferry tolls, airfare, and car rental**.	Home modification consultant.	**Mileage** **Lodging** for 1 person when the onsite visit requires: • Two or more consecutive days, *and* • Is greater than 125 miles one way. **Airfare** (economy) for 1 person when travel is greater than 180 miles one way. **Car rental** (economy) when air travel is involved.	**State rates**.
0391R **Travel**.	Home modification consultant.	**Travel time or wait time**	**$5.09** per unit (1 unit = 6 minutes)

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

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Requirements for billing

To get reimbursed, you must submit a copy of receipts for:

- Materials,
- Lodging,
- Airfare, *and*
- Car rental.

Payment limits

The maximum payable for all home modification construction and design is the current Washington State average annual wage.

Note: For additional information about home modifications, see links in Related Topics at the end of this chapter.

Payment policy: Job modifications and pre-job accommodations

(See definition of **Job modification and pre-job accommodation** in Definitions at the beginning of this chapter.)

Link: More information about job modifications is available online at: www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/.

Prior authorization

The need for a job modification or pre-job accommodation must be identified and documented by L&I, the attending healthcare provider, treating occupational or physical therapist, employer, worker, or vocational rehabilitation counselor.

Consultations for a specific job modification or pre-job accommodation must be preauthorized after the need has been identified.

Job modifications

Prior authorization is required for all job modification services.

Pre-job accommodations

Prior authorization is required for all pre-job accommodation services.

Who must perform these services to qualify for payment

Consultations

The provider of a job modification or pre-job accommodation consultation must be a:

- Licensed occupational therapist or physical therapist, *or*
- Vocational rehabilitation provider, *or*
- Ergonomic specialist.

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Services that can be billed

Consultation services

In some cases, the department may reimburse for consultation services.

Consultations: Vocational providers in the firm assigned to the referral

Vocational providers in the firm assigned to the vocational referral must bill using procedure codes **0823V** or **0824V**.

Link: For more billing information, see: Chapter 30: Vocational Services

Consultations: Non-vocational providers and vocational providers that aren't with the firm assigned to referral must bill the following:

Billing code	Description	Activities	Maximum fee
0389R	**Pre-job or job modification consultation, analysis of physical demands** (non-VRC), per 6 minutes.	Consultation time with worker, Composing the report, Communication, Instruction in work practices, When indicated: • Obtaining bids, • Completing and submitting assistance application packet, Analyzing job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only).	**$11.24**
0391R	**Travel/wait time** (non-VRC), per 6 minutes.	Traveling to work/training site as part of direct consultation services.	**$5.09**
0392R	**Mileage** (non-VRC), per mile.	Mileage to work/training site as part of direct consultation services.	**State rate**
0393R	**Ferry charges** (non-VRC).	Ferry travel if required to travel to work/training site as part of direct consultation services.	**State rate**

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Note: If services are provided to a worker with an open vocational referral, see: Chapter 30: Vocational Services

Authorized equipment vendors

The following codes can be billed by equipment vendors:

Billing code	Description	Activities	Maximum fee
0380R	**Job modification**	Equipment/tools: • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work area modification or reconfiguration.	Maximum allowable for 0380R is **$5,000.00** per job or job site.
0385R	**Pre-job accommodation**	Equipment/tools: • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work/training area modification or reconfiguration.	Maximum allowable for 0385R is **$5,000.00** per claim. Combined costs of 0380R and 0385R for the same return to work goal can't exceed **$5,000.00**.

Note: Consultants may supply the equipment/tools only if:

- Custom design and fabrication of unique equipment or tool modification is required, *and*
- Prior authorization is obtained, *and*
- Proper justification and cost estimates are provided.

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Link: Additional information is available at: www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/ .

Services that aren't covered

These services aren't covered:

- Performing vocational rehabilitation services as described in: WAC 296-19A on claims with open vocational referrals (except for activities noted in: WAC 296-19A-180 through WAC 296-19A-200), *and*

Link: Additional information is available in: WAC 296-19A.

- Activities associated with reports other than composing or dictating complete draft of the report, including:
  - Editing, revising, or typing,
  - Filing, *or*
  - Distributing or mailing, *and*
- Time spent on any administrative and clerical activity, including:
  - Typing,
  - Copying,
  - Faxing, mailing, or distributing,
  - Filing,
  - Payroll,
  - Recordkeeping, *or*
  - Delivering or picking up mail.

Requirements for billing

OTs, ergonomic specialists, and vocational providers not with firm assigned referral:

Use the **Statement for Retraining and Job Modification Services** (F245-030-000) form.

PTs

PTs should no longer use the Statement for Retraining and Job Modification Services (F245-030-000) form. Use a billing method which includes the diagnosis code field.

Vendors

If billing for job modification:

- Send in the **Statement for Retraining Job Modification Services** (F245-030-000) form
- Use billing code **0380R**, *and*
- Attach a copy of the approved **Job Modification Assistance Application** form.

If billing for pre-job accommodation:

- Send in the **Statement for Retraining Job Modification Services** (F245-030-000) form
- Use billing code **0385R**, *and*
- Attach a copy of the approved **Pre-job Accommodation Assistance Application** form

Note: These forms are supplied to you by the employer, therapist, or vocational provider, etc.

Payment limits

The combined costs of both codes **0380R** and **0385R** for same return to work goal can't exceed **$5,000.00**.

For self-insured claims, pre-job accommodations can't be approved.

Note: Self-insured employers may pay any pre-job accommodation expenses for injured workers who no longer work for them.

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Payment policy: Vehicle modifications

Link: More information about vehicle modifications is available in: RCW 51.36.020(8).

Prior authorization

Vehicle modifications require prior authorization based on approval by the Assistant Director of L&I's Insurance Services Program.

Who must perform these services to qualify for payment

Consultations

The vehicle modification consultant must:

- Be a licensed occupational or physical therapist, or licensed medical professional, *and*
- Have training or experience in both rehabilitation and vehicle modification.

Services that can be billed

If the **HCPCS and local billing code** is…	Then the **provider who can bill** is:	And **the insurer pays for**:	And the **maximum fee** is:
8915H: Vehicle modification	Contractor	**Vehicle modification**	Maximum payable for all work is **½ the current Washington State average wage**. The amount paid may be increased by no more than $4,000.00 by written order of the Supervisor of Industrial Insurance (see Link below table).

If the **HCPCS and local billing code** is…	Then the **provider who can bill** is:	And **the insurer pays for**:	And the **maximum fee** is:
8917H: Vehicle modification mileage, lodging, bridge and ferry tolls, airfare, and car rental	Vehicle modification consultants	**Mileage Lodging** for 1 person when the onsite visit requires: • Two or more consecutive days, *and* • Is greater than 125 miles one way. **Airfare** (economy) for 1 person when travel is greater than 180 miles one way. **Car rental** (economy) when air travel is involved.	**State rates**
8918H Vehicle modification initial evaluation or consult	Vehicle modification consultants	**Time spent** doing: • Onsite home evaluation, • Consultation, *or* • Required reports.	**By Report.**
0391R: Travel	Vehicle modification consultants	**Travel time** or **wait time**	**$5.09** per unit (1 unit = 6 minutes)

Link: For more information about vehicle modification payment increases, see: RCW 51.36.020(8)(b).

Requirements for billing

To get reimbursed, you must submit copies of receipts for:

- Lodging,
- Airfare, *and*

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- Car rental.

Payment limits

For local billing code **8915H**, the maximum payable for all vehicle modification is 50% of the current Washington State average wage. The amount paid may be increased by no more than **$4,000.00** by written order of the Supervisor of Industrial Insurance.

Link: For more information about vehicle modification payment increases, see: RCW 51.36.020(8)(b).

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for home modifications	Washington Administrative Code (WAC) 296-14-6200 through WAC 296-14-6238 available in WAC 296-14: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-14
Administrative rules for vocational rehabilitation	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: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Contractors' questions and answers about home modifications for workers with catastrophic injuries	L&I's website (form F252-061-000): www.Lni.wa.gov/FormPub/Detail.asp?DocID=2199
Fact sheet on home modifications for workers with catastrophic injuries	L&I's website (form F252-060-000): www.Lni.wa.gov/FormPub/Detail.asp?DocID=2194
Fee schedules for all healthcare and vocational services	L&I's website: http://feeschedules.Lni.wa.gov
Home Modification Acknowledgement of Responsibilities form	L&I's website (form F247-003-000): www.Lni.wa.gov/FormPub/Detail.asp?DocID=2189
Home modifications policies	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/HomeModification
Job modifications and pre-job accommodations policies	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/
Laws for definitions	Revised Code of Washington (RCW) 50.04.355: http://apps.leg.wa.gov/rcw/default.aspx?cite=50.04.355
Laws for modification to	RCW 51.36.020(7) and (8):

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If you're looking for more information about…	Then go here:
residences or motor vehicles	http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.020
Laws for residence modification services	RCW 51.36.022: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.022
Laws for right to and amount	RCW 51.32.095(4): http://apps.leg.wa.gov/rcw/default.aspx?cite=51.32.095 RCW 51.32.250: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.32.250
Statement for Retraining and Job Modification Services form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1617

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

Chapter 19: Naturopathic Physicians

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

- **Established patient:** One who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definition for established patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

- **New patient:** One who hasn't received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

  L&I uses the CPT® definitions for new patients. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

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Payment policy: Naturopathic office visits

Who must perform these services to qualify for payment

Naturopathic physicians must perform these services to qualify for payment.

Services that can be billed

For **initial office visits**, these local billing codes can be billed:

- **2130A** (Routine examination, history, and/or treatment – routine procedure – and submission of a report),
- **2131A** (Extended office visit including treatment – report required), *and*
- **2132A** (Comprehensive office visit including treatment – report required in addition to the report of accident).

Note: To determine whether or not a visit is an initial office visit, see the definition of **new patient** in "Definitions" at the beginning of this chapter.

For **follow up office visits**, these local billing codes can be billed:

- **2133A** (Routine office visit including evaluation and/or treatment)*and*
- **2134A** (Extended office visit including treatment – report required).

Note: To determine whether or not a visit is a follow up office visit, see the definition of **established patient** in Definitions at the beginning of this chapter.

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Services that aren't covered

The insurer won't pay naturopathic physicians for services that aren't specifically allowed, including consultations.

Link: For additional information, see: WAC 296-23-205 and WAC 296-23-215.

Requirements for billing

When billing for services, naturopathic physicians should use:

- The local codes listed in this payment policy (under Services that can be billed) to bill for office visit services,
- CPT® codes **99367** and **99441-99444** to bill case management services, *and*
- The appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Link: For details about **payment criteria and documentation requirements** for case management services, see the payment policies for Case management services in Chapter 10: Evaluation and Management.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for naturopathic physicians	Washington Administrative Code (WAC) 296-23-205: http://apps.leg.wa.gov/wac/default.aspx?cite=296-23-205 WAC 296-23-215: http://apps.leg.wa.gov/wac/default.aspx?cite=296-23-215
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: http://feeschedules.Lni.wa.gov

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

Chapter 20: Nurse Case Management

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

- **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.

- **Nurse case management (NCM):** A collaborative process used to meet worker's healthcare and rehabilitation needs. The nurse case manager:

  - Works with the attending provider, worker, allied health personnel, and insurers' staff to assist in locating a provider and/or with coordination of the prescribed treatment plan, *and*
  - Organizes and facilitates timely receipt of medical and healthcare resources and identifies potential barriers to medical and/or functional recovery of the worker, *and*
  - Communicates this information to the attending doctor, claim manager, or ONC to develop a plan for resolving or addressing the barriers.

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Payment policy: Case management records and reports

Requirements for reports

Nurse case management reports must be completed monthly.

Initial assessment, monthly, progress, and closure reports must include **all** of the following information:

- Type of report (initial, progress, or closing), *and*
- Worker name and claim number, *and*
- Report date and reporting period, *and*
- Worker date of birth and date of injury, *and*
- Contact information, *and*
- Diagnoses, *and*
- Reason for referral, *and*
- Current medical status, *and*
- Recommendations for future actions, *and*
- Actions taken and dates, *and*
- Ability to positively impact a claim, *and*
- Health care provider(s) name(s) and contact information, *and*
- Psychosocial/economic issues, *and*
- Vocational profile, *and*
- Hours incurred to date on the referral, *and*
- Amount of time spent completing the report.

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Requirements for records

Case management records must:

- Be created and maintained on each claim, *and*
- Present a chronological history of the worker's progress in NCM services.

Requirements for case notes

Case notes must be written when a service is given and must specify:

- When the service was provided, *and*
- What type of service was provided using local billing codes, *and*
- Description of the service provided including subjective and objective data, *and*
- How much time was spent providing each service.

Payment limits

Payment is restricted to:

- Up to 2 hours (20 units) for **initial reports**, *and*
- Up to 1 hour (10 units) for **progress and closure reports**.

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Payment policy: Nurse case management (NCM)

(See definition of **nurse case management** in "Definitions" at the beginning of this chapter.)

Prior authorization

NCM services

Prior authorization by the insurer's claim manager or L&I's ONC is required for NCM services. Contact the insurer to make a referral for NCM services.

Workers must meet one or more of these criteria to be selected to receive NCM services:

- Catastrophic work related injuries, *and/or*
- Moved out of state and need assistance locating a provider, *and/or*
- Medically complex conditions, *and/or*
- Barriers to successful claim resolution.

Expenses

The claim manager must give prior authorization to reimburse for expenses for:

- Parking,
- Ferry,
- Toll fees,
- Cab,
- Lodging, *and*
- Airfare

Note: These expenses correspond to local billing code **1225M** and have a payment limit of **$725.00** (see Requirements for billing and Payment limits, below).

Who must perform these services to qualify for payment

To qualify for payment, NCM services must be performed by a registered nurse:

- With case management certification, *and*
- Who is aware of resources in the worker's location.

Services that aren't covered

Expenses that aren't covered include:

- Nurse case manager training,
- Supervisory visits,
- Postage, printing and photocopying (except medical records requested by L&I),
- Telephone/fax equipment,
- Clerical activity (for example: faxing documents, preparing documents to be mailed, organizing documents, etc.),
- Travel time to post office or fax machine,
- Wait time exceeding 16 hours per referral,
- Fees related to legal work, such as deposition and testimony (see Note, below), *and*
- Any other administrative costs not specifically mentioned above.

Note: Legal fees may be charged to the requesting party, but not the claim.

Requirements for billing

Local billing codes

Nurse case managers must use the following local billing codes to bill for NCM services, including nursing assessments:

- **1220M** (Phone calls, per 6 minute unit),
- **1221M** (Visits, per 6 minute unit),
- **1222M** (Case planning, per 6 minute unit),
- **1223M** (Travel/Wait, per 6 minute unit – 16 hour limit per referral),

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- **1224M** (Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager), which pays at the **state rate**, *and*
- **1225M** (Expenses – parking, ferry, toll fees, cab, lodging, and airfare – at cost or state per diem rate – meals and lodging. Requires prior authorization from the claim manager – $725 limit), which pays **by report**.

Note: Also see Prior authorization, above, and Payment limits, below.

For a definition of **by report**, see Definitions at the beginning of this chapter.

Billing units

When billing for the local codes for NCM services (listed above), units are whole numbers only (don't use tenths of units), and 1 unit of service equals:

- Each traveled mile, *or*
- Each 6 minutes of phone calls, visits, case planning, or travel/wait time (see table below), *or*
- Each related travel expense.

If the **time** is…	Then **bill**:
6 minutes	1 unit
12 minutes	2 units
18 minutes	3 units
24 minutes	4 units
30 minutes	5 units
36 minutes	6 units
42 minutes	7 units
48 minutes	8 units
54 minutes	9 units
60 minutes	10 units

Payment limits

NCM services

NCM services are capped at **50 hours** of service per referral, including professional and travel/wait time.

Note: An **additional 25 hours** may be authorized after staffing with the insurer. For State Fund claim, please contact the ONC. Further extensions may be granted in exceptional cases, contingent upon review by the insurer

Expenses

Local billing code **1225M** has a payment limit of **$725.00**. (Also see Prior authorization and Requirements for billing, above.)

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Links: Related topics

If you're looking for more information about…	Then go here:
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: http://feeschedules.Lni.wa.gov
General Provider Billing Manual (publication F248-100-000)	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2148

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

Chapter 21: Obesity Treatment

Effective July 1, 2016

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

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/

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Definitions

- **Body Mass Index (BMI):** BMI is a number calculated from a person's weight and height and is used as an indicator of body fatness (the higher the number, the more body fat).

  Link: A BMI calculator is available on the National Institute of Health website, at: http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm.

- **Severe obesity:** For the purposes of providing obesity treatment services, L&I defines severe obesity as a **BMI** of 35 or greater. (See definition of **BMI**, above.)

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Payment policy: Obesity treatment

Prior authorization

Parameters for coverage

All obesity treatment services require prior authorization.

Obesity doesn't meet the definition of an industrial injury or occupational disease. **Temporary treatment** may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

To be eligible for obesity treatment services, the worker must be severely obese (have a **BMI** of 35 or greater).

Note: See definitions of **BMI** and **severe obesity** in Definitions at the beginning of this chapter.

Requesting a weight reduction program

The attending provider should contact the insurer to request a weight reduction program if the worker meets *all* of the following criteria:

- Is severely obese, *and*
- Obesity is the primary condition retarding recovery from the accepted condition, *and*
- The weight reduction is necessary to undergo required surgery, participate in physical rehabilitation, or return to work.

The attending provider who believes that the worker may qualify for obesity treatment:

- Must advise the insurer of the worker's weight and level of function prior to the injury and how it has changed, *and*
- Must submit medical justification for obesity treatment, including tests, consultations, or diagnostic studies that support the request, *and*
- May request a consultation with a certified dietitian (CD) to determine if an obesity treatment program is appropriate for the worker.

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Required: Treatment plan

Prior to receiving authorization for an obesity treatment program, the attending provider and worker are required to develop a **treatment plan**, which will include:

- The amount of weight the worker must lose to undergo surgery, *and*
- Estimated length of time needed for the worker to lose the weight, *and*
- A diet and exercise plan, including a weight loss goal, approved by the attending provider as safe for the worker, *and*
- Specific program or other weight loss method requested, *and*
- Attending provider's plan for monitoring weight loss, *and*
- Documented weekly weigh-ins, *and*
- Group support facilitated by trained staff, *and*
- Counseling and education provided by trained staff, *and*
- For State Fund claims, sign the Claim Manager generated authorization letter, which serves as a memorandum of understanding between the insurer, the worker, and the attending provider.

Note: The treatment plan won't include requirements to buy supplements or special foods.

Authorization or not?

The insurer authorizes obesity treatment for **up to 90 days at a time** as long as the worker does all of the following to ensure continued authorization of the obesity treatment plan.

- Loses an average of at least one to two pounds a week, *and*
- Regularly attends weekly treatment sessions (meetings and weigh-ins), *and*
- Cooperates with the approved obesity treatment plan, *and*
- Is evaluated by the attending provider at least every 30 days, *and*
- Pays the joining fee and weekly membership fees up front and is reimbursed by the insurer using the codes listed below, under Services that can be billed, *and*
- Sends the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

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The insurer will no longer authorize obesity treatment when any one of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan (see Note below), *or*
- Obesity no longer interferes with recovery from the accepted condition (see Link, below), *or*
- The worker isn't losing weight **an average** of at least one to two pounds each week, *or*
- The worker isn't cooperating with the approved obesity treatment plan.

Note: If the worker chooses to continue the weight loss program for general health, it will be at his or her own expense.

Link: To see more information about why it is prohibited to treat an unrelated condition once it no longer retards recovery from the accepted condition, see WAC 296-20-055.

Attending provider's responsibilities

Upon approval of the obesity treatment plan, the attending provider's role is to:

- Examine the worker every 30 days to monitor and document weight loss, *and*
- Notify the insurer when:
  - The worker reaches the weight loss goal, *or*
  - Obesity no longer interferes with recovery from accepted condition, *or*
  - The worker is no longer losing the weight needed to meet the weight loss goal in the treatment plan.

Who must perform these services to qualify for payment

Nutrition counseling

Only CDs will be paid for nutrition counseling services.

Note: Providers practicing in a state other than Washington that are similarly certified or licensed may apply to be considered for payment.

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Services that can be billed

Nutrition counseling

CDs may bill for authorized services using these CPT® billing codes:

- **97802** at initial visit, with a maximum of four units; the maximum fee per unit is **$61.52**, *or*
- **97803** with a maximum of two units per visit and a maximum of three visits; the maximum fee per unit is **$52.91**.

Note: 1 unit of either CPT® **97802** or **97803** equals 15 minutes.

Expenses for weight loss program

The **worker** will be reimbursed for the obesity treatment program when billing using the following local codes:

- **0440A** (Weight loss program, joining fee, worker reimbursement), which has a fee limit of **$164.76**, *and*
- **0441A** (Weight loss program, weekly fee, worker reimbursement), which has a weekly fee limit of **$32.96**.

Services that aren't covered

The insurer doesn't pay the obesity treatment provider directly.

The insurer doesn't pay for:

- Surgical treatments of obesity (for example, gastric stapling, or jaw wiring),
- Drugs or medications used primarily to assist in weight loss,
- Special foods (including liquid diets),
- Supplements or vitamins,
- Educational material (such as food content guides and cookbooks),
- Food scales or bath scales, *or*
- Exercise programs or exercise equipment.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for treating conditions unrelated to the accepted condition	Washington Administrative Code (WAC) 296-20-055: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-055
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including obesity treatment services)	L&I's website: http://feeschedules.Lni.wa.gov
How to **calculate BMI**	National Institute of Health's website: http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm.

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 22: Other Services

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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Payment policy: After hours services

Services that can be billed

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

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

Note: Also see Payment limits, below.

Documentation requirements

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

Payment limits

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

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

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

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

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Payment policy: Locum tenens

Who must perform these services to qualify for payment

A locum tenens physician must provide these services.

Link: For information about requirements for Who may treat, see WAC 296-20-015.

Requirements for billing

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

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

Payment policy: Provider mileage

Prior authorization

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

The round trip mileage must exceed 14 miles.

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

Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **$5.17** per mile.

Note: (Also see Prior authorization, above.)

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Payment policy: Ventilator management services

Services that can be billed

The insurer pays for **either** the:

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

Payment limits

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

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

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Links: Related topics

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

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 23: Pathology and Laboratory Services

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

- **CPT® code modifier mentioned in this chapter:**

  –91 Repeat clinical diagnostic laboratory test

  Performed on the same day to obtain subsequent report test value(s). **Modifier –91** must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use **modifier –91** with the appropriate procedure code.

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Payment policy: Bloodborne pathogens

Prior authorization

The insurer may pay for post exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease.

Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim later.

The exposed worker must submit an accident report form before the insurer can pay for testing and treatment.

Services that can be billed

Diagnostic test or procedure

For diagnostic tests and procedures, the following CPT® codes can be billed:

- **47100**,
- **81370-81383**
- **86689**,
- **86701**,
- **86704**,
- **86706**,
- **86803-86804**,
- **87340**,
- **87390**,
- **87521-87522**,
- **87901**, and
- **87903-87904**.

Testing related procedure

For testing related procedures, the following CPT® codes can be billed:

- **78725**,
- **86360**,
- **87536**,
- **80076,**
- **90371**,
- **90746** (adult),
- **90772-90779**,
- **99201-99215**, *and*
- **99217-99220**.

The department has published a coverage decision about bloodborne pathogens. See link below.

Link: For more information, go to:
www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/PEP/

Treating a reaction to testing or treatment of an exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to covered treatment for a probable exposure.

Covered test protocols

Testing schedule

Testing for hepatitis B, hepatitis C, and HIV should be done:

- At the time of exposure, *and*
- At 3, 6, and 12 months post exposure.

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Hepatitis B

For hepatitis B (HBV), the following test protocols are covered:

- HbsAg (hepatitis B surface antigen),
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen), *and*
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Note: Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate for post exposure prophylaxis.

Hepatitis C

For hepatitis C (HCV), the following test protocols are covered:

- Enzyme Immunoassay (EIA),
- Recombinant Immunoblot Assay (RIBA), *and*
- Strip Immunoblot Assay (SIA).

Note: The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services **only if HCV is an accepted condition** on the claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR),
- Branched chain DNA (bDNA),
- Genotyping, *and*
- Liver biopsy.

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HIV

For HIV, two blood tests are needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, *and*
- Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test,
- EIA test,
- Western Blot test, *and*
- Immunofluorescent antibody.

The following tests are covered services **only if HIV is an accepted condition** on the claim:

- HIV antiretroviral drug resistance testing,
- Blood count, kidney, and liver function tests,
- CD4 count, *and*
- Viral load testing.

Note: When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. **Prior authorization isn't required**.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count, *and*
- Renal and hepatic chemical function tests.

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Covered bloodborne pathogen treatment regimens

Chronic hepatitis B

For chronic hepatitis B (HBV):

- Interferon alfa-2b, *and*
- Lamivudine.

Hepatitis C

For hepatitis C (HCV) – acute:

- Mono therapy, *and*
- Combination therapy.

HIV/AIDS

For HIV/AIDS, covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS).

Link: The ATIS guidelines are available on the web at: http://aidsinfo.nih.gov/.

Payment policy: Drug screens

Services that can be billed

The insurer will pay for:

- Drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver, *and*
- Confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

The department will pay for drug screening using the following HCPCS codes:

- G6058 (Drug confirmation, each procedure),
- For presumptive testing HCPCS codes **G0477**, **G0478**, or **G0479**, *or*
- For definitive testing HCPCS codes **G0480**, **G0481, G0482,** or **G0483**.

Note: Also see Payment limits on these codes, below.

Payment limits

HCPCS billing codes **G0477, G0478, G0479 and G6058** are only payable to laboratories that don't require a CLIA certificate of waiver.

HCPCS billing codes **G0480**, **G0481**, **G0482** and **G0483** are limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.

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Payment policy: Non-CLIA Waived Testing

Requirements for billing

Complex or moderately complex clinical pathology procedures that arn't waived under the Clinical Laboratory Improvement Act (CLIA) must be performed in laboratories that are accredited or have a categorized status under the State Department of Health or equivalent accrediting body.

Payment limits

Payment for complex and moderately complex clinical pathology procedures won't be paid to any provider that only has a CLIA certificate of waiver or the Provider Performed Microscopic Procedure certificate.

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Payment policy: Panel tests

Services that can be billed

Automated multichannel tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

Please refer to our fee schedule for code coverage and fees.

The following tests (CPT® codes) are automated multichannel tests or panels comprised solely of automated multichannel tests:

- **80048**,
- **80051**,
- **80053**,
- **80069**,
- **80076**,
- **82040**,
- **82247-82248**,
- **82310**,
- **82374**,
- **82435**,
- **82465**,
- **82550**,
- **82565**,
- **82947**,
- **82977**,
- **83615**,
- **84075**,

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- **84100**,
- **84132**,
- **84155**,
- **84295**,
- **84450**,
- **84460**,
- **84478**,
- **84520**, *and*
- **84550**.

Additional information: How to calculate payments

Automated tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient.

Calculate the payment using the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined, *then*
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day, *then*
- Any duplicated tests are denied, *then*
- The total number of remaining unduplicated automated tests is counted.

To determine the payable fee based on the total number of unduplicated automated tests performed, see the following table:

If the **number of unduplicated automated tests performed** is…	Then the **fee** is:
1 test	Lesser of the single test or **$9.94**.
2 tests	$9.94
3-12 tests	$12.18

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If the **number of unduplicated automated tests performed** is…	Then the **fee** is:
13-16 tests	$16.27
17-18 tests	$18.23
19 tests	$21.11
20 tests	$21.77
21 tests	$22.47
22-23 tests	$23.13

Panels with automated and nonautomated tests

When panels are comprised of both automated multichannel tests and individual nonautomated tests, they are priced based on the:

- Automated multichannel test fee based on the number of tests, *added to*
- Sum of the fee(s) for the individual nonautomated test(s).

For example, CPT® code **80061 i**s comprised of 2 automated multichannel tests and 1 nonautomated test. As shown in the table below, the fee for **80061** is **$25.56.**

If the **CPT® 80061 component tests** is:	And the **number of automated tests** is…	Then the **maximum fee** is:
Automated: CPT® **82465** and CPT® **84478**	2	Automated: **$9.94**
Non-automated: CPT® **83718**	n/a	Nonautomated: **$15.62**
Maximum payment for CPT® code 80061:		**$25.56**

Multiple panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be **limited to the total fee allowed for the unduplicated component tests**.

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The table below shows how to calculate the maximum payment when:

- **Panel codes 80050, 80061**, and **80076** *are billed with*
- **Individual test codes 82977, 83615, 84439**, and **85025**.

Test type	CPT® panel codes			Individual tests	Test count	Max fee
	80050	80061	80076			
Automated tests	82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84450, 84460, *and* 84520	82465 and 84478	82248 + these duplicated tests: 82040, 82247, 84075, 84155, 84450, *and* 84460	82977 83615	= **19** unduplicated automated tests (Note the fee in previous table on fees for automated tests)	**$21.11**
	84443	—	—	—	—	**$31.92**
	85025 *or* 85027 and 85004 *or* 85027 and 85007 *or* 85027 and 85009	—	—	—	—	**$14.83**
	83718	—	—	—	—	**$15.62**
	—	—	—	84439	—	**$16.67**
Non-automated tests	—	—	—	85025 *or* 85027 and 85004 *or* 85027 and 85007 *or* 85027 and duplicated test 85009	—	**$0.00**
					Maximum payment:	**$100.15**

Payment policy: Repeat tests

Requirements for billing

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) **must be taken** from separate encounters. Also, the medical necessity for repeating the test(s) **must be documented** in the patient's record.

When billing, **modifier –91** must be used to identify the repeated test(s).

Note: Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests payment policy section of this chapter (above).

Payment limits

Test(s) normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

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Payment policy: Specimen collection and handling

Who must perform these services to qualify for payment

The fee for billed specimen collection services is payable only to the provider who actually draws the specimen.

Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.

Services that can be billed

Specimen collection

Complex vascular injection procedures, such as arterial punctures and venisections, aren't subject to this policy and will be paid with the appropriate CPT® or HCPCS billing codes.

Travel

Travel will be paid in addition to the specimen collection fee when all of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility, or homebound patient, *and*
- The provider personally draws the specimen, *and*
- The trip is solely for collecting the specimen.

Note: Also see Services that aren't covered and Payment limits, below.

Services that aren't covered

Specimen collection

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

Travel

HCPCS code **P9604** (Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient, prorated trip charge) isn't covered.

Requirements for billing

Specimen collection

Use HCPCS billing codes:

- **P9612**, which is for "Catheterization for collection of specimen, single patient, all places of service," *and*
- **P9615**, which is for "Catheterization for collection of specimen(s) multiple patient(s)."

For venipuncture, use CPT® billing code **36415**.

Travel

To bill for actual mileage, use HCPCS code **P9603** (1 unit equals 1 mile).

Note: Also see information about travel in Services that can be billed, above, and Payment limits, below.

Payment limits

Specimen collection

Costs for media, labor, and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection.

Note: Payment for performing the test is separate from the specimen collection fee.

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A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:

- A throat culture, *or*
- Pap smear, *or*
- A routine capillary puncture for clotting or bleeding time.

Handling

Handling and conveyance won't be paid (for example, shipping, messenger, or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are integral to the process and are bundled into the total fee for testing service.

Travel

Travel won't be paid to nursing home or skilled nursing facility staff that performs specimen collection.

If the specimen draw is incidental to other services, no travel is payable.

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Payment policy: Stat lab fees

Services that can be billed

Usual laboratory services are covered under the Professional Services Fee Schedule.

Link: The fee schedule is available on L&I's website at http://feeschedules.Lni.wa.gov.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS codes **S3600** or **S3601**.

Requirements for billing

Tests ordered STAT should be limited only to those needed to manage the patient in a true emergency situation. Also:

- The medical record must reflect the medical necessity and urgency of the service, *and*
- The laboratory report should contain the name of the provider who ordered the STAT test(s).

Note: Payment is limited to one (1) STAT charge per episode (not once per test).

Payment limits

The STAT charge will **only be paid with these tests**:

- HCPCS code **G0306** (Complete CBC, auto w/diff), *or*
- HCPCS code **G0307** (Complete CBC, auto), *or*
- For presumptive testing HCPCS codes G0477, G0478, or G0479, *or*
- For definitive testing HCPCS codes G0480, G0481, G0482, or G0483.
-

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… with these CPT® billing codes:								
80047	80184	81003	82435	83874	84520	85049	86880	87210
80048	80185	81005	82550	83880	84550	85378	86900	87281
80051	80188	82009	82565	84100	84702	85380	86901	87327
80069	80192	82040	82803	84132	84704	85384	86902	87400
80076	80194	82150	82945	84155	85004	85396	86920	89051
80156	80197	82247	82947	84157	85007	85610	86921	
80162	80198	82248	83615	84295	85025	85730	86922	
80164	81000	82310	83663	84450	85027	86308	86923	
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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
AIDS Treatment Intervention Service (ATIS) guidelines	National Institute of Health (NIH) website: http://aidsinfo.nih.gov/
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 (including pathology and laboratory services)	L&I's website: http://feeschedules.Lni.wa.gov

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 24: Pharmacy Services

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

General

Average wholesale price (AWP): A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

Initial prescription drug or "first fill": Any drug prescribed for an alleged industrial injury or occupational disease during the initial visit.

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

Preferred drug list

- **Endorsing practitioner:** A practitioner who has reviewed the preferred drug list and has notified the health care authority that he or she has agreed to allow therapeutic interchange of a preferred drug for any nonpreferred drug in a given therapeutic class,
- **Preferred drug list (PDL):** The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased healthcare programs,
- **Refill (protection):** The continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral or immunosuppressive drug, or for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least 24 weeks but no more than 48 weeks,
- **Therapeutic alternative:** Drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses,
- **Therapeutic interchange:** To dispense with the endorsing practitioner's authorization, a therapeutic alternative to the prescribed drug,

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- **Wrap around formulary:** The formulary the department uses for the drug classes that aren't part of the PDL but are part of the department's allowed drug benefit.

Note: Also see WAC 296-20-01002 for the above definitions.

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Payment policy: All pharmacy services

(See definition of **preferred drug list (PDL)** in Definitions at the beginning of this chapter.)

Services that can be billed

The Outpatient Drug Formulary is a list of therapeutic classes and drugs that are covered under L&I's drug benefit. L&I uses a subset of the Washington State PDL and a wrap-around formulary for the remaining drug classes. Drugs or therapeutic classes listed on the formulary do not guarantee coverage and may be subject to specific L&I policy and determination of appropriateness for the accepted conditions.

Links: The outpatient formulary can be found online at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/OutpatientDrug.asp.

A current list of the drug classes that are part of the workers' compensation benefit and on the PDL is available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/PDL.

A list of policies relating to drug coverage, including limitations, criteria for coverage and treatment guidelines is available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/.

Prior authorization

Nonpreferred drugs

To obtain authorization for nonpreferred drugs:

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If the **non-preferred drug** is part of the…	And you are a **PDL endorsing provider**, then:	Or you are a **non-endorsing provider**, then:
Preferred drug list	Change to the preferred drug or Write DAW for non-preferred drug.	Change to the preferred drug or For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.
Wrap-around classes	Change to the preferred drug or For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.	Change to the preferred drug or For State Fund claims, contact the PDL Hotline. For self-insured claims, contact the self-insured employer.

Note: The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm (Pacific Time), and the toll free contact number is **1-888-443-6798**.

Links: For a list of SIE/TPAs, see: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

Filling prescriptions after hours

If a pharmacy receives a prescription for a nonpreferred drug when authorization can't be obtained, the pharmacist may dispense an **emergency supply** of the drug by entering a value of 6 in the DAW field.

The insurer must authorize additional coverage for the nonpreferred drug.

Note: An **emergency supply** is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

Who must perform pharmacy services to qualify for payment

The pharmacy services fee schedule applies to pharmacy providers only. It doesn't apply to medical providers administering drugs in the office. Please see Chapter 16: Medication Administration.

Requirements for writing prescriptions

Prescription forms

Orders for over the counter non-oral drugs or nondrug items must be written on standard prescription forms.

Recordkeeping for prescriptions

Records must be maintained for audit purposes for a minimum of 5 years.

Link: For more information on recordkeeping requirements, see WAC 296-20-02005.

Requirements for billing

NCPDP payer sheet, version D.0 and 5.1

For State Fund claims, L&I currently accepts versions D.0 and 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system.

POS hours:

- **6 a.m. to midnight** Monday through Saturday.
- **6 a.m. to 10 p.m.** on Sunday.

Link: The current version of the NCPDP payer sheet is available online at: www.Lni.wa.gov/ClaimsIns/Files/Providers/NCPDPD0PayerSheetFinal.

Payment methods

Link: For a definition of Average Wholesale Price (AWP), see WAC 296-20-01002.

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Payment for drugs and medications, including all oral over the counter drugs, will be based on these pricing methods:

If the **drug type** is…	Then the **payment method** is:
Generic	AWP less 50% (+) **$ 4.50** professional fee
Single or multisource brand	AWP less 10% (+) **$ 4.50** professional fee
Brand with generic equivalent (dispense as written only)	AWP less 10% (+) **$ 4.50** professional fee
Compounded prescriptions	Allowed cost of ingredients (+) **$4.50** professional fee (+) **$4.00** compounding time fee (per 15 minutes)

Notes: Orders for over the counter non-oral drugs or nondrug items are priced on a 40% margin.

Prescription drugs and oral or topical over the counter medications are nontaxable.

No payment will be made for repackaged drugs.

Link: For more information on tax exemptions for sales of prescription drugs, see RCW 82.08.0281.

Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk non-payment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any noncommercially available preparations.

Link: For more information, see the department's coverage policy on compound drugs, available at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/SpecCovDec/Compounded

Services that aren't covered

Compounded topical preparations containing multiple active ingredients **aren't covered.** There are many commercially available, FDA-approved alternatives, such as oral generic non-steroidal anti-inflammatory drugs, muscle relaxants, tricyclic antidepressants, gabapentin and topical salicylate and capsaicin creams on the Outpatient Drug Formulary.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient. No separate payment will be made for this service:

- **99070** (Supplies and materials)

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Payment policy: Emergency contraceptives and pharmacist counseling

Coverage policy

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, *and*
- The ECP and/or counseling service is sought by the worker, *and*
- The claim manager authorizes payment for the ECP and/or the counseling, *and*
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Requirements for billing

Once the Coverage policy conditions listed above have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code **S9445**.

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Payment policy: Endorsing Practitioner and Therapeutic Interchange Program

(See definitions of **endorsing practitioner, refill, therapeutic alternative,** and **therapeutic interchange** in Definitions at the beginning of this chapter.)

Requirements for writing prescriptions

Endorsing practitioners may indicate Dispense as Written (DAW) on a prescription for a nonpreferred drug on the PDL, and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates “substitution permitted” on a prescription for a nonpreferred drug on the PDL:

- The pharmacist will interchange a preferred drug for the nonpreferred drug, *and*
- A notification will be sent to the prescriber.

Additional information: When therapeutic interchange won’t occur

Therapeutic interchange won’t occur when the prescription is a refill of a drug, as exempted by law, that is:

- An antipsychotic, *or*
- An antidepressant, *or*
- Chemotherapy, *or*
- Antiretroviral, *or*
- Immunosuppressive drug, *or*
- An immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

Due to federal regulations, therapeutic interchange won't take place when the prescription is for a schedule II nonpreferred drug. However, L&I will honor the prescription if an endorsing practitioner indicates DAW for a schedule II nonpreferred drug.

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Note: Transdermal fentanyl (Duragesic) and buprenorphine (Butrans) won't be routinely covered.

Link: For exception criteria, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/.

Payment policy: Infusion therapy

Prior authorization

Regardless of who is providing services, prior authorization is required for:

- Home infusion nurse services, *and*
- Drugs, *and*
- Any supplies.

The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Home infusion services can be authorized independently or in conjunction with home health services.

Home infusion skilled nurse services will only be authorized when infusion therapy is, approved as treatment for the worker's allowed industrial condition.

Who must perform these services to qualify for payment

Home infusion nurse services

Skilled nurses contracted by the home infusion service provide infusion therapy as well as:

- Education of the worker and family,
- Evaluation and management of the infusion therapy, *and*
- Care for the infusion site.

Drugs

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers, either electronically through the point-of-service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

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Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for “Home infusion services” in Chapter 11: Home Health Servicesfor more information.

Link: For information on home infusion therapy in general, see the Home infusion services section of Chapter 11: Home Health Services.

Note: Billing instructions for non-pharmacy providers are detailed in the Payment policy for Injectable medications (the next section of this chapter).

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Payment policy: Initial prescription drugs or "first fills" for State Fund claims

Payment methods

Payment for "first fills" will be based on L&I's fee schedule including but not limited to:

- Screening for drug utilization review (DUR) criteria, *and*
- Preferred drug list (PDL) provisions, *and*
- 30 day supply limit and formulary status.

Note: L&I will pay pharmacies or reimburse workers for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance.

Links: For definitions of "initial prescription drug" and "initial visit," see WAC 296-20-01002.

For billing and payment for initial prescription drugs information, see WAC 296-20-17004.

Requirements for billing

Your bill must be received by L&I within one year of the date of service.

For non-state fund claims, pharmacies should bill the appropriate federal or self-insured employer.

Note: If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

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Link: For additional information and billing instructions, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Billing/, or see the Pharmacy Prescription Billing Instructions manual.

For a list of SIE/TPAs, see: www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

Payment limits

L&I won't pay:

- For refills of the initial prescription before the claim is accepted, *or*
- For a new prescription written after the initial visit but before the claim is accepted, *or*
- If it is a federal or self-insured claim.

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Payment policy: Third party billing for pharmacy services

Requirements for billing

Pharmacy services billed through a third party pharmacy biller will be paid using the pharmacy fee schedule **only when**:

- A valid L&I claim exists, *and*
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I, *and*
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

Pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement, *and*
- Allow third party pharmacy billers to route bills on their behalf, *and*
- Agree to follow L&I rules, regulations and policies, *and*
- Ensure that third party pharmacy billers use L&I's online POS system, *and*
- Review and resolve all online POS system edits using a licensed pharmacist during the dispensing episode.

Payment limits

Third party pharmacy billers **can't resolve** POS edits.

Additional information: Third Party Pharmacy Supplemental Agreements

Third Party Pharmacy Supplemental Agreements can be obtained either:

- Through the third party pharmacy biller, *or*
- By contacting L&I's Provider Credentialing (see contact info, below).

The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I.

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Links: To contact L&I's Provider Credentialing, call **360-902-5140**.

For more information about these agreements, refer to the Pharmacy Services website at: www.lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for pharmacy services	Washington Administrative Code (WAC) 296-20-01002: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-01002 WAC 296-20-17004: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-17004 WAC 296-20-03014(6): http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03014 WAC 296-20-1102: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-1102 WAC 296-20-02005: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-02005
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
Drug coverage policies	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/
PDL	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/PDL.asp
Endorsing the PDL	Online registration at: www.hca.wa.gov/pdp/Pages/index.aspx Call Washington State Endorsing Practitioner Customer Service: **1-877-255-4637**

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If you're looking for more information about…	Then go here:
Fee schedules for all healthcare facility services (including ASCs)	L&I's website: http://feeschedules.Lni.wa.gov
NCPDP payer sheet current version	L&I's website: www.Lni.wa.gov/ClaimsIns/Files/Providers/NCPDPD0PayerSheetFinal.pdf
Outpatient formulary	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/OutpatientDrug.asp
PDL Hotline	Open Monday through Friday, 8:00 am to 5:00 pm (Pacific Time): **1-888-443-6798**
Therapeutic Interchange Program exception criteria	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Duragesic.asp
Third Party Pharmacy Supplemental Agreements	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2209

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 25: Physical Medicine Services

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

- **Body regions:** For osteopathic manipulation treatment (OMT) services, body regions are defined as:
  - Head,
  - Cervical,
  - Thoracic,
  - Lumbar,
  - Sacral,
  - Pelvic,
  - Rib cage,
  - Abdomen and viscera regions,
  - Lower and upper extremities.

- **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.CPT® and local code modifiers mentioned in this chapter:**

  –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.

  –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.

  –52 Reduced services

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

- **Work conditioning:** An intensive, work related, goal oriented conditioning program designed specifically to restore function for work.

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- **Work hardening:** An interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular, and psychosocial functioning of the worker.

Link: More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program, and other work hardening program standards is available on L&I's website at: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/.

This information is also available by calling the work hardening program reviewer at **360-902-4480**.

Payment policy: Electrical stimulators (including TENS)

Prior authorization

These HCPCS codes for **electrical stimulator devices for home use or surgical implantation** require prior authorization:

HCPCS code	Brief description	Additional coverage information
E0745	Neuromuscular stimulator for shock	This code is covered for **muscle denervation only**.
E0747	Electrical osteogenesis stimulator, not spine	—
E0748	Electrical osteogenesis stimulator, spinal	—
E0749	Electrical osteogenesis stimulator, implanted	Authorization for this code is subject to **utilization review**.
E0760	Osteogenesis ultrasound, stimulator	This code is covered for appendicular skeleton only (**not the spine**).
E0764	Functional neuromuscular stimulator	—

Services that can be billed

For electrical stimulator devices **used in the office setting**:

- When it is within the provider's scope of practice, a provider may bill professional services for application of stimulators with the CPT® physical medicine codes.
- Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code **1044M**.

For electrical stimulator devices and supplies **for home use or surgical implantation**, HCPCS code **E0761** (Nonthermal electromagnetic device) is covered.

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Services that aren't covered

For **use outside of medically supervised facility settings** (including home use and purchase or rental of durable medical equipment and supplies), the insurer doesn't cover:

- Transcutaneous Electrical Nerve Stimulators (TENS) units and supplies, *or*
- Interferential current therapy (IFC) devices, *or*
- Percutaneous neuromodulation therapy (PNT) devices.

Note: Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

For **home use or surgical implantation devices and supplies**, these HCPCS codes aren't covered:

- **E0731** (Conductive garment for TENS),
- **E0740** (Incontinence treatment system),
- **E0744** (Neuromuscular stimulator for scoliosis),
- **E0755** (Electronic salivary reflex stimulator),
- **E0762** (Transcutaneous electrical joint stimulation device system),
- **E0765** (Nerve stimulator for treatment of nausea and vomiting),
- **E0769** (Electric wound treatment device, not otherwise classified),
- **L8680** (Implantable neurostimulator electrode),
- **S8130** (Interferential current stimulator, 2 channel),
- **S8131** (Interferential current stimulator, 4 channel).

For home use or in medically supervised facility settings, CPT® code 64555 (Peripheral nerve neurostimulator) isn't covered.

Payment limits

These supplies are **bundled and not payable separately for office use**:

- **A4365** (Adhesive remover wipes),

- **A4455** (Adhesive remover per ounce),
- **A4556** (Electrodes, pair),
- **A4557** (Lead wires, pair),
- **A4558** (Conductive paste or gel),
- **A5120** (Skin barrier wipes box per 50),
- **A6250** (Skin seal protect moisturizer).

Additional information: Why the insurer doesn't cover TENS

On October 30, 2009, the State Health Technology Clinical Committee (HTCC) met in an open public meeting to review the evidence for Electrical Nerve Stimulation (ENS), including TENS, interferential current therapy (IFC), and percutaneous neuromodulation therapy (PNT), as treatments for acute and chronic pain.

Based on a review of the best available evidence of safety, efficacy, and cost effectiveness, the committee determined that ENS is non-covered for use outside of medically supervised facilities. Purchase or rental of TENS, IFC, and PNT equipment and supplies isn't covered.

The determination was finalized by the HTCC on November 20, 2009.

Link: Complete information on this HTCC determination is available at: www.hta.hca.wa.gov and at:

www.hca.wa.gov/hta/Pages/tens.aspx.

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Payment policy: Massage therapy

Who must perform these services to qualify for payment

To qualify for payment, massage therapy services must be performed by:

- A licensed massage therapist, *or*
- Other covered provider whose scope of practice includes massage techniques.

Link: For more information, see WAC 296-23-250.

Services that can be billed

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. The insurer won't pay massage therapists for additional codes.

Requirements for billing

Massage therapists must bill CPT® code **97124** for all forms of massage therapy, regardless of the technique used. Massage therapists must also use CPT® code **97124** for evaluations and reevaluations.

Massage therapists must bill their usual and customary fee and document the duration of the massage therapy treatment.

Documentation must support the units of service billed. Document the amount of time spent performing evaluations and reevaluations as well as the treatment.

Payment limits

Massage therapy is paid at **75%** of the maximum daily rate for PT and OT services, *and*

The daily maximum allowable amount is **$94.26**.

These are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices,
- Lubricants (for example, oils, lotions, emollients).

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Link: For more information, see WAC 296-23-250.

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Payment policy: Osteopathic manipulative treatment (OMT)

Who must perform these services to qualify for payment

Only osteopathic physicians may bill for OMT services.

Services that aren't covered

CPT® code **97140** isn't covered for osteopathic physicians.

Requirements for billing

OMT includes pre and post service work (for example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT only when all of the following conditions are met:

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included with OMT, *and*
- The worker's record contains documentation supporting the level of E/M service billed, *and*
- The E/M service is billed using **modifier –25**. Without **modifier –25**, the insurer won't pay for E/M codes billed on the same day as OMT.

Note: The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of E/M in addition to OMT services on the same day.

Payment limits

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

For OMT services, only one code is payable per treatment. This is because codes for **body regions** ascend in value to accommodate the additional **body regions** involved.

> **Example:** If three body regions were manipulated, one unit of the correct CPT® code would be payable.
>
> (See definition of **Body regions** in Definitions at the beginning of this chapter.)

Payment policy: Functional capacity evaluation

Prior authorization

- Requires prior authorization by the claim manager.

Who must perform these services to qualify for payment

To qualify for payment, a functional capacity evaluation must be performed by:

- Physicians who are board qualified or certified in physical medicine and rehabilitation, *or*
- Physical and occupational therapists.

Services that can be billed

Qualified providers can bill local code **1045M** which has a maximum fee of **$751.34**.

Documentation must include a report with a detailed summary of capacities. In-state FCE providers are required to use form F245-434-000 and meet L&I's minimum test standards.

Requirements for billing

The evaluation must be provided as a one-on-one service lasting a minimum of 3 hours. A report detailing the evaluation must be submitted to the department.

Payment limits

Local code **1045M** is payable only once per 30 days per worker.

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Payment policy: Physical medicine CPT® codes billing guidance

Timed codes

Some physical medicine services (such as ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as “timed services” and are billed using “timed codes.”

Timed codes can be identified in CPT® by the code description. The definition will include words such as “each 15 minutes.”

Providers **must document** in the daily medical record (chart note and flow sheet, if used):

- The amount of time spent for each time based service performed, *and*
- The specific interventions or techniques performed, including:
  - Frequency and intensity (if appropriate), *and*
  - Intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

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.

The **number of units you can bill** is:

- Determined by the time spent performing each “timed service,” *and*
- Constrained by the total minutes spent performing these services on a given day.

To obtain the total minutes spent performing time based services, add together the minutes spent performing each individual time based service.

To obtain the number of units that can be billed for these services, use the table below.

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If the combined duration of all time based services is **at least**…	**and less than**…	Then, when **billing**, **report**:
8 minutes	**23** minutes	**1** unit
23 minutes	**38** minutes	**2** units
38 minutes	**53** minutes	**3** units
53 minutes	**68** minutes	**4** units
68 minutes	**83** minutes	**5** units
83 minutes	**98** minutes	**6** units
98 minutes	**113** minutes	**7** units
113 minutes	**128** minutes	**8** units

Note: The above schedule of times doesn‘t imply that any of the first eight minutes should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

For **example**, if you perform:

- **10 minutes** of CPT® **97110** (therapeutic exercises), *and*
- **12 minutes** of CPT® **97140** (manual therapy),

… you have performed **22 minutes** of timed code services. This equates to **one unit of service** that can be billed. Since the most time was spent performing manual therapy, **bill one unit of 97140**.

Examples of how to document and bill timed codes

The following examples show how the required elements of interventions can be documented and billed. These examples aren’t reflective of a complete medical record for the patient’s visit. The other elements of reporting (SOAP) **also must be documented**.

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Example 1:

Procedural intervention	Specific intervention	Purpose	Treatment time
Therapeutic exercise	Left leg straight leg raises x 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting	**20 minutes**
Neuromuscular reeducation	One leg stance, 45 seconds left; 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead	**15 minutes**
Cold pack	Applied to left knee	Decrease edema	10 minutes
Total treatment time = 45 minutes			
Total timed intervention (treatment time spent performing timed services) = **35 minutes**			

A maximum of **two units** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, *and*
- **97112** (Neuromuscular reeducation) x 1 unit.

Example 2:

Procedural intervention	Specific intervention	Purpose	Treatment time
Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm^2 ; 100% right forearm	Increase joint mobility	**8 minutes**
Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation	8 minutes
Therapeutic exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping	**10 minutes**
Total treatment time = 26 minutes			
Total timed intervention (treatment time spent performing timed services) = **18 minutes**			

A maximum of **one unit** of timed services can be billed. Correct billing for the services documented is:

- **97110** (Therapeutic exercise) x 1 unit, *and*
- **97022** (Whirlpool) x 1 unit.

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Prohibited pairs: What CPT® codes can't be billed together

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to one or more patients **for the same time period**:

- Any two codes for "therapeutic procedures" requiring direct, one-on-one patient contact, *or*
- Any two codes for modalities requiring "constant attendance" and direct, one-on-one patient contact, *or*
- Any two codes requiring either constant attendance or direct, one-on-one patient contact, as described above (for example, any CPT® codes for a therapeutic procedure with any attended modality CPT® code), *or*
- Any code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy code (for example, CPT® code **97150** with CPT® code **97112**), *or*
- Any code for modalities requiring constant attendance with the group therapy code (for example, CPT® code **97150** with CPT® code **97035**), *or*
- An untimed evaluation or reevaluation code with any other timed or untimed codes, including constant attendance modalities, therapeutic procedures, and group therapy.

Determining what time counts towards timed codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services:

- Pre and post delivery services aren't counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or a PT or OT assistant under the supervision of a physician or therapist) is working directly with the patient to deliver treatment services.
- The patient should already be in the treatment area (for example, on the treatment table or mat or in the gym) and prepared to begin treatment.
- The time counted is the time the patient is treated.
- The time the patient spends not being treated because of the need for toileting or resting shouldn't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

Note: For more information about L&I's PT, OT, and massage therapy policies, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/.

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Payment policy: Physical therapy (PT) and occupational therapy (OT)

Who must perform these services to qualify for payment

PT services

PT services must be ordered by the worker's attending doctor, nurse practitioner, or the physician's assistant for the attending doctor. The services must be provided by a:

- Licensed physical therapist, *or*
- Physical therapist assistant serving under a licensed physical therapist's direction, *or*
- Athletic trainer serving under a licensed physical therapist's direction.

Link: For more information, see WAC 296-23-220.

OT services

OT services must be ordered by the worker's attending doctor, nurse practitioner, or the physician's assistant for the attending doctor. The services must be provided by a:

- Licensed occupational therapist, *or*
- Occupational therapy assistant serving under a licensed occupational therapists direction.

Link: For more information, see WAC 296-23-230.

Physical medicine services

Physical medicine services may be provided by:

- Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation (physiatry), *or*
- Attending doctors who aren't board qualified or certified in physical medicine and rehabilitation. For non-board certified/qualified providers, special payment policies apply. (See Requirements for billing and Payment limits, below.)

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Link: For more information, see WAC 296-21-290.

Who won't be paid for physical medicine services

- Physical or occupational therapist students, *or*
- Physical or occupational therapist assistant students, *or*
- Physical or occupational therapist aides, *or*
- Gym Supervisors

Services that can be billed

Physical and occupational therapists must use the appropriate CPT® and HCPCS codes **64550**, **95831-95852**, **95992**, **97001-97799**, and **G0283**. These therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies.

Note: Some of these codes aren't covered or are bundled. See these exceptions noted in the Services that aren't covered and Payment limits (Bundled items or services), below.

For information on Surgical dressings dispensed for home use, see Chapter 28: Supplies, Materials, and Bundled Services.

If more than one patient is treated at the same time, use CPT® code **97150**.

Note: For more information, see Billing guidance: Using physical medicine CPT® codes earlier in this chapter.

For PT and OT evaluations and reevaluations, bill using CPT® codes **97001** through **97004**.

To report the evaluation by the physician or therapist to establish a plan of care, use CPT® codes **97001** and **97003**.

To revise the plan of care by reporting the evaluation of a patient who has been under a plan of care established by the physician or therapist, use CPT® codes **97002** and **97004**.

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Note: CPT® codes **97002** and **97004** have no limit on how often they can be billed.

Services that aren't covered

Physical medicine CPT® codes **97005**, **97006**, and **97033** aren't covered.

Requirements for billing

Physical medicine services

Board qualified and board certified physiatrists bill for services using:

- CPT® codes **97001** through **97799**, and **95831** through **95852**, *or*
- CPT® code **64550** (payable only once per claim).

Non-board certified/qualified physical medicine attending providers may perform physical medicine modalities and procedures described in CPT® codes **97001-97750** if their scopes of practice and training permit it, but for these services **must bill local code 1044M**. (See Payment limits for local code **1044M**, below.)

Note: The description for local code **1044M** is "Physical medicine modality(ies) and/or procedure(s) by attending doctor who isn't board qualified or certified in physical medicine and rehabilitation." The maximum fee for the code is **$45.83**.

Payment limits

Physical medicine services

CPT® code **64550** is payable only once per claim, and is payable only to board certified/qualified physiatrists.

Non-board certified/qualified physical medicine providers won't be paid for CPT® codes **97001-97799**.

Local code **1044M** is limited to six units per claim. After six units, the patient **must be referred** to a licensed physical or occupational therapist or physiatrist except when the attending doctor practices in a remote location where no licensed physical or occupational therapist or physiatrists is available.

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Bundled items or services

- Activity supplies used in work hardening, such as leather and wood,
- Application of hot or cold packs, (this includes all forms of cryotherapy with or without compression)
- Electrodes and gel,
- Exercise balls,
- Ice packs, ice caps, and ice collars,
- Thera-tape,
- Wound dressing materials used during an office visit and/or PT treatment.

Note: For complete lists of bundled codes, see Chapter 28: Supplies, Materials and Bundled Services.

Daily maximum for services

The daily maximum allowable fee for PT and OT services is $125.68.

Link: For more information, see WAC 296-23-220 and WAC 296-23-230.

The daily maximum allowable fee doesn't apply to:

- Physicians board certified in Physical Medicine, or
- Functional capacity evaluations FCEs), *or*
- Work hardening services, *or*
- Work evaluations, *or*
- Job modification/prejob accommodation consultation services.

When performed for the same claim for the same date of service, the daily maximum applies to CPT® codes **64550**, **95831-95852**, and **97001-97799**, and HCPCS code **G0283**.

Work conditioning programs are reimbursed as outpatient PT and OT under the daily fee cap.

If PT, OT, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type.

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If the worker is treated for two separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition:

- Therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit.
- In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to one unit per day. This applies to these CPT® and HCPCS codes:

- **97001-97004**,
- **97012**,
- **97014**,
- **97016**,
- **97018**,
- **97022**,
- **97024**,
- **97026**,
- **97028**,
- **97150**,
- **G0283.**

Note: Providers must document the actual service provided including the intended purpose for each service. Simply documenting the procedure code is insufficient and may result in denial of the bill or recoupment of payment. All documentation **must be submitted** to support your billing (for example, flow sheets, chart notes, and reports).

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Work conditioning: Guidelines

(See definition of **Work conditioning** in Definitions at the beginning of this chapter.)

- **Frequency**: At least three times per week and no more than 5 times per week.
- **Duration**: No more than 8 weeks for one set. One set equals up to 20 visits.
  - An additional 10 visits may be approved upon review of progress.
- **Plan of Care**: Goals are related to:
  - Increasing physical capacities, *and*
  - Return to work function, *and*
  - Establishing a home program allowing the worker to progress and/or maintain function after discharge.
- **Documentation**: Besides standard documentation, it must include return to work capacities, which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances.
- **Treatment**: May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
  - PT and OT visits accumulate separately and both are allowed on the same date of service.
  - Billing reflects active treatment. Examples include CPT® **97110**, **97112**, **97530**, **97535**, and **97537**.

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Payment policy: Powered traction therapy

Services that can be billed

Powered traction devices are covered as a physical medicine modality.

Payment limits

The insurer won't pay any additional cost when powered devices are used.

Additional information: Why the insurer won't pay additional cost when powered devices are used

Published literature hasn't substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices.

For more information go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Pwdtractiondevices.asp

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Payment policy: Work hardening

(See definition of **Work hardening** in Definitions at the beginning of this chapter.)

Prior authorization

Work hardening programs require:

- Prior approval by the worker's attending physician, *and*
- Prior authorization by the claim manager.

Providing **additional services** during a work hardening program is atypical and must be authorized in advance by the claim manager.

Note: Documentation must support the billing of additional services.

Program extensions must be authorized in advance by the claim manager and are based on:

- Documentation of progress, *and*
- The worker's ability to benefit from the program extension up to two additional weeks.

Who must perform these services to qualify for payment

Only L&I approved work hardening providers will be paid for work hardening services.

Services that can be billed

Work hardening

- For the evaluation, bill using local code **1001M**.
- For treatment, bill using CPT® codes **97545** and **97546**.

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Services that aren't covered

Billing for less than two hours of service in one day (CPT® code 97545)

Services provided for less than two hours on any day don't meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. This should be considered as an absence in determining worker compliance with the program.

> **Example:** The worker arrives for work hardening, but isn't able to participate fully that day.

Requirements for billing

Work hardening

CPT® codes should be billed that appropriately reflect the services provided.

A worker typically starts at four hours per day and gradually increases to 7-8 hours per day by week four.

Billing less than one hour of CPT® code 97546

After the first two hours of service on any day, if less than 38 minutes of service are provided **modifier –52** must be billed. For that increment of time:

- CPT® code **97546** must be billed as a separate line item with **modifier –52**, *and*
- The charged amount prorated to reflect the reduced level of service.

> **Example:** Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include three lines:

Code	Modifier	Charged amount	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	**–52**	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

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Billing for evaluation and treatment on the same day (multiple disciplines)

If both the OT and the PT need to bill for one hour of evaluation and one hour of treatment on the same date of service, the services must be billed as follows:

If the **provider type** is…	and the **service** provided is…	Then **bill as:**
OT	1 hour of evaluation	1 unit of **1001M**
PT	1 hour of evaluation	1 unit of **1001M**
OT (or PT)	1 hour of treatment	1 unit of **97545** with **modifier –52** (billed amount proportionate to 1 hour)
PT (or OT)	1 hour of treatment	1 unit of **97546**

Examples of billing options for services in multidisciplinary programs

Scenario: The OT is responsible for the work simulation portion of the worker's program, which lasted four hours. On the same day, the worker performed two hours of conditioning/aerobic activity for which the PT is responsible.

The providers could bill for the six hours of services in either one of two ways:

Billing option 1		
PT:	1 unit **97545**	2 hours
OT:	4 units **97546**	4 hours
	Total hours billed:	**6 hours**

Billing option 2		
OT:	1 unit **97545** + 2 units **97546**	2 hours 2 additional hours
PT:	2 units **97546**	2 hours
	Total hours billed:	**6 hours**

Payment limits

Work hardening

Work hardening programs are authorized for up to four weeks. Only one unit of **97545** (first two hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

These codes are subject to the following limits:

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Code	Description	**Unit limit** (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	**$124.57**
97545	Initial two hours per day	20 units per program; Maximum of one unit per day per worker (1 unit = 2 hours)	**$147.21**
97546	Each additional hour	70 units per program Add-on, won't be paid as a stand-alone procedure per worker per day. (1 unit = 1 hour)	**$75.12**

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes **97545** and **97546** takes into consideration that some work occurs outside of the time the client is present (for example, team conference, plan development).

Time spent in treatment conferences isn't covered as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using CPT® codes **97545** and **97546**.

Program extensions

Additional units available for extended programs:

Code	Description	Six week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial two hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Additional information: L&I's work hardening program

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program, and other work hardening program standards is available:

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- At: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/, *or*
- By calling the work hardening program reviewer at **360-902-4480**.

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Payment policy: Wound care

Prior authorization

Electrical stimulation for chronic wounds

If electrical stimulation for chronic wounds is requested for use on an outpatient basis, prior authorization is required using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy, *and*
- In addition to electrical stimulation, standard wound care must continue.

Note: In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days. (See Requirements for billing, below.)

Services that can be billed

Debridement

Therapists must bill CPT® **97597**, **97598**, or **97602** when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies **sent home with the patient** for self-care may be billed with HCPCS codes appended with local **modifier –1S**.

Note: For wound dressings and supplies used in the office, see Payment limits, below.

Link: For more information on billing with local **modifier –1S**, see the Surgical dressings for home use section (Requirements for billing and Payment limits) of Chapter 28: Supplies, Materials, and Bundled Services.

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Electrical stimulation for chronic wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is covered for the following chronic wound indications:

- Stage III and IV pressure ulcers,
- Arterial ulcers,
- Diabetic ulcers,
- Venous stasis ulcers.

To bill for electrical stimulation for chronic wounds, use HCPCS code **G0281**.

Link: For more information on electrical stimulation for chronic wounds, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/elecStimofChronicWounds.asp

Requirements for billing

Debridement

When performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool), therapists must bill CPT® **97597**, **97598**, or **97602**.

Electrical stimulation for chronic wounds

In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Payment limits

Debridement

Wound dressings and supplies used in the office are bundled and aren't payable separately.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules (Washington state laws) for physical medicine	Washington Administrative Code (WAC) 296-21-290: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21-290
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
Electrical stimulation of chronic wounds	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/elecStimofChronicWounds.asp
L&I's general policies and rules for **PT, OT,** and **massage therapy**	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/
Massage therapy administrative rules	Washington Administrative Code (WAC) 296-23-250: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-250
Occupational therapy administrative rules	Washington Administrative Code (WAC) 296-23-230: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-230
Physical therapy administrative rules	Washington Administrative Code (WAC) 296-23-220: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-220
Powered traction devices for intervertebral decompression	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Pwdtractiondevices.asp
Fee schedules for all healthcare professional services	L&I's website: http://feeschedules.Lni.wa.gov
Payment policies for **supplies, materials, and bundled services**	Chapter 28: Supplies, Materials, and Bundled Services
TENS coverage decision	State Health Technology Clinical Committee (HTCC) website: www.hta.hca.wa.gov and:

If you're looking for more information about…	Then go here:
	www.hca.wa.gov/hta/Pages/tens.asp
Work hardening program at L&I	Program reviewer: **360-902-4480** L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 26: Radiology Services

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

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

  –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.)

  –52 Reduced services

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

  –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.

  –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.

  –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

- **Full spine study:** A full spine study is a radiologic exam of the entire spine: anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic, and lumbar spine). (See definition of **incomplete full spine study**, below.)

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- **Incomplete full spine study:** An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. (See definition of **full spine study**, above.)

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Payment policy: Contrast material

Services that aren't covered

HCPCS code **A9525** isn't valid for contrast material.

Requirements for billing

Use the following HCPCS codes to bill for contrast material:

- Low osmolar contrast material (LOCM): **Q9951**, **Q9965** - **Q9967**
- High contrast osmolar material (HOCM): **Q9958** - **Q9964**

For LOCM, bill one unit per ml.

Providers may use either HOCM or LOCM. The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart.

Note: Separate payment will be made for contrast material for imaging studies.

Payment limits

HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml.

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Payment policy: Nuclear medicine

Payment limits

The standard multiple surgery policy applies to the following radiology CPT® codes for nuclear medicine services:

- **78306**,
- **78320**,
- **78802**,
- **78803**,
- **78806**, *and*
- **78807**.

The multiple procedures reduction will be applied when these codes are billed:

- With other codes subject to the standard multiple surgery policy, *and*
- For the same patient:
  - On the same day by the same physician, *or*
  - By more than one physician of the same specialty in the same group practice.

Link: For more information about the standard multiple surgery payment policies, refer to Chapter 29: Surgery Services.

Payment policy: Radiology consultation services

Services that aren't covered

CPT® code **76140** isn't covered.

Requirements for billing

For radiology codes where a consultation service is performed, providers who perform the service must bill the specific X-ray code with **modifier –26**.

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6,
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis,
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?, *and*
- Does this disc protrusion shown on MRI look new or preexisting?

Payment limits

The insurer won't pay separately for review of films taken previously or elsewhere if a face to face service is performed on the same date as the X-ray review.

Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit, or other procedure(s) performed.

Payment for a radiological consultation will be made at the established professional component (**modifier –26**) rate for each specific radiology service. A written report of the consultation is required.

Note: For specific reporting requirements, see the next section of this chapter.

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Payment policy: Radiology reporting requirements

Requirements for billing

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with **modifier –26** or as part of the global service.

Note: Documentation refers to charting of justification, findings, diagnoses, and test result integration.

Any provider who produces and interprets his/her own imaging studies, and any radiologist who over reads imaging studies must produce a report of radiology findings to bill for the professional component. The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, and date of procedure, *and*
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc.), *and*
- Specific views (AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc., as applicable), *and*
- Brief sentence summarizing history and/or reason for the study, such as:
    - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
    - "Neck pain radiating to upper extremity; rule out disc protrusion," *and*
- Description of, or listing of, imaging findings:
    - **Advanced imaging reports** should follow generally accepted standards to include relevant findings related to the particular type of study, *and*
    - Radiology **reports on plain films of skeletal structures** should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings, *and*

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- Radiology **reports on chest plain films** should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine), *and*

Note: Chart notes such as "X-rays are negative" or "X-rays are normal" don't fulfill the reporting requirements described in this section and the insurer **won't pay** for the professional component in these circumstances (see Payment limits, below).

- Imaging impressions, which summarize and provide significance for the imaging findings described in the body of the report. For example:
  - For a skeletal plain film report that described normal osseous density and contours and no joint abnormalities, the impression could be: "No evidence of fracture, dislocation, or gross osseous pathology."
  - For a skeletal plain film report that described reduced bone density and thinned cortices, the impression could be: "Osteoporosis, compatible with the patient's age."
  - For a chest report that described vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be: "Emphysema."

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes. Examples include:

- "Imaging rules out fracture, so rehab can proceed."
- "Flexion/extension plain films indicate hypermobility at C4/C5, and spinal manipulation will avoid that region."
- "MRI identifies disc protrusion at L4/L5, and a conservative course of inversion therapy will begin."

Payment limits

Chart notes such as "X-rays are negative" or "X-rays are normal" don't fulfill the reporting requirements described in this section and the insurer **won't pay** for the professional component in these circumstances.

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Payment policy: X-ray services

Requirements for diagnostic imaging studies

Documentation

Attending health care providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain, *or*
- PA and lateral chest films to determine cause for dyspnea.

Technical quality

All imaging studies must be of adequate technical quality to rule out radiologically detectable pathology.

Custody

X-rays must be retained for 10 years.

Link: For more information on custody requirements, see WAC 296-20-121 and WAC 296-23-140(1).

Requirements for billing

Billing code modifiers –RT and –LT

HCPCS modifiers **–RT** (right side) and **–LT** (left side) don't affect payment. They may be used with CPT® radiology codes **70010-79999** to identify duplicate procedures performed on opposite sides of the body.

Global radiology services

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the study). If only the:

- **Technical component** of a radiology service is performed, then **modifier –TC** must be used, and only the technical component fees are allowable, *and*
- **Professional component** of a radiology service is performed, then **modifier –26** must be used, and only the professional component fees are allowable.

Incomplete full spine studies

(See definitions of **full spine study** and **incomplete full spine study** in Definitions at the beginning of this chapter.)

For a single view bill **72081**.

For 2 or 3 views bill **72082**.

For 4 or 5 views bill **72083**.

For 6 or more views bill **72084**.

Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving:
    - Extremities,
    - Pelvis,
    - Vertebral column, *or*
    - Skull,
- Chest or abdominal films that don't involve the use of contrast media, *and*
- Diagnostic mammograms.

HCPCS codes for transportation of portable X-ray equipment **R0070** (one patient) or **R0075** (multiple patients) may be paid in addition to the appropriate radiology code(s).

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R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table.

For transport portable X-ray services:

If the **number of patients served** is…	Then the appropriate **HCPCS code** to bill is…	Along with this billing code **modifier**:	The **maximum fee**, effective July 1, 2016 is:
1	**R0070**	—	**$175.49**
2	**R0075**	**–UN**	**$87.74**
3	**R0075**	**–UP**	**$58.50**
4	**R0075**	**–UQ**	**$43.86**
5	**R0075**	**–UR**	**$35.10**
6 or more	**R0075**	**–US**	**$29.25**

Payment limits

Number of views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

If the **CPT® code** is…	Then it is **payable**:
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Repeat X-rays

The insurer won't pay for excessive or unnecessary X-rays.

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Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for X-ray custody requirements	Washington Administrative Code (WAC) 296-20-121: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-121 WAC 296-23-140(1): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-140
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
Payment policies for **surgery**	Chapter 29: Surgery Services
Professional Services **Fee Schedules**	L&I's website: http://feeschedules.Lni.wa.gov/

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

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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**

Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 28: Supplies, Materials, and Bundled Services

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

- **Acquisition cost:** The acquisition cost equals:
  - The wholesale cost, *plus*
  - Shipping and handling, *plus*
  - Sales tax.

- **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 defintion of By report, see **WAC 296-20-01002.**

  Bundled codes: Procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services. Pharmacy and DME providers can bill HCPCS codes listed as bundled in the fee schedules. This is because, for these provider types, there isn't an office visit or a procedure into which supplies can be bundled.

  Link: For the legal definition of **Bundled codes**, see WAC 296-20-01002.

- **HCPCS and local code modifiers mentioned in this chapter:**

  –NU **New purchased DME**

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

  –RR **Rented DME**

  Use the **–RR** modifier when DME is to be rented.

  –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.

- **Primary surgical dressings:** Therapeutic or protective coverings directly applied to wounds or lesions on the skin or caused by an opening on the skin. These dressings include items such as:

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- Telfa,
- Adhesive strips for wound closure, *and*
- Petroleum gauze.

- **Secondary surgical dressings:** Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. These dressings include items such as:
  - Adhesive tape,
  - Roll gauze,
  - Binders, *and*
  - Disposable compression material.

- **Supplies:** Supplies include, but aren't limited to:
  - Drugs administered in a provider's office,
  - Medical and surgical supplies, *and*
  - Prefabricated orthotics.

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Payment policy: Acquisition cost policy

(See definition of **Acquisition cost** in Definitions at the beginning of this chapter.)

Note: This policy doesn't apply to hospital bills.

Link: For the Hospital acquisition cost policy, see Chapter 35: Hospitals.

Requirements for billing

Billing acquisition cost

The total acquisition cost should be billed as one charge. The acquisition cost equals:

- The wholesale cost, *plus*
- Shipping and handling, *plus*
- Sales tax.

Note: Supply codes without a fee listed will be paid at their acquisition cost.

Sales tax and shipping and handling charges aren't paid separately and must be included in the total charge of the supply. An itemized statement showing net price (cost) plus tax may be attached to bills, but isn't required.

Wholesale invoices

Providers must keep wholesale invoices for all supplies and materials in their office files for a minimum of 5 years.

A provider must submit a hard copy of the wholesale invoice to the insurer:

- When billing for a supply item that costs **$150.00** or more, *or*
- Upon request.

Note: The insurer may delay payment of the provider's bill if the insurer hasn't received this information.

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Payment policy: Casting materials

Services that can be billed

Bill for casting materials with HCPCS codes **Q4001**-**Q4051**.

Services that aren't covered

No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

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Payment policy: Catheterization

Link: For more information about catheterization to obtain specimen(s) for lab tests, see the Specimen collection and handling payment policy in Chapter 23: Pathology and Laboratory Services.

Services that can be billed

Separate payment is allowed for placement of a temporary indwelling catheter when:

- Performed in a provider's office, *and*
- Used to treat a temporary obstruction.

Payment limits

Separate payment isn't allowed when placement of a temporary indwelling catheter is performed:

- On the same day as a major surgical procedure, *or*
- During the postoperative period of a major surgical procedure that has a follow up period.

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Payment policy: Hot or cold therapy durable medical equipment (DME)

Note: This policy is identical to the Hot or cold therapy DME payment policy that appears in Chapter 9: Durable Medical Equipment (DME).

Services that can be billed

Ice cap or collar (HCPCS code **A9273**) is payable for DME providers only and is **bundled** for all other provider types.

Services that aren't covered

Hot water bottles, heat and/or cold wraps aren't covered.

Hot or cold therapy DME isn't covered.

For example, heat devices for home use, including heating pads. These devices either aren't covered or are **bundled**.

Link: For more information, see WAC 296-20-1102.

Payment limits

Application of hot or cold packs (CPT® code **97010**) is **bundled** for all providers.

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

Link: For more information, see , the payment policy for Hot and cold therapy DME in Chapter 9: Durable Medical Equipment (DME).

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Payment policy: Miscellaneous supplies

(See definition of **Supplies** in Definitions at the beginning of this chapter.)

Services that can be billed

HCPCS billing code **E1399** can be billed for a miscellaneous supply that meets both of these criteria:

- The supply (or DME item) doesn't have a valid HCPCS code assigned, *and*
- The item must be appropriate relative to the injury or type of treatment being received by the worker.

Services that aren't covered

The insurer won't pay CPT® code **99070**, which represents miscellaneous supplies and materials provided by the provider.

Requirements for billing

All bills for **E1399** items must have:

- Either the **–NU** or **–RR modifier**, *and*
- A description must be on the paper bill or in the remarks section of the electronic bill.

These specific miscellaneous supplies **must be billed** using HCPCS code **E1399**:

- Therapy putty and tubing, *and*
- Anti-vibration gloves.

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Payment policy: Services and supplies

(See definition of **Supplies** in Definitions at the beginning of this chapter.)

Requirements for billing

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of an accepted condition.

Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services.

For covered medical and surgical supplies that pay **by report**, providers must bill their usual and customary fees.

Note: Also see Payment limits for **by report** medical and surgical supplies, below. See definition of **by report** in Definitions at the beginning of this chapter.

Links: For more information on billing usual and customary fees, see WAC 296-20-010(2).

To find out which codes pay **by report**, see the Medical and Surgical Supplies section of the Professional Services Fee Schedule, available at: www.Feeschedules.Lni.wa.gov.

Services that aren't covered

The insurer won't pay CPT® code **99070**, which represents miscellaneous supplies and materials provided by the provider.

Payment limits

Under the fee schedules, some services and supply items are considered **bundled** into the cost of other services (associated office visits or procedures) and won't be paid separately. These include:

- Supplies used in the course of an office visit, *and*
- Fitting fees, which are **bundled** into the office visit or into the cost of any DME.

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For medical and surgical supplies that pay **by report**, **(except E1399)**, the insurer will pay **80%** of the billed charge.

Note: Also see Requirements for billing for **by report** medical and surgical supplies, above. See definition of **Bundled** in Definitions at the beginning of this chapter.

Link: To see which billing codes are **bundled**, see L&I's Professional Services Fee Schedule; in the dollar value column, such items show the word **bundled** (instead of a dollar amount). The fee schedule is available at: www.Feeschedules.Lni.wa.gov.

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Payment policy: Supply Codes, Bundled

(Some supplies are bundled, see below.)

Bundled CPT® supply codes

These CPT® service codes are bundled:

- **99070**, *and*
- **99071**.

Bundled HCPCS supply codes

In the following table, items with an asterisk (*) are used as orthotics/prosthetics and may be paid separately **for permanent conditions** if they are provided in the physician's office.

If the condition is **acute or temporary**, these items aren't considered prosthetics.

For example:

- Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions may be paid separately when provided in the physician's office, *and*
- The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction wouldn't be paid separately because it is treating a temporary problem, *and*
- If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthetic/orthotic and would be paid separately.

This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A0380	Basic life support mileage
A0382	Basic support routine suppls
A0384	Bls defibrillation supplies
A0390	Advanced life support mileag
A0392	Als defibrillation supplies
A0394	Als IV drug therapy supplies
A0396	Als esophageal intub suppls

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A0398	Als routine disposble suppls
A0420	Ambulance waiting 1/2 hr
A0422	Ambulance 02 life sustaining
A0424	Extra ambulance attendant
A4206	1 CC sterile syringe & needle
A4207	2 CC sterile syringe & needle
A4208	3 CC sterile syringe & needle
A4209	5+ CC sterile syringe & needle
A4211	Supp for self-adm injections
A4212	Non coring needle or stylet
A4213	20+ CC syringe only
A4215	Sterile needle
A4216	Sterile water/saline, 10 ml
A4217	Sterile water/saline, 500 ml
A4218	Sterile saline or water
A4244	Alcohol or peroxide per pint
A4245	Alcohol wipes per box
A4246	Betadine/phisohex solution
A4247	Betadine/iodine swabs/wipes
A4248	Chlorhexidine antisept
A4250	Urine reagent strips/tablets
A4252	Blood ketone test or strip
A4253	Blood glucose/reagent strips
A4256	Calibrator solution/chips
A4257	Replace Lensshield Cartridge
A4258	Lancet device each
A4259	Lancets per box
A4262	Temporary tear duct plug

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4263	Permanent tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML
A4306	Drug delivery system <=5 ML
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4320	Irrigation tray
A4321	Cath therapeutic irrig agent
A4322	Irrigation syringe
A4326*	Male external catheter
A4327*	Fem urinary collect dev cup
A4328*	Fem urinary collect pouch
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for cath insertion
A4333	Urinary cath anchor device
A4334	Urinary cath leg strap
A4335*	Incontinence supply
A4336	Urethral insert
A4338*	Indwelling catheter latex

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4340*	Indwelling catheter special
A4344*	Cath indw foley 2 way silicn
A4346*	Cath indw foley 3 way
A4349	Disposable male external cat
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356*	Ext ureth clmp or compr dvc
A4357*	Bedside drainage bag
A4358*	Urinary leg bag
A4360	Disposable ext urethral dev
A4361*	Ostomy face plate
A4362*	Solid skin barrier
A4363	Ostomy clamp, replacement
A4364*	Ostomy/cath adhesive
A4366*	Ostomy vent
A4367*	Ostomy belt
A4368*	Ostomy filter
A4369*	Skin barrier liquid per oz
A4371*	Skin barrier powder per oz
A4372*	Skin barrier solid 4x4 equiv
A4373*	Skin barrier with flange
A4375*	Drainable plastic pch w fcpl
A4376*	Drainable rubber pch w fcplt
A4377*	Drainable plstic pch w/o fp
A4378*	Drainable rubber pch w/o fp

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4379*	Urinary plastic pouch w fcpl
A4380*	Urinary rubber pouch w fcplt
A4381*	Urinary plastic pouch w/o fp
A4382*	Urinary hvy plstc pch w/o fp
A4383*	Urinary rubber pouch w/o fp
A4384*	Ostomy faceplt/silicone ring
A4385*	Ost skn barrier sld ext wear
A4387*	Ost clsd pouch w att st barr
A4388*	Drainable pch w ex wear barr
A4389*	Drainable pch w st wear barr
A4390*	Drainable pch ex wear convex
A4391*	Urinary pouch w ex wear barr
A4392*	Urinary pouch w st wear barr
A4393*	Urine pch w ex wear bar conv
A4394*	Ostomy pouch liq deodorant
A4395*	Ostomy pouch solid deodorant
A4396	Peristomal hernia supprt blt
A4397	Irrigation supply sleeve
A4398*	Ostomy irrigation bag
A4399*	Ostomy irrig cone/cath w brs
A4400*	Ostomy irrigation set
A4402*	Lubricant per ounce
A4404*	Ostomy ring each
A4405*	Nonpectin based ostomy paste
A4406*	Pectin based ostomy paste
A4407*	Ext wear ost skn barr <=4sq"
A4408*	Ext wear ost skn barr >4sq"
A4409*	Ost skn barr w flng <=4 sq"

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4410*	Ost skn barr w flng >4sq"
A4411	Ost skn barr extnd =4sq
A4412	Ost pouch drain high output
A4413*	2 pc drainable ost pouch
A4414*	Ostomy sknbarr w flng <=4sq"
A4415*	Ostomy skn barr w flng >4sq"
A4416*	Ost pch clsd w barrier/filtr
A4417*	Ost pch w bar/bltinconv/fltr
A4418*	Ost pch clsd w/o bar w filtr
A4419*	Ost pch for bar w flange/flt
A4420*	Ost pch clsd for bar w lk fl
A4421*	Ostomy supply misc
A4422*	Ost pouch absorbent material
A4423*	Ost pch for bar w lk fl/fltr
A4424*	Ost pch drain w bar & filter
A4425*	Ost pch drain for barrier fl
A4426*	Ost pch drain 2 piece system
A4427*	Ost pch drain/barr lk flng/f
A4428*	Urine ost pouch w faucet/tap
A4429*	Urine ost pouch w bltinconv
A4430*	Ost urine pch w b/bltin conv
A4431*	Ost pch urine w barrier/tapv
A4432*	Os pch urine w bar/fange/tap
A4433*	Urine ost pch bar w lock fln
A4434*	Ost pch urine w lock flng/ft
A4435	1pc ost pch drain hgh output
A4450	Non-waterproof tape
A4452	Waterproof tape

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A4455	Adhesive remover per ounce
A4456	Adhesive remover, wipes
A4458	Reusable enema bag
A4461	Surgicl dress hold non-reuse
A4463	Surgical dress holder reuse
A4465	Non-elastic extremity binder
A4466	Elastic garment/covering
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4520	Incontinence garment anytype
A4550	Surgical trays
A4554	Disposable underpads
A4556	Electrodes, pair
A4557	Lead wires, pair
A4558	Conductive paste or gel
A4559	Coupling gel or paste
A4649	Surgical supplies
A4670	Auto blood pressure monitor
A4930	Sterile, gloves per pair
A5051*	Pouch clsd w barr attached
A5052*	Clsd ostomy pouch w/o barr
A5053*	Clsd ostomy pouch faceplate
A5054*	Clsd ostomy pouch w/flange
A5055*	Stoma cap
A5061*	Pouch drainable w barrier at
A5062*	Drnble ostomy pouch w/o barr
A5063*	Drain ostomy pouch w/flange
A5071*	Urinary pouch w/barrier

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A5072*	Urinary pouch w/o barrier
A5073*	Urinary pouch on barr w/flng
A5081*	Continent stoma plug
A5082*	Continent stoma catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory convex inse
A5102*	Bedside drain btl w/wo tube
A5105*	Urinary suspensory
A5112*	Urinary leg bag
A5113*	Latex leg strap
A5114*	Foam/fabric leg strap
A5120	Skin barrier, wipe or swab
A5121*	Solid skin barrier 6x6
A5122*	Solid skin barrier 8x8
A5126*	Disk/foam pad +or- adhesive
A5131*	Appliance cleaner
A6011	Collagen gel/paste wound fil
A6010	Collagen based wound filler
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	alginate dressing > 48 sq in
A6199	Alginate drsg wound filler

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/border
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/border
A6215	Foam dressing wound filler
A6216	Non-sterile gauze<=16 sq in
A6217	Non-sterile gauze>16<=48 sq
A6218	Non-sterile gauze > 48 sq in
A6219	Gauze <= 16 sq in w/border
A6220	Gauze >16 <=48 sq in w/bordr
A6221	Gauze > 48 sq in w/border
A6222	Gauze <=16 in no w/sal w/o b
A6223	Gauze >16<=48 no w/sal w/o b
A6224	Gauze > 48 in no w/sal w/o b
A6228	Gauze <= 16 sq in water/sal
A6229	Gauze >16<=48 sq in watr/sal
A6230	Gauze > 48 sq in water/salne
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A6234	Hydrocolld drg <=16 w/o bdr
A6235	Hydrocolld drg >16<=48 w/o b
A6236	Hydrocolld drg > 48 in w/o b
A6237	Hydrocolld drg <=16 in w/bdr
A6238	Hydrocolld drg >16<=48 w/bdr
A6239	Hydrocolld drg > 48 in w/bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w/o bdr
A6243	Hydrogel drg >16<=48 w/o bdr
A6244	Hydrogel drg >48 in w/o bdr
A6245	Hydrogel drg <= 16 in w/bdr
A6246	Hydrogel drg >16<=48 in w/b
A6247	Hydrogel drg > 48 sq in w/b
A6248	Hydrogel drsg gel filler
A6250	Skin seal protect moisturizr
A6251	Absorpt drg <=16 sq in w/o b
A6252	Absorpt drg >16 <=48 w/o bdr
A6253	Absorpt drg > 48 sq in w/o b
A6254	Absorpt drg <=16 sq in w/bdr
A6255	Absorpt drg >16<=48 in w/bdr
A6256	Absorpt drg > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6260	Wound cleanser any type/size
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6407	Packing strips, non-impreg
A6410	Sterile eye pad
A6411	Non-sterile eye pad
A6412	Occlusive eye patch
A6413	Adhesive bandage, first-aid
A6441	Pad band w>=3” <5”/yd
A6442	Conform band n/s w<3”/yd
A6443	Conform band n/s w>=3”<5”/yd
A6444	Conform band n/s w>=5”/yd
A6445	Conform band s w <3”/yd
A6446	Conform band s w>=3” <5”/yd
A6447	Conform band s w >=5”/yd
A6448	Lt compres band <3”/yd
A6449	Lt compres band >=3” <5”/yd
A6450	Lt compres band >=5”/yd
A6451	Mod compr band w>=3”<5”/yd
A6452	High compr band w>=3”<5”yd
A6453	Self-adher band w <3”/yd
A6454	Self-adher band w>=3” <5”/yd
A6455	Self-adher band >=5”/yd
A6456	Zinc paste band w >=3”<5”/yd
A6457	Tubular dressing
A9150	Nonprescription drug
A9273	Hot/cold H20bot/cap/col/wrap

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
A9900	Supply/accessory/service
J3535	Metered dose inhaler drug
J7599	Immunosuppressive drug, noc
J7699	Noninhalation drug for DME
J7799	Non-inhalation drug for DME
J8498	Antiemetic drug, rctal/supp, nos
J8499	Oral prescript drug nonchemo
J8597	Antiemetic drug, oral, nos
J8999	Oral prescription drug chemo
L8614	Cochlear device
L8699	Prosthetic implant NOS
T4521	Adult size brief/diaper sm
T4522	Adult size brief/diaper med
T4523	Adult size brief/diaper lg
T4524	Adult size brief/diaper xl
T4525	Adult size pull-on sm
T4526	Adult size pull-on med
T4527	Adult size pull-on lg
T4528	Adult size pull-on xl
T4533	Youth size brief/diaper
T4534	Youth size pull-on
T4535	Disposable liner/shield/pad
T4536	Reusable pull-on any size
T4537	Reusable underpad bed size
T4539	Reuse diaper/brief any size
T4540	Reusable underpad chair size
T4541	Large disposable underpad
T4542	Small disposable underpad

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This **HCPCS supply code** is bundled:	And it has this **abbreviated description**:
T4544	Adlt disp und/pull on abv xl

Payment policy: Surgical dressings dispensed for home use

(See definitions of **Primary surgical dressings** and **Secondary surgical dressings** in Definitions at the beginning of this chapter.)

Requirements for billing

Providers must bill the appropriate HCPCS code for each dressing item, along with the local billing code **modifier –1S** for each item.

Payment limits

Primary surgical dressings and **secondary surgical dressings** dispensed for home use are payable at **acquisition cost** when all of these conditions are met:

- They are dispensed to a patient for home care of a wound,
- They are medically necessary, *and*
- The wound is due to an accepted work related condition.

Note: See definition of **Acquisition cost** in Definitions at the beginning of this chapter, and also the payment policy for Acquisition cost policy earlier in this chapter.

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. Separate payment isn't allowed.

Items such as elastic stockings, support hose, and pressure garments aren't secondary surgical dressings and must be billed with the appropriate HCPCS code.

Surgical dressing supplies and codes billed without the **local modifier –1S** are considered **bundled** and won't be paid.

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

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Payment policy: Surgical trays and supplies used in the physician's office

Payment limits

L&I follows CMS's policy of **bundling** HCPCS codes for surgical trays and supplies used in a physician's office. Surgical trays and supplies won't be paid separately.

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

Special note: Surgical dressings and other items dispensed for home use

Surgical dressings and other items dispensed for home use are separately payable when billed with local **modifier –1S**.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for topics relevant to this chapter	Washington Administrative Code (WAC) 296-20-1102: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-1102 WAC 296-20-01002: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-01002
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	L&I's website: www.Feeschedules.Lni.wa.gov
Payment policies for **catheterization to obtain specimens for lab tests**	Chapter 23: Pathology and Laboratory Services
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Payment policies for **hospital acquisition cost policy**	Chapter 35: Hospitals

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 29: Surgery Services

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

- **Certified or accredited facility or office:** L&I defines a certified or accredited facility or office that has certification or accreditation from one of the following organizations:
  - Medicare (CMS – Centers for Medicare and Medicaid Services),
  - Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
  - Accreditation Association for Ambulatory Health Care (AAAHC),
  - American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF),
  - American Osteopathic Association (AOA),
  - Commission on Accreditation of Rehabilitation Facilities (CARF).

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

–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.)

–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

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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.

–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 shouldn't 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

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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.

–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.

–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.)

- **Endoscopy:** For the purpose of these payment policies, “endoscopy” will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

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Payment policy: Autologous chondrocyte implant (ACI)

Services not covered

Autologous chondrocyte implants are not covered.

Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/autologouschondrocyteimplant.asp

Payment policy: Angioscopy

Payment limits

Payment for angioscopies CPT® code **35400** is limited to only one unit based on its complete code description encompassing multiple vessels.

Note: The work involved with varying numbers of vessels was incorporated in the RVUs.

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Payment policy: Bilateral surgeries

Requirements for billing

Bilateral surgeries should be billed as two line items:

- **Modifier –50** must be applied to the second line item, *and*
- The second line item is paid at the lesser of the billed charge, or 50% of the fee schedule maximum.

Bilateral surgeries are considered one procedure when determining the highest valued procedure before applying multiple surgery rules.

Link: To see if **modifier –50** is valid with the procedure performed, check the Professional Services Fee Schedule at:

http://feeschedules.Lni.wa.gov

Example 1: Billing for bilateral surgeries

Line item	CPT® code (and modifier)	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	**64721**	**$756.70**	—	**$756.70** (1)
2	**64721-50**	**$756.70**	**$378.35** (2)	**$378.7.35**
Total allowed amount in non-facility setting:				**$1,135.05** (3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a **modifier –50** is paid at 50% of the value paid for the first line item.

(3) Represents total allowable amount.

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Example 2: Billing for bilateral surgeries and multiple procedures

Line item	CPT® code (and modifier)	Max payment (non-facility setting)	Bilateral policy applied	Multiple procedure policy applied	Allowed amount
1	**63042**	**$2,207.34**	—	—	**$2,207.34** (1)
2	**63042-50**	**$2,207.34**	**$1,103.67**(2)	—	**$1,103.67**
				Subtotal:	**$3,311.01**3)
3	**22612-51**	**$2,705.65**	—	**$1,352.82**(4)	**$1,352.82**
				Total allowed amount in non-facility setting:	**$4,663.83** (5)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.

(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a **modifier –50** is paid at 50% of the value paid for the first line item.

(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.

(4) The third line item billed with **modifier –51** is paid at 50% of the maximum payment.

(5) Represents total allowable amount.

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Payment policy: Bone growth stimulators

Prior authorization

These HCPCS (billing) codes for bone growth stimulators require prior authorization:

- **E0747** (Osteogenesis stimulator, electrical, noninvasive, other than spinal application), *and*
- **E0748** (Osteogenesis stimulator, electrical, noninvasive, spinal application), *and*
- **E0749** (Osteogenesis stimulator, electrical (surgically implanted)), *and*
- **E0760** (Osteogenesis stimulator, low intensity ultrasound, noninvasive).

The insurer, with prior authorization, pays for bone growth stimulators for specific conditions when proper and necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, *and*
- Implanted electrical stimulators that supply a direct current to the bone.

Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonegrowthstimulators.asp

Payment policy: Bone morphogenic protein (BMP)

Prior authorization

The insurer may cover the use of bone morphogenic protein 7 (rhBMP-7) as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. The insurer may also cover the use of rhBMP-2 for primary anterior open or laparoscopic lumbar fusion at one level between L4 and S1, or revision lumbar fusion on a compromised patient for whom autologous bone and bone marrow harvest are not feasible or not expected to result in fusion.

Note:

- Bone morphogenic protein-2 (rhBMP-2) **isn't covered** for use in long bone nonunion fractures.
- Bone morphogenic protein-7 (rhBMP-7) **isn't covered** for use in lumbar fusion.
- BMP **isn't covered** for use in cervical spinal fusion or any other indication.

All of the criteria and guidelines must be met before the insurer will authorize the procedures.

Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonemorphogenics.asp

In addition, lumbar fusion guidelines must be met.

Link: For more information, go to:
http://www.Lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/LumbarFusion.pdf

Requirements for billing

CPT® codes used depend on the specific procedure being performed.

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Payment policy: Closure of enterostomy

Payment limits

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy.

CPT® code **44139** will be denied if it is billed with CPT® code **44625** or **44626**.

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Payment policy: Endoscopy procedures

(See definition of **endoscopy** in Definitions at the beginning of this chapter.)

Endoscopy family groupings

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule.

Link: For more information, go to the Professional Services Fee Schedule at: http://feeschedules.Lni.wa.gov

Link: To determine the endobase procedure, please reference the "Endo" column in the complete fee schedule.

How multiple endoscopy procedures pay

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- The endoscopy procedure with the highest dollar value is 100% of the fee schedule value, *then*
- For subsequent endoscopy procedures, payment is the difference between the family member and the base fee (see Example 1, below), *then*
- When the maximum fee for the family member is less than the maximum base fee, the payment is $0.00 for the family member (see Example 2, below), *then*
- No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group.

If more than one endoscopic group or other non-endoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4, below).

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Multiple endoscopies that aren't related (each is a separate and unrelated procedure) are priced as follows:

- 100% for each unrelated procedure, *then*
- Apply the standard multiple surgery policy.

Payment limits

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure **unless**:

- A documented, separately identifiable service is provided, *and*
- **Modifier –25** is used.

Example 1: Billing for two endoscopy procedures in the same family

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	**29805**	**$825.60**	**$0.00** (2)	—
1	**29820**	**$936.95**	**$111.35** (4)	**$111.35** (5)
2	**29824**	**$1,173.19**	**$1,173.19** (3)	**$1,173.19** (5)
Total allowed amount in non-facility setting:				**$1,284.54** (6)

(1) Base code listed is reference only (not included on bill form).

(2) Payment isn't allowed for a base code when a family member is billed.

(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(5) Amount allowed under the endoscopy policy.

(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only one family of endoscopic procedures was billed.

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Example 2: Billing for endoscopy family member with fee less than base procedure

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Allowed amount
Base (1)	**43235**	**$557.99**	—	—
1	**43241**	**$261.46**	**$0.00** (3)	
2	**43243**	**$430.02**	**$430.02** (2)	**$430.02** (4)
			Total allowed amount in non-facility setting:	**$430.02** (5)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.

(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.

(4) Allowed amount under the endoscopy policy.

(5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

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Example 3: Billing for two surgical procedures billed with an endoscopic group (highest fee)

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	11402	$292.22	—	$146.11 (5)
2	11406	$543.84	—	$271.92(5)
Base (1)	29830	$800.38	—	—
3	29835	$882.20	$81.82 (3)	$81.82 (4)
4	29838	$1,026.77	$1,026.77 (2)	$1,026.77 (4)
Total allowed amount in non-facility setting:				$1,526.62(6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

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Example 4: Billing for one surgical procedure (highest fee) billed with an endoscopic group

Line item	CPT® code	Maximum payment (non-facility setting)	Endoscopy policy applied	Standard multiple surgery policy applied
1	23412	$1,478.33		$1,478.33 (4)
Base (1)	29805	$825.60		
2	29820	$936.95	$111.35 (3)	$ 55.68 (5)
3	29824	$1,173.19	$1,173.19 (2)	$ 586.59 (5)
Total allowed amount in non-facility setting:				$2,120.60(6)

(1) Base code listed is for reference only (not included on bill form).

(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.

(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.

(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.

(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.

(6) Represents total allowed amount after applying all applicable global surgery policies.

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Payment policy: Epidural adhesiolysis

The department has published a coverage decision about epidural adhesiolysis.

Link: For more information, go to:

www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Epiduraladhesiolysis.asp

Payment policy: Global surgery

Global surgery follow up periods

Many surgeries have a follow up period during which charges for normal post-operative care are bundled into the global surgery fee.

The global surgery follow up period for each surgery is listed in the Follow Up column in the Professional Services Fee Schedule.

What is included in the follow up period

The follow up period always applies to the following CPT® codes, unless **modifier –22**, **–24**, **–25**, **–57**, **–58**, **–78**, or **–79** is appropriately used:

- **E/M codes:**
  - **99211-99215**, *and*
  - **99218-99220**, *and*
  - **99231-99239**, *and*
  - **99291-99292**, *and*
  - **99304-99310**, *and*
  - **99315-99318**, *and*
  - **99334-99337**, *and*
  - **99347-99350**, *and*
- **Ophthalmological codes: 92012-92014**

The following services and supplies **are included** in the global surgery follow up period and are considered bundled into the surgical fee:

- The operation itself, *and*
- Pre-operative visits, in or out of the hospital, beginning on the day before the surgery, *and*
- Services by the primary surgeon, in or out of the hospital, during the post-operative period, *and*

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- The following services:
    - Dressing changes, *and*
    - Local incisional care and removal of operative packs, *and*
    - Removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, *and*
    - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric, and rectal tubes, *and*
    - Change and removal of tracheostomy tubes, *and*
    - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

What isn't included in the follow up period

The following services and supplies **aren't included** in the global surgery follow up period:

- Casting materials aren't part of the global surgery policy and are paid separately, *and*
- The initial consultation or evaluation by the surgeon to determine the need for surgery, *and*
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care, *and*
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications, *and*
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery, *and*
- Diagnostic tests and procedures, including diagnostic radiological procedures, *and*
- Distinct surgical procedures during the post-operative period which aren't reoperations or treatment for complications, *and*

Note: A new post-operative period begins with the subsequent procedure.

- Treatment for post-operative complications which requires a return trip to the operating room, *and*
- Immunotherapy management for organ transplants, *and*

- Critical care services (CPT® codes **99291** and **99292**) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the provider, *and*
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

Who must perform these services to qualify for payment

The follow up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the patient; identified by **modifiers –56**, **–54**, and **–55**), *and*
- Assistant surgeon (identified by **modifiers –80**, **–81**, and **–82**), *and*
- Two surgeons (identified by **modifier –62**), *and*
- Team surgeons (identified by **modifier –66**), *and*
- Anesthesiologists and CRNAs.

Payment limits

Professional inpatient services (CPT® codes **99221-99223**) are only payable during the follow up period if they are performed on an emergency basis.

Example: They aren't payable for scheduled hospital admissions.

Codes that are considered bundled aren't payable during the global surgery follow up period.

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Payment policy: Meniscal allograft transplantation

The department has published a coverage decision about meniscal allograft transplantation.

Link: For more information, go to: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/Meniscal.asp

Payment policy: Microsurgery

Services that can be billed

CPT® code **69990** is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

Payment limits

CPT® code **69990** isn't payable when:

- Using magnifying loupes or other corrected vision devices, *or*
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), *or*
- Another code describes the same procedure being done with an operative microscope.

> **Example:** CPT® code **69990** can't be billed with CPT® code **31535** because CPT® code **31536** describes the same procedure using an operating microscope. (See below for a complete list of all such codes.)

These CPT® codes aren't allowed with CPT® **69990**:

- **15756-15758**, *or*
- **15842**, *or*
- **19364**, *or*
- **19368**, *or*
- **20955-20962**, *or*
- **20969-20973**, *or*
- **22551, *or***
- **22552, *or***
- **22856-22861, *or***
- **26551-26554**, *or*
- **26556**, *or*

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- **31526**, *or*
- **31531**, *or*
- **31536**, *or*
- **31541-31546**, *or*
- **31561**, *or*
- **31571**, *or*
- **43116**, *or*
- **43180, *or***
- **43496**, *or*
- **46601, *or***
- **46607, or**
- **49906**, *or*
- **61548**, *or*
- **63075-63078**, *or*
- **64727**, *or*
- **64820-64823**, *or*
- **65091-68850**, *or*
- **0184T, or**
- **0308T.**

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Payment policy: Minor surgical procedures

Services that can be billed

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the post-operative period and **modifier –24** is used, *or*
- The provider who performs the procedure is seeing the patient for the first time an initial new patient E/M service can be billed (also see Requirements for billing, below).

Services that aren't covered

Modifier –57, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

Note: Also see Payment limits, below.

Requirements for billing

When the provider who performed the minor surgical procedure is seeing the patient for the first time **bills an initial new patient E/M service**:

- This is considered a significant, separately identifiable service, *and*
- **Modifier –25** must be used, *and*
- Appropriate documentation must be made in the chart describing the E/M service.

Payment limits

Modifier –57 is payable with an E/M service **only** when the visit results in the initial decision to perform major surgery.

Note: Also see Services that aren't covered, above**.**

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Payment policy: Pre, intra, or post-operative services

Services that can be billed

The insurer will allow separate payment when different providers perform the pre-operative, intra-operative, or post-operative components of the surgery.

Note: Also see Requirements for billing, below.

Link: The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule, available at: http://feeschedules.Lni.wa.gov

Requirements for billing

When different providers perform pre-operative, intra-operative, or post-operative components of the surgery, **modifiers** (**–54**, **–55**, or **–56**) must be used.

Note: Also see Services that can be billed, above.

If different providers perform different components of the surgery (pre, intra, or post-operative care), the global surgery policy applies to each provider.

> **Example:** If the surgeon performing the operation transfers the patient to another provider for the post-operative care, the same global surgery policy, including the restrictions in the follow up day period, applies to both providers.

Note: Also see the Global surgery payment policy earlier in this chapter.

Payment policy: Procedures performed in a physician's office

Services that are covered

Procedures performed in a provider's office are paid at non-facility rates that include office expenses.

Services that aren't covered

Services billed with **modifier –SU** aren't covered.

Requirements for billing

Providers' offices must meet ASC requirements to qualify for separate facility payments.

Link: For information about these requirements, see WAC 296-23B.

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Payment policy: Registered nurses as surgical assistants

Who must perform these services to qualify for payment

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application:

- A photocopy of her/his valid and current registered nurse license, *and*
- A letter granting onsite hospital privileges for **each institution** where surgical assistant services will be performed.

Payment limits

Payment for these services is 90% of the allowed fee that would be paid to an assistant surgeon.

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Payment policy: Standard multiple surgeries

How multiple surgeries pay

When **multiple surgeries** are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

- **100%** of the global fee for the procedure or procedure group with the highest value, according to the fee schedule, *and*
- **50%** of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

When **different types of surgical procedures** are performed on the patient on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures, *then*
- Other modifier policies, *then*
- Standard multiple surgery policy.

Requirements for billing

More than five surgical procedures performed on the same patient on the same day require documentation and individual review to determine payment amount.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item.

Note: For additional instructions on billing bilateral procedures, see the payment policy on bilateral procedures earlier in this chapter.

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Payment policy: Tobacco Cessation Treatment for Surgical Care

Insurer Policy

The department has published a coverage decision for Tobacco Cessation Treatment for Surgical Care.

Requirements for billing

CPT codes **99406** and **99407** may be billed for tobacco cessation counseling.

Billing for each claim is limited to a maximum of eight units of any combination of the two codes.

Link: For information about these requirements, see www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/TobaccoCessation.asp.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for Ambulatory Surgery Center (ASC) payment	Washington Administrative Code (WAC) 296-23B: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23B
Ambulatory Surgery Center **Fee Schedule**	L&I's website: http://feeschedules.Lni.wa.gov
Autologous chondrocyte implant (ACI)	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/autologouschondrocyteimplant.asp
Becoming an L&I Provider	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Bone growth stimulators	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonegrowthstimulators.asp
Bone morphogenic protein (BMP)	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonemorphogenics.asp
Condition and Treatment Index	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/
Epidural adhesiolysis	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Epiduraladhesiolysis.asp
Medical treatment guideline for Lumbar fusion arthrodesis	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/lumbarfusionarthrodesis.asp
Meniscal allograft transplantation	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/Meniscal.asp

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Professional Services **Fee Schedules**	L&I's website: http://feeschedules.Lni.wa.gov
Tobacco Cessation Treatment for Surgical Care	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/

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

Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 30: Vocational Services

Effective July 1, 2016

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

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

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 the legal definition of By report, see WAC 296-20-01002.

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Payment policy: Billing by referral type

Link: For more detailed information on billing, consult the **Miscellaneous Services Billing Instructions** (F245-072-000), 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

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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)	**$9.33**

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:

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- 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 non-vocational providers

Certain non-vocational 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	**$11.35**
0390R	Vocational evaluation, 1 unit = 6 minutes	**$9.33**
0391R	Travel/wait (non-VRC), 1 unit = 6 minutes	**$5.14**
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.

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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.

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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**
Resume services	**0844V, 0845V**	**$300.00**

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.

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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 Vocational Services Specialist (VSS), or Self-insured employer (SIE)/Third party administrator (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.

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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

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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.

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Payment policy: Special services, non-vocational 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. For self-insured claims, contact the SIE/TPA for prior authorization.

Who must perform these services to qualify for payment

A non-vocational 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.

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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 non-vocational 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.

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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.

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

Other requests for return to work information

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

- Return to work decisions based on 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.

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- 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,

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- 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.

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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.

Non-vocational providers

Non-vocational 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*
- Non-vocational 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.

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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

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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.

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In all other cases, the paper report must be submitted to State Fund at the same time the recommendation is made.

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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/

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**.

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Selected plan procedure code definitions

L&I has defined the following retraining codes:

- **R0312**, Retraining books, equipment, and supplies are consumable goods such as:
  - Books,
  - Paper,
  - Pens,
  - CDs
  - Disposable gloves.
  - Calculator,
  - Software,
  - Survey equipment,
  - Computers
  - 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.

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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: Form F245-030-000 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.

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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/2016FS/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/P

If you're looking for more information about…	Then go here:
	rovider/
Submitting a vocational assessment or retraining plan for self-insured claims	What is the Self-Insurance Vocational Reporting Form? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4302 What must the self-insurer do when an assessment report is received? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4304 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 What must the vocational rehabilitation plan include? http://apps.leg.wa.gov/WAC/default.aspx?cite=296-15-4308 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 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 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

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 31: Washington RBRVS Payment System

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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Related topics **31-9**

Definitions

- **Relative value units (RVUs):** Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

  - The work,
  - Practice expense, *and*
  - Liability insurance (malpractice expense)

  A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

  Links: A list of current RVUs can be accessed online at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched/or a copy published in the *Federal Register* can be purchased from the U.S. government in hard copy, microfiche, or disc formats. The *Federal Register* can be ordered from the following addresses:

  Superintendent of Documents
  PO Box 371954
  Pittsburgh, PA 15250-7954

  or

  http://bookstore.gpo.gov/.

- **Resource based relative value scale (RBRVS):** RBRVS is a prospective payment method used by many healthcare insurers to develop fee schedules for services and procedures provided by healthcare professionals. Each fee is based on the relative value of resources required to deliver a service or procedure.

  This chapter includes details on the RBRVS, which L&I uses to pay for most professional services. These services have a fee schedule indicator (FSI) of R in L&I's Professional Services Fee Schedule.

  Link: L&I's fee schedule is available at: www.feeschedules.Lni.wa.gov.

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Payment policy: Basis for calculating RBRVS payment levels

(See definitions of **RBRVS** and **RVUs** in Definitions at the beginning of this chapter.)

Payment methods

Fee development

RBRVS fee schedule **allowances** are based on:

- Relative value units (RVUs),
- Geographic adjustment factors for Washington State *and*
- A conversion factor

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU (see RVU geographic adjustments, below).

The **maximum fee for a procedure** is obtained by multiplying the adjusted RVUs by the conversion factor. The maximum fees are published as dollar values in the Professional Services Fee Schedule.

The **conversion factor** has the same value for all services priced according to the RBRVS. L&I may annually adjust the conversion factor.

Link: The conversion factor is published in WAC 296-20-135**,** and the process for adjusting the conversion factor is defined in WAC 296-20-132**.**

Note: Two state agencies, L&I and Health Care Authority (HCA), use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

RVU geographic adjustments

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State.

The Washington State geographic adjustment factors for July 1, 2016 are:

- 100.8% of the work component RVU,
- 105.7% of the practice expense RVU, *and*
- 48.1% of the malpractice RVU.

Calculation for maximum fees

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor, *then*
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth, *then*
3. Multiply the rounded sum by L&I's RBRVS conversion factor, *and finally*
4. Round to the nearest penny.

Link: The conversion factor is published in WAC 296-20-135**.**

Site of service payment differential

Based on where the service was performed, the insurer will pay professional services at the RBRVS rates for:

- Facility settings (such as hospitals and ASCs), *and*
- Non-facility settings.

The site of service payment differential is based on CMS's payment policy.

Link: The maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule, available at: www.feeschedules.Lni.wa.gov.

Requirements for billing

Due to the site of service payment differential (see above), it is important to include a valid 2 digit place of service code on your bill.

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Payment policy: Facility setting services paid at the RBRVS rate

Payment methods

When services are performed in a facility setting, the insurer makes 2 payments:

- One to the professional provider, *and*
- One to the facility.

The payment to the facility includes resource costs such as:

- Labor,
- Medical supplies, *and*
- Medical equipment.

Note: To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for professional services in facility settings.

Requirements for billing

Remember to include a valid 2 digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Professional services billed with the following place of service codes will be paid at the rate for **facility settings**:

If the **place of service description** is:	Then bill using this **2 digit place of service code:**
Ambulance (air or water)	42
Ambulance (land)	41
Ambulatory surgery center	24
Birthing center	25
Comprehensive inpatient rehabilitation facility	61
Comprehensive outpatient rehabilitation facility	62

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If the **place of service description** is:	Then bill using this **2 digit place of service code:**
Emergency room hospital	23
Hospice	34
Indian health service free standing facility	05
Indian health service provider based facility	06
Inpatient hospital	21
Inpatient psychiatric facility	51
Military treatment facility	26
Outpatient hospital	22
Psychiatric facility partial hospitalization	52
Psychiatric residential treatment center	56
Skilled nursing facility	31
Tribal 638 free standing facility	07
Tribal 638 provider based facility	08
Other unlisted facility	99
(Place of service code not supplied)	(none)

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Payment policy: Non-facility setting services paid at the RBRVS rate

Payment methods

When services are provided in non-facility settings, the professional provider typically bears the costs of:

- Labor,
- Medical supplies, *and*
- Medical equipment

These costs are included in the RBRVS rate for non-facility settings.

Professional services will be paid at the RBRVS rate for non-facility settings when the insurer doesn't make a separate payment to a facility.

When the insurer doesn't make a separate payment directly to the provider of the professional service, the facility will be paid for the service at the RBRVS rate for non-facility settings.

Requirements for billing

Remember to include a valid 2 digit place of service code on your bill.

Note: Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Professional services billed with the following place of service codes will be paid at the rate for **non-facility settings**:

If the **place of service description** is:	Then bill using this **2 digit place of service code:**
Assisted living facility	13
Community mental health center	53
Correctional facility	09
Custodial care facility	33

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If the **place of service description** is:	Then bill using this **2 digit place of service code:**
End stage renal disease treatment facility	65
Federally qualified health center	50
Group home	14
Home	12
Homeless shelter	04
Independent clinic	49
Independent laboratory	81
Intermediate care facility/mentally retarded	54
Mass immunization center	60
Mobile unit	15
Nonresidential substance abuse treatment center	57
Nursing facility	32
Office	11
Pharmacy	01
Residential substance abuse treatment center	55
Rural health clinic	72
School	03
State or local public health clinic	71
Temporary lodging	16
Urgent care facility	20
Walk in retail health clinic	17

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for the conversion factor	Washington Administrative Code (WAC) 296-20-132: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-132 WAC 296-20-135: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-135
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 professional services	L&I's website: www.feeschedules.Lni.wa.gov
A list of the current RVUs used in calculating the insurer's conversion factor	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 32: Ambulatory Surgery Centers (ASCs)

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/

Note: More information about ASC payments can be found in WAC 296-23B.

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Definitions

- **CPT® code modifiers affecting ASC payment:**

–50 Bilateral procedures

Modifier –50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. **Modifier –50** must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

–51 Multiple procedures

Modifier –51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. **Modifier –51** should be applied to the second line item. The total payment equals the sum of:

- **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, *plus*
- **50%** of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.

–52 Reduced services

Modifier –52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the **modifier –52**, signifying that the service is reduced.

A **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that do not require anesthesia (ASCs should use **modifier –52** to report such an occurrence).

–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.

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–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.

–99 Multiple modifiers

Modifier –99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, **modifier –99** must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

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Payment policy: All ASC services

Prior authorization

Procedures not on L&I's ASC fee schedule require prior authorization. Specifically:

- Under certain conditions, the director, the director's designee, or self-insurer, at their sole discretion, may determine that a procedure not listed on L&I's ASC fee schedule may be authorized in an ASC.

  For **example**, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC.

- The healthcare provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. Requests for coverage under these special circumstances require prior authorization. The written request must contain:
  - A description of the proposed procedure with associated CPT® or HCPCS procedure codes, *and*
  - The reason for the request, *and*
  - The potential risks and expected benefits, *and*
  - The estimated cost of the procedure.
- The healthcare provider must provide any additional information about the procedure requested by the insurer.

What facilities qualify for payment

To qualify for payment for ASC services, an ASC must:

- Be licensed by the state(s) in which it operates, unless that state does not require licensure, *or*
- Have at least one of the following credentials:
  - Medicare (CMS) Certification as an ASC, *or*
  - Accreditation as an ASC by a nationally recognized agency acknowledged by CMS, *and*
- Have an active ASC provider account with L&I.

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Note: For contact information about how to become accredited or Medicare certified as an ASC, see below.

Services that can be billed

L&I uses the CMS list of procedure codes covered in an ASC, plus additional procedures determined to be appropriate.

Note: L&I's rates for ASC procedures are based on a modified version of the current system developed by CMS for ASC services. L&I expanded the CMS list by adding some procedures CMS identified as excluded procedures.

Link: All procedures covered in an ASC are listed online at: http://feeschedules.Lni.wa.gov

Services that aren't covered

Procedure codes not listed in L&I's ASC fee schedule are not covered in an ASC.

Note: Also see Prior authorization, above.

Additional information: Who to contact to become accredited or Medicare certified as an ASC

For national accreditation, contact:

Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
847-853-6060; www.aaahc.org/

American Association for Accreditation of Ambulatory Surgery Facilities
5101 Washington Street, Suite #2F
PO BOX 9500 Gurnee, IL 60031
888-545-5222; www.aaaasf.org/

American Osteopathic Association

142 East Ontario Street

Chicago, IL 60611

800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities

6951 East Southpoint Road

Tucson, AZ 85756

888-281-6531; www.carf.org/

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

630-792-5000; www.jcaho.org/

For Medicare certification, contact:

Department of Health, Office of Health Care Survey

Facilities and Services Licensing

PO BOX 47874

Olympia, WA 98504-7874

360-236-4983 email: fslhhhacs@doh.wa.gov

www.doh.wa.gov/AboutUs/ProgramsandServices/HealthSystemsQualityAssurance.aspx

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for ASC payment policies	Washington Administrative Code (WAC) 296-23B: http://apps.leg.wa.gov/wac/default.aspx?cite=296-23B
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	L&I's website: http://feeschedules.Lni.wa.gov

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Washington State Department of
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Workers' Compensation Services

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

Chapter 33: Brain Injury Rehabilitation Services

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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Payment policy: Brain injury rehabilitation services

Note: **The brain injury rehabilitation services policy is being revised.** Until the new policy is written, upon approval by an Occupational Nurse Consultant (ONC), self-insured employer, or third party administrator (TPA), individual services and therapies can be done separately through outpatient services when the provider submits a coordinated plan of care. Services can include but aren't limited to:

- Psychotherapy services,
- Speech therapy,
- Medical services,
- Neural therapy, *and*
- Occupational therapy.

Prior authorization

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment.

State Fund claims

To determine whether or not to authorize post-acute brain injury rehabilitation for a claim, both an ONC and L&I claim manager will review the claim separately. (See Approval criteria, below.)

The Provider Hotline can't authorize brain injury treatment; however, the Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

Self-insured claims

Contact the SIE or TPA for authorization (see Approval criteria, below).

Link: See SIE or TPA contact information at: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

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Approval criteria

Before a worker can receive treatment, all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim,
- The brain injury is related to the industrial injury or is retarding recovery,
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program,
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury, *and*
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Who must perform these services to qualify for payment

Only providers approved by the department can provide post-acute brain injury rehabilitation services for workers.

Qualifying programs

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation,
- Treatment, *and*
- Follow up.

When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to:

Department of Labor and Industries
Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Special L&I provider account number required

Providers participating in the Brain Injury Program must have a special provider account number if they have Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation to treat and bill for a complete course of evaluation and treatment.

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Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at **1-800-848-0811**.

Note: Providers billing for individual services and therapies don't need to obtain a special provider account number.

Services that can be billed

Nonhospital based programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs are **effective July 1, 2016**:

Local code	Description	Maximum fee
8950H	Comprehensive brain injury evaluation	**$4,481.08**
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,016.50**
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$707.97**

Hospital based programs

The following revenue codes and payment amounts for hospital-based outpatient post-acute brain injury rehabilitation treatment programs are **effective July 1, 2016**:

Local rev code	Description	Maximum fee
0014	Comprehensive brain injury evaluation	**$4,481.08**
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,016.50**
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$707.97**

Requirements for billing

For State Fund claims billing, providers participating in the Brain Injury Program must bill for brain rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. (See who must perform these services to qualify for payment, above.)

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Comprehensive brain Injury evaluation requirements

A comprehensive brain injury evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in depth analysis of the worker's mental, emotional, social, and physical status, and functioning. The evaluation must be provided by a multidisciplinary team that includes all of the following:

- Medical physician,
- Psychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist,
- Speech therapist, *and*
- Neuropsychologist.

Additional medical consultations are referred through the program's physician. For State Fund claims, each consultation may be billed under the provider account number of the consulting physician. Services must be preauthorized by an L&I claim manager or the self-insured employer.

Therapy assessments documentation requirements

The following documentation is required of providers when billing for post-acute brain injury rehabilitation treatment programs:

- Providers are required to keep a daily record of a workers attendance, activities, treatments and progress
- All test results and scoring must also be kept in the workers medical record to include:
    - Documentation of interviews with family, *and*
    - Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program.

Progress reports must be sent to the insurer regularly, including all preadmission and discharge reports.

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Payment limits

Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation and **can't be billed separately**:

- Neuropsychological Diagnostic Interview(s), testing, and scoring,
- Initial consultation and exam with the program's physician,
- Occupational and Physical Therapy evaluations,
- Vocational Rehabilitation evaluation,
- Speech and language evaluation, *and*
- Comprehensive report.

Note: The above tests and service can be performed in any combination depending on the workers condition.

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is **considered part of the provider's administrative overhead**. It includes but isn't limited to:

- Obtaining and reviewing the workers historical medical records,
- Interviewing family members, if applicable,
- Phone contact and letters to other providers or community support services,
- Writing the final report, *and*
- Office supplies and materials required for service(s) delivery.

Treatment

These therapies, treatments, and/or services are included in the Brain Injury Program maximum fee schedule amount for the full day or half-day brain injury rehabilitation treatment and **can't be billed separately:**

- Physical therapy and occupational therapy,
- Speech and language therapy,

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- Psychotherapy,
- Behavioral modification and counseling,
- Nursing and health education and pharmacology management,
- Group therapy counseling,
- Activities of daily living management,
- Recreational therapy (including group outings),
- Vocational counseling, *and*
- Follow up interviews with the worker or family, which may include home visits and phone contacts.

Ancillary work, materials, and preparation that may be necessary to carry out Brain Injury Program functions and services are considered part of the provider's administrative overhead and **aren't payable separately**. These include, but aren't limited to:

- Daily charting of patient progress and attendance,
- Report preparation,
- Case management services,
- Coordination of care,
- Team conferences and interdisciplinary staffing, *or*
- Educational materials (for example, workbooks and tapes).

Follow up care is **included in the cost** of the full day or half-day program. This includes, but isn't limited to:

- Telephone calls,
- Home visits, *and*
- Therapy assessments.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services	L&I's website: http://feeschedules.Lni.wa.gov

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Workers' Compensation Services

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

Chapter 34: Chronic Pain Management

Effective July 1, 2016

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

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

Note: Portions of these policies are supported by WAC 296-20-12055 through WAC 296-20-12095.

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Definitions

- **Important associated conditions:** Medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

- **SIMP (structured intensive multidisciplinary program):** A chronic pain management program with the following four components:

  - **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
  - **Intensive** means the Treatment Phase is delivered on a daily basis, six to eight hours per day, five days per week, for up to four consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
  - **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare professionals with expertise in pain management in *at least* the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits, *and*
  - **Program** means an interdisciplinary pain rehabilitation program that provides outcome focused, coordinated, goal oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

- **Treatment plan:** An individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

- **Valid tests and instruments:** Those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

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Payment policy: Structured, intensive, multidisciplinary program (SIMP)

(See definition of **SIMP** in Definitions at the beginning of this chapter.)

Coverage decision

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP**.

Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain. (See details about Prior authorization requirements later in this Payment policy section).

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

Note: Special requirements apply to workers who are considering having a lumbar intervertebral artificial disc replacement. **Links:** See more information in RCW Title 51 and WAC 296-20-12065.

Program design: Phases of an approved SIMP

An approved SIMP has three phases:

- Evaluation Phase,
- Treatment Phase, *and*
- Follow up Phase.

See below for details about each of these three phases.

Note: For information about how and when each phase may be prior authorized by the claim manager, see Prior authorization (below).

1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes **treatment plan** development and a report. Only one evaluation is allowed per authorization but it can be conducted over one to two days (see definition of **treatment plan** in Definitions at the beginning of this chapter).

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*

- Review of medical records and reports, including diagnostic tests and previous efforts at pain management, *and*

- Assessment of any **important associated conditions** that may hinder recovery, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease (see definition of **important associated conditions** in Definitions at the beginning of this chapter), *and*

  Note: If such conditions exist, also see the information in Prior authorization, Provider requirements, and Worker requirements (below).

- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs, *and*

- Psychological and social assessment by a licensed clinical psychologist using **valid tests and instruments** (see definition of **valid tests and instruments** in Definitions at the beginning of this chapter), *and*

- Identification of the worker's family and support resources, *and*

- Identification of the worker's reasons and motivation for participation and improvement, *and*

- Identification of factors that may affect participation in the program, *and*

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- Assessment of pain and function using **valid tests and instruments**; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
  - Activities of Daily Living (ADLs),
  - Range of Motion (ROM),
  - Strength,
  - Stamina, *and*
  - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for SIMP claimants section of this chapter), *and*

A summary report of the evaluation and a preliminary recommended **treatment plan**. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts six to eight hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the **treatment plan**, *and*

Education and skill development on the factors that contribute to pain, responses to pain, and effective pain management, *and*

- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using **valid tests and instruments**, *and*

- **Ongoing assessment** of **important associated conditions**, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment, *and*

- **Performance** of real or simulated work or daily functional tasks, *and*

- SIMP vocational services may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and*

- A **discharge care plan** for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase, *and*

- A **report** at the conclusion of the Treatment Phase that addresses all the following questions:

  - To what extent did the worker meet his or her treatment goals?

  - What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?

  - What changes if any, have occurred in the worker's pain level and functional capacity as measured by **valid tests and instruments**?

  - What changes if any, have occurred in the worker's ability to manage pain?

  - What is the status of the worker's readiness to return to work or daily activities?

  - What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?

  - How much and what kind of follow up care does the worker need?

3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within six months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;

- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;

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- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), *or*
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.

Non face-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems,
- What was done during the Follow up Phase,

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- What resulted from the follow up care, *and*
- Measures of pain and function using **valid tests and instruments**.

This summary report must be submitted at the following intervals:

- For non **lumbar artificial disc surgery candidates**: at one and three months
- For **lumbar artificial disc surgery candidates**: at one, three, and six months.

Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with **valid tests and instruments**, *and*
- Evaluating whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase, *and*
- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing **important associated conditions** and psychological status especially as related to reintegration in the workplace, home, and community, *and*
- Assessing what kind of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist, *and*
- Adjusting the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*

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- Teaching new techniques or skills that were not part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain, *and*
- Making recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources, *and*
- Holding case conferences with the:
  - Interdisciplinary team of clinicians, *and/or*
  - Worker's attending provider, *and/or*
  - Other individuals closely involved with the worker's care and functional recovery.

Follow up Phase special considerations

When determining what follow up services the worker needs, SIMP providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a SIMP provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the SIMP provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*

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- If a SIMP provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

Links: For more information about Helping Workers Get Back to Work, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/.

Prior authorization

General referral and prior authorization requirements

All SIMP services require:

- Prior authorization by the claim manager, *and*
- A referral from the worker's attending provider.

Note: An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this can't substitute for a referral from the attending provider.

SIMP referral

SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the attending provider refers a worker to a SIMP, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

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Note: It is required that **lumbar artificial disc surgery candidates** be evaluated by a SIMP prior to requesting the surgery.

Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the SIMP provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the SIMP provider recommends the worker move on to the Treatment Phase, the SIMP provider must provide the insurer with a report and **treatment plan** as described under the Evaluation Phase, *or if the worker*
- **Doesn't meet the requirements**, the SIMP provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*
  - The goals the worker must meet before he or she can return and participate in the program, *also*

  If the worker is found to have **important associated conditions** during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the SIMP provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

Lumbar Intervertebral Artificial Disc Replacement

Surgery candidates must successfully complete a SIMP to obtain authorization for a lumbar artificial disc surgery. Also:

- If a **lumbar artificial disc surgery candidate** previously participated in a SIMP as a **lumbar artificial disc surgery candidate** but didn't successfully complete treatment, one additional SIMP may be authorized only if:

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  - The worker obtains an additional surgical recommendation noting clinical changes one year or more after the date first referred to a SIMP, *or*
  - The reason the worker didn't participate fully or successfully complete a SIMP the first time was **important associated conditions** that are now fully resolved.
- If a **lumbar artificial disc surgery candidate** successfully completed a SIMP and didn't have the surgery, and in the future becomes a **lumbar artificial disc surgery candidate** again, another SIMP may be authorized, but isn't required.
- If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the claim manager may authorize resuming or restarting the SIMP if recommended by the SIMP provider.
- If a SIMP provider plans to travel to the worker's community to deliver face-to-face services, mileage may be reimbursed, but only if it is prior authorized. Also:
  - Lodging and meals (per diem expenses) aren't reimbursable, *and*
  - Actual travel time isn't included in the 24 hour limit, *and*
  - When requesting prior authorization for mileage, the SIMP provider must explain both the reason for the visit and how it will benefit the worker.

SIMP provider requirements

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see Definitions at the beginning of this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, and
- Communicate with providers who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's attending provider, *and*
- Inform the claim manager if the worker:
  - Stops services prematurely,
  - Has unexpected adverse occurrences, or
  - Doesn't meet the worker requirements, *and*

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- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Note: Providers must maintain CARF accreditation and provide the Department of Labor & Industries (L&I) with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the **provider's responsibility** to notify L&I when an accreditation visit is delayed.

Worker requirements

An injured worker must make a good faith effort to participate and comply with the **treatment plan** prescribed for him or her by the SIMP provider. To complete a SIMP successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her **treatment plan**, *and*
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her **treatment plan**, *and*
- Agree to be evaluated and comply with treatment prescribed for any **important associated conditions** that hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease), *and*
- Attend each day and each session that is part of his or her **treatment plan**. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward **treatment plan** goals, *and*
- Cooperate and comply with his or her **treatment plan**, *and*
- Not pose a threat or risk to himself or herself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

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Services that can be billed

SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table.

The fee schedule applies to injured workers only in an outpatient program:

Description	Local code	Duration/ limits	Units of service	Maximum fee
SIMP Evaluation Services	**2010M**	One evaluation per authorization, which may be conducted over one to two days.	Bill only 1 unit for evaluation even if conducted over 2 days	**$1,164.19**
SIMP Treatment Services, each 6-8 hour day	**2011M**	Not to exceed 20 treatment days (6-8 hours per day).	1 day equals 1 unit of service	**$745.69** per day
SIMP Follow up Services: **Face-to-face** services with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community	**2014M**	Not to exceed four hours per day and not to exceed 24 hours total (time must be billed in one minute units).	1 minute equals 1 unit of service	**$1.56** per minute (**$93.32** per hour)
SIMP Follow up Services: **Non face-to-face** coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community	**2015M**	Not to exceed 40 hours (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.23** per minute (**$73.93** per hour)
Mileage for traveling to and from the worker's community	**0392R**	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

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Requirements for billing

Outpatient chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form.

Billing for partial days for the treatment phase

Clinics can bill only for that percent of an eight hour day that has been provided, (even if the patient was scheduled for less than eight hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after two hours (25% of the treatment day). The clinic would bill **$745.69** x 25% = **$186.42**

Payment limits

SIMP evaluation services

Only one evaluation per authorization is allowed, which may be conducted over the course of one to two days. If the evaluation is conducted over a two day period, bill only one unit and span the dates.

SIMP treatment services

These services can't exceed 20 treatment days (6-8 hours per day).

SIMP follow up services

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Face-to-face services (local code **2014M**) can't:

- Exceed four hours per day, *and*
- 24 hours total.

Note: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit (see more information in the SIMP fee schedule, above).

Payment policy: Vocational services for SIMP claimants

Prior authorization

Vocational referrals

Prior to authorizing participation in a SIMP, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

- Is working, *or*
- Is scheduled to return to work, *or*
- Has been found employable or not likely to benefit from vocational services.

Requirements for a Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with SIMP treatment and the claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

Note: At the end of the program, the **outcomes** listed in the Return to Work Action Plan **must be included** with the Treatment Phase summary report.

If a vocational counselor is assigned, he or she will work with the SIMP vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

Return to Work Action Plan roles and responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the SIMP vocational counselor, the attending provider, and the worker are involved.

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The specific roles and responsibilities of each are as follows:

- The **SIMP vocational counselor** will:
  - Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
  - Present the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the SIMP recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal, *and*
  - Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.
- The **insurer assigned vocational counselor** will:
  - Co-develop the Return to Work Action Plan with the SIMP vocational counselor, *and*
  - Attend the chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
  - Negotiate with the attending provider when the initial Return to Work Action Plan isn't approved in order to resolve the attending provider's concerns, *and*
  - Obtain the worker's signature on the Return to Work Action Plan, *and*
  - Communicate with the SIMP vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
  - Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

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- The **attending provider** will:
  - Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
  - Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
  - Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.
- The **worker** will:
  - Participate in the selection of a return to work goal, *and*
  - Review and sign the final Return to Work Action Plan, *and*
  - Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

Note: If the worker fails to be cooperative, the sanctions as set out in RCW 51.32.110 will be applied.

Link: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules supporting SIMP payment policies	Washington Administrative Code (WAC) 296-20-12055 through WAC 296-20-12095: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-12055
Becoming an L&I provider	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Crime Victims Compensation Program contact information	Phone: **1-800-762-3716** (toll free) Fax: **1-360-902-5333** L&I's website: www.CrimeVictims.Lni.wa.gov
Fee schedules for all healthcare services	L&I's website: http://feeschedules.Lni.wa.gov
Return to work: "Helping Workers Get Back to Work"	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/
Self-insured claims authorization from the self-insured employer (SIE) or their third party administrator (TPA)	Contact list of SIE/TPAs on L&I's website: http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/
Worker refuses to cooperate with care plan: Legal issues defined in Washington state laws	Revised Code of Washington (RCW) 51.32.11: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.32.110

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 35: Hospitals

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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Payment policy: All hospitals

Payment methods

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury.

For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance.

Links: Hospital payment policies established by L&I are reflected in the Hospital Billing Instructions (call L&I's Provider Hotline at **1-800-848-0811** for a current copy) and in WAC 296-20, WAC 296-21, WAC 296-23, and WAC 296-23A.

Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a **UB-04** billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a patient admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via the POAC rate.

Note: For POAC rates for outpatient hospitals, see the State Fund payment methods section of the payment policy for Outpatient hospitals later in this chapter.

Payment limits

No copayments or deductibles are required or allowed from workers.

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Payment policy: Hospital acquisition cost policy

Payment methods

Items covered under the acquisition cost policy will be paid using a hospital specific percent of allowed charges (POAC) rate.

Nonhospital facilities will be paid a statewide average POAC rate.

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Payment policy: Inpatient hospital acute care

Self-insured employer payment methods

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital specific POAC factors for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program payment methods

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using DSHS POAC factors (see WAC 296-30-090).

State Fund provider network coverage requirements

Services from both network and non-network providers can be covered:

- If done in an emergency room at an acute care hospital, *or*
- If done prior to discharge for a patient who was directly hospitalized from an initial emergency room visit.

Link: For more information about the network, see WAC 296-20-01010(3), and for information on Who may treat, see WAC 296-20-015(1).

State Fund payment methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using three payment methods:

- An All Patient Refined Diagnosis Related Group (APR DRG) system. L&I currently uses APR DRG Grouper version 31. For exclusions and exceptions, see WAC 296-23A-0470, *or*
- A statewide per diem rate for those APR DRGs that have low volume or for inpatient services provided in Washington rural hospitals, *or*
- A POAC rate for hospitals excluded from the APR DRG system.

Link: For the current APR DRG Assignment List, see: http://feeschedules.Lni.wa.gov/

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Note: The following tables in this section provide a summary of how the above methods are applied.

Payment methods for hospital types or locations:

Hospital types or locations…	**Payment method** for inpatient hospital acute care services is:
Hospitals not in Washington State	Paid by an out of state POAC rate. Effective **July 1, 2016** the POAC rates are 60.4**%** for hospitals within the United States and 100% for hospitals outside the United States.
Hospitals in Washington State that are excluded: • Children's hospitals, • Health Maintenance Organizations (HMOs), • Military hospitals, • Veterans Administration facilities, • State psychiatric facilities.	Paid 100% of allowed charges.
Hospitals in Washington State that are major teaching hospitals: • Harborview Medical Center, • University of Washington Medical Center. *OR* All other Washington hospitals	Paid on a per case basis for admissions falling within designated APR DRGs. For low volume APR DRGs, Washington hospitals are paid using the statewide per diem rates for the designated APR DRG categories below: • Chemical dependency, • Psychiatric, • Rehabilitation, • Medical, • Surgical.

Hospital inpatient acute care rates

Links: For information on how specific rates are determined see WAC 296-23A.

The APR DRG Assignment List with APR DRG codes and descriptions and length of stay is in the fee schedules section, available at: http://feeschedules.Lni.wa.gov.

APR DRG base rates, effective July 1, 2016:

If the **hospital** is…	Then the **base rate** is:
Harborview Medical Center	**$11,435.85**
University of Washington Medical Center	**$10,060.54**
All other Washington hospitals	**$9,562.39**

APR DRG per diem rates, effective July 1, 2016:

If the **payment category** is…	Then the **rate** is…	And the **definition** is:
Psychiatric APR DRG per diem	**$918.98** multiplied by the number of days allowed by L&I.	APR DRGs identified as Psych
Chemical dependency APR DRG per diem	**$759.08** multiplied by the number of days allowed by L&I.	APR DRGs identified as Chem Dep
Rehabilitation APR DRG per diem	**$1,585.36** multiplied by the number of days allowed by L&I.	APR DRGs identified as Rehab
Medical APR DRG per diem	**$2,180.92** multiplied by the number of days allowed by L&I.	APR DRGs identified as Medical
Surgical APR DRG per diem	**$4,274.12** multiplied by the number of days allowed by L&I.	APR DRGs identified as Surgical

Note: Payments won't exceed allowed billed charges.

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Additional inpatient acute care hospital rates:

If the **payment category** is…	Then the **rate** is…	And the **definition** is:
Transfer-out cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the APR DRGs average length of stay. If the worker's stay is less than the average length of stay, a per-day rate is established by dividing the APR DRG payment amount by the average length of stay for the APR DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the worker's stay is equal to or greater than the average length of stay, the APR DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low outlier cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost (see note below table) of the stay is less than 10% of the statewide APR DRG rate or **$590.97**, whichever is greater.
High outlier cases (costs are greater than the threshold)	APR DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (see note below table) of the stay exceeds **$17,726.58** or 2 standard deviations above the statewide APR DRG rate, whichever is greater.

Notes: Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

Hospitals outside of the United States will be paid at a POAC rate of 100%.

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Payment policy: Outpatient hospitals

Self-insured employer payment methods

Services for hospital outpatient care provided to workers covered by self-insurers are paid using facility specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program payment methods

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either DSHS POAC factors or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund payment methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

- Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system.

Link: For a description of L&I's OPPS system, see WAC 296-23A (Section 4), WAC 296-23A-0220, and WAC 296-23A-0700 through WAC 296-23A-0780.

- An amount established through L&I's Professional Services Fee Schedule for items not covered by the APC system
- POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule

Note: The following tables explain how the above payment methods are applied.

Note: When ER visits develop into inpatient stays, hospitals should bill all charges on an inpatient bill. Use the inpatient admit date as the first covered date.

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How the above payment methods are applied:

Hospital types or locations…	Then the **payment method** for hospital outpatient services is:
Hospitals not in Washington State	Paid by out of state POAC rate factors. Effective **July 1, 2016** the rates are 60.4**%** for hospitals within the United States and 100% for hospitals outside the United States.
Hospitals in Washington State that are excluded: • Children's hospitals, • Military hospitals (see Note 1 below table), • Veterans Administration facilities, • State psychiatric facilities.	Paid 100% of allowed charges
Rehabilitation hospitals, Cancer hospitals, Critical access hospitals, Private psychiatric facilities	Paid a facility specific POAC rate or a fee schedule amount depending on procedure
All other hospitals in Washington State	Paid on an APC (see Note 2 below table) basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility specific POAC (see Note 1 below table).

Note 1: Military hospitals may bill HCPCS code **T1015** for all outpatient clinic services.

Note 2: Hospitals will be sent their individual POAC and APC rates each year.

Note 3: Hospitals outside the United States will be paid at a POAC rate of 100%.

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Pass-through devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device has not already been incorporated into an APC.

Hospitals will be paid fee schedule or if no fee schedule exists, a hospital specific POAC for new or current pass-through devices.

New or current drug or biological pass-through items will be paid by fee schedule or POAC (if no fee schedule exists).

Hospital OPPS payment process:

Question:	If the **answer** is…	Then the **payment method** is:
1. Does L&I cover the service?	No	Don't pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Don't pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC (see Note 1 below table)
4. Is the service packaged?	No	Go to question 5
	Yes	Don't pay, but total the Costs for possible outlier consideration (see Note 2 below table). Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier consideration (see Note 2 below table). Go to question 7.

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Question:	If the **answer** is…	Then the **payment method** is:
6. Is the service listed in a fee schedule?	No	Pay POAC
	Yes	Pay the facility amount for the service
7. Does the service qualify for outlier? (See Note 1 below table)	No	No outlier payment
	Yes	Pay outlier amount (see Note 3 below table)

Note 1: If only 1 line item on the bill is inpatient (IP), the entire bill will be paid POAC.

Note 2: Only services packaged or paid by APCs are used to determine outlier payments.

Note 3: Outlier amounts are in addition to regular APC payments.

OPPS relative weights and payment rates

The relative weights used by CMS are used for the OPPS program.

Each hospital's blended APC rate was determined using a combination of the average hospital specific APC rate and the statewide average APC rate.

Links: Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720.

Hospitals will receive notification of their blended APC rates via separate letter from L&I or by accessing http://feeschedules.Lni.wa.gov and going to the Hospital Rates link.

OPPS outlier payments

L&I follows the current CMS outlier payment policy. See the current federal register for a complete description of the policy.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for hospital payment policies	Washington Administrative Code (WAC) 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20 WAC 296-21: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-21 WAC 296-23: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23 WAC 296-23A: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23A WAC 296-30-090: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-30-090
Administrative rules for the State Fund provider network and Who may treat	WAC 296-20-01010: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-01010 WAC 296-20-015: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-015
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including hospitals)	L&I's website: http://feeschedules.Lni.wa.gov

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

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Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 36: Nursing Home and Other Residential Care Services

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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Payment policy: All residential care services

When residential services are covered

The insurer covers:

- Proper and necessary residential care services that require **twenty-four hour institutional care** to meet the worker's needs, abilities, and safety, *and*
- Medically necessary **hospice care**, comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Services must be:

- Proper and necessary,
- Required due to an industrial injury or occupational disease,
- Requested by the attending physician, *and*
- Authorized by an L&I ONC or self-insured employer before care begins.

Note: Services provided in adult day care center facilities aren't covered by the insurer.

Prior authorization and reauthorization

Initial admission

Residential care services require prior authorization. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator.

Link: For authorization procedures on a self-insured claim, contact the self-insurer. Contact information is available at: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/.

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When care needs change

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for reauthorization of the workers care.

Who must provide these services to qualify for payment

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for twenty-four hour institutional care including:

- Skilled Nursing Facilities (SNF),
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital,
- Critical Access Hospitals (CAHs) licensed by DOH and Veterans Hospitals using swing beds to provide long term care or sub-acute care,
- Adult Family Homes,
- Assisted Living Facilities,
- Secure Residential Facilities,
- Boarding Homes, *and*
- Hospice care providers.

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

Note: TCUs must obtain a separate provider number from L&I.

Services that aren't covered

Adult day care center facilities or assisted living facilities performing adult day care services

Services provided in adult day care center facilities aren't covered by the insurer.

Pharmaceuticals and durable medical equipment (DME)

Residential facilities can't bill for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed by a pharmacy or DME supplier.

Note: Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

Requirements for billing

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this chapter.

Link: The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125 (see Billing procedures).

All residential care services should be billed on form **F245-072-000** (Statement for Miscellaneous Services).

Link: The **F245-072-000** form is available at: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627

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Additional information: Negotiated payment arrangements

Insurers with existing negotiated arrangements made **prior to January 1, 2005** may continue their current arrangements and continue to use billing code **8902H** until the worker's need for services no longer exists or the worker is transferred to a new facility.

Note: Billing code **8902H** (Negotiated payment arrangements) is a code that pays by report.

Additional information: Residential services review, periodic independent nursing evaluations

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to:

- Onsite review of the worker, *and*
- Review of medical records.

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

Link: For more information, see RCW 51.36.100 and RCW 51.36.110.

Payment policy: Residential services, including boarding homes, assisted living facilities, and adult family homes

Requirements for the Long Term Care Assessment Tool

At the insurers' request, a Long Term Care Assessment Tool must be completed by an independent Registered Nurse (RN):

- Within 10 days of admission, *and*
- At least once per year after the initial assessment.

The tool determines the appropriate L&I payment grouping.

Link: The tool is available at

www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345

Services that can be billed

For dates of service July 1, 2016 or after:

The numeric score determined by the Long Term Care Assessment Tool will determine which billing code to use. The three levels of care will be applied to all nonskilled nursing facility types. The payment rates are daily payment rates (see table below).

Note: Don't bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

If the **assessment score** is…	Then the appropriate **billing code** is:	Which has this **description**:	And a **maximum fee** (daily rate) of:
6 – 20	**8893H**	L&I RF Low	**$168.49**
21 – 36	**8894H**	L&I RF Medium	**$204.62**

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37 – 57	**8895H**	L&I RF High	**$240.72**

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Payment policy: Critical Access Hospitals (CAHs) and Veterans Administration Hospitals using swing beds for sub-acute care

Payment methods

Critical Access Hospitals and Veterans Administration Hospitals will be paid for swing bed services utilizing a hospital specific POAC rate.

Prior authorization

You may contact an occupational nurse consultant (ONC) for approval.

Link: To obtain information about contacting an ONC, call L&I's Provider Hotline at **1-800-831-5227**.

Requirements for billing

Upon approval from a Labor and Industries ONC, CAHs and Veterans Administration Hospitals should bill their usual and customary charge for sub-acute care (swing bed use) on the **UB-04** billing form.

Identify these services in the Type of Bill field (Form Locator 04) with the 018x series (hospital swing beds).

Link: To view the UB-04 form, see: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1651

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Does this policy apply to self-insured employers?

No. Self-insured employers' payment formula for hospital inpatient services and non-fee schedule hospital outpatient services = *Your hospital specific POAC factor* **x** *Allowed charges*. Contact your insurer for correct form and payment procedures.

Payment policy: Hospice care

Requirements for billing

Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Hospice programs must bill the following HCPCS codes:

If the **hospice care is provided in**…	Then bill for services using **HCPCS code**:	Which has a **maximum fee** of:
Nursing long term care facility	**Q5003**	**By report**
Skilled nursing facility	**Q5004**	**By report**
Inpatient hospital	**Q5005**	**By report**
Inpatient hospice facility	**Q5006**	**By report**
Long term care facility	**Q5007**	**By report**
Inpatient psychiatric facility	**Q5008**	**By report**
Place NOS	**Q5009**	**By report**

Payment limits

Hospice claims are paid on a by report basis (see table above).

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Occupational, physical, and speech therapies are included in the daily rate and aren't separately payable.

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Payment policy: Skilled nursing facilities

Requirements for the Minimum Data Set Basic Assessment Tracking Form

Within 10 working days of admission, nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker. The completed MDS with the Resource Utilization Group (RUG) score must be sent to the ONC or SIE/TPA for authorization of the appropriate billing code.

Link: The form is available from CMS at: www.cms.gov/NursingHomeQualityInits/.

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment group to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

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Payment policy: Skilled nursing facility and transitional care unit beds

Payment methods

L&I uses a modified version of the skilled nursing facility (SNF) prospective payment system for developing the residential facility payment rates.

The fee schedule for SNF and transitional care unit (TCU) beds is a series of daily facility payment rates including:

- Room rates,
- Therapies, *and*
- Nursing components depending on the needs of the worker.

Note: Medications aren't included in the L&I rate.

Prior authorization

A modified RUG score must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code.

Additional information: Fee schedule, effective July 1, 2016

Billing code	Description	Included Medicare RUG groups	Maximum fee
		Rehab groups:	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	**$674.19**
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	**$505.06**
8882H	Rehab-High	RHX, RHL, RHC, RHB, RHA	**$470.75**
8883H	Rehab-Medium	RMX, RML, RMC, RMB, RMA	**$435.19**
8884H	Rehab-Low	RLX, RLB, RLA	**$339.37**

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Billing code	Description	Included Medicare RUG groups	Maximum fee
		Nursing services groups:	
8885H	Extensive Services	ES3, EES2, ES1	**$421.21**
8886H	Special Care High	HE2, HE1, HD2,HD1, HC2, HC1, HB2, HB1	**$313.37**
8887H	Special Care Low	LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1	**$312.03**
8888H	Clinically Complex	CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1	**$230.18**
8889H	Behavioral Symptoms and Cognitive Performance	BB2, BB1, BA2, BA1	**$228.48**
		Reduced physical function groups:	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	**$240.72**

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-125
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services	L&I's website: http://feeschedules.Lni.wa.gov
Long Term Care Assessment Tool for completion by an independent RN	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345
Minimum Data Set (MDS) Basic Assessment Tracking Form *or* **Resource Utilization Group Residential Care Services for Injured Workers form**	Medicare's (CMS's) website: www.cms.gov/NursingHomeQualityInits L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=2460
Payment policies for **durable medical equipment (DME)**	Chapter 9: Durable Medical Equipment
Statement for Miscellaneous Services form	L&I's website: www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.100 RCW 51.36.110: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.36.110

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