

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-20-125 Billing procedures. All services rendered must be in accordance with the medical aid rules, fee schedules, and department policy. The department or self-insurer may reject bills for services rendered in violation of these rules. Workers may not be billed for services rendered in violation of these rules.

(1) Bills must be itemized on department or self-insurer forms or other forms which have been approved by the department or self-insurer. Bills may also be transmitted electronically using department file format specifications. Providers using any of the electronic transfer options must follow department instructions for electronic billing. Physicians, osteopaths, advanced registered nurse practitioners, chiropractors, naturopaths, podiatrists, psychologists, and registered physical therapists use the current national standard ((HCFA-1500)) Health Insurance Claim Form (as defined by the National Uniform Claim Committee) with the bar code placed 2/10 of an inch from the top and 1 1/2 inches from the left side of the form. Hospitals use the (~~UB-92~~) current National Uniform Billing Form (as defined by the National Uniform Billing Committee) for institution services and the current national standard ((HCFA-1500)) Health Insurance Claim Form (as defined by the National Uniform Claim Committee) with the bar code placed 2/10 of an inch from the top and 1 1/2 inches from the left side of the form for professional services. Hospitals should refer to chapter 296-23A WAC for billing rules pertaining to institution, or facilities, charges. Pharmacies use the department's statement for pharmacy services. Dentists, equipment suppliers, transportation services, vocational services, and massage therapists use the department's statement for miscellaneous services. When billing the department for home health services, providers should use the "statement for home nursing services." Providers may obtain billing forms from the department's local service locations.

(2) Bills must specify the date and type of service, the appropriate procedure code, the condition treated, and the charges for each service.

(3) Bills submitted to the department must be completed to include the following:

- (a) Worker's name and address;
- (b) Worker's claim number;
- (c) Date of injury;
- (d) Referring doctor's name and L & I provider account number;
- (e) Area of body treated, including ICD-9-CM code(s), identification of right or left, as appropriate;
- (f) Dates of service;

- (g) Place of service;
- (h) Type of service;
- (i) Appropriate procedure code, hospital revenue code, or national drug code;
- (j) Description of service;
- (k) Charge;
- (l) Units of service;
- (m) Tooth number(s);
- (n) Total bill charge;
- (o) The name and address of the practitioner rendering the services and the provider account number assigned by the department;
- (p) Date of billing;
- (q) Submission of supporting documentation required under subsection (6) of this section.

(4) Responsibility for the completeness and accuracy of the description of services and charges billed rests with the practitioner rendering the service, regardless of who actually completes the bill form;

(5) Vendors are urged to bill on a monthly basis. Bills must be received within one year of the date of service to be considered for payment.

(6) The following supporting documentation is required when billing for services:

- (a) Laboratory and pathology reports;
- (b) X-ray findings;
- (c) Operative reports;
- (d) Office notes;
- (e) Consultation reports;
- (f) Special diagnostic study reports;
- (g) For BR procedures - see chapter 296-20 WAC for requirements; and
- (h) Special or closing exam reports.

(7) The claim number must be placed on each bill and on each page of reports and other correspondence in the upper right-hand corner.

(8) The following considerations apply to rebills.

(a) If you do not receive payment or notification from the department within one hundred twenty days, services may be rebilled.

(b) Rebills must be submitted for services denied if a claim is closed or rejected and subsequently reopened or allowed. In these instances, the rebills must be received within one year of the date the final order is issued which subsequently reopens or allows the claim.

(c) Rebills should be identical to the original bill: Same charges, codes, and billing date.

(d) In cases where vendors rebill, please indicate "REBILL" on the bill.

(9) The department or self-insurer will adjust payment of charges when appropriate. The department or self-insurer must provide the health care provider or supplier with a written

explanation as to why a billing or line item of a bill was adjusted at the time the adjustment is made. A written explanation is not required if the adjustment was made solely to conform with the maximum allowable fees as set by the department. Any inquiries regarding adjustment of charges must be received in the required format within ninety days from the date of payment to be considered. Refer to the medical aid rules for additional information.

AMENDATORY SECTION (Amending WSR 97-06-066, filed 2/28/97, effective 4/1/97)

WAC 296-23A-0160 How must hospitals submit charges for ambulance and professional services? Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the current Health Insurance Claim Form (as defined by the National Uniform Claim Committee), (~~HCFA 1500~~) using the provider account number(s) assigned by the department for these services. Hospitals using any of the electronic transfer options must follow department instructions for electronic billing.

WAC 296-23A-0230 How does the department or self-insurer pay out-of-state hospitals for hospital services? The department or self-insurer pays out-of-state hospitals for hospital services using a percent of allowed charges (POAC) factor or department fee schedule. The POAC factor may differ for services performed in inpatient and outpatient settings. Payment rates to hospitals located outside of Washington state are calculated by multiplying the out-of-state percent of allowed charges factor (POAC) by the allowed charges.

Amount paid = (out-of-state POAC Factor) X (Allowed Charges).

Out-of-state hospital providers should bill and the department or self-insurer will pay out-of-state hospitals services according to the following table:

<i>Hospital Professional and Ambulance Services</i>	<i>Hospital Outpatient Services</i>	<i>Hospital Inpatient Services</i>
<p>Professional and ambulance services should be billed with CPT and HCPCS codes on ((HCFA 1500)) <u>current Health Insurance Claim Forms (as defined by the National Uniform Claim Committee)</u> under separate provider numbers.</p> <p>These services will be paid using the fee schedule rates and payment policies stated in the Washington <i>Medical Aid Rules and Fee Schedules</i>.</p>	<p>All hospital outpatient services should be billed on UB forms under the hospital provider number with revenue codes.</p> <p>These services will be paid at the out-of-state percent of allowed charges (POAC) factor as stated in the Washington <i>Medical Aid Rules and Fee Schedules</i>.</p>	<p>All hospital inpatient services should be billed on UB forms under the hospital provider number using revenue codes.</p> <p>These services will be paid at the out-of-state percent of allowed charges (POAC) factor as stated in the Washington <i>Medical Aid Rules and Fee Schedules</i>.</p>
<p>Military and veteran's administration professional and ambulance services should be billed on ((HCFA 1500)) <u>current Health Insurance Claim Forms (as defined by the National Uniform Claim Committee)</u> and will be paid at 100% of allowed charges.</p>	<p>Military, veteran's administration, health maintenance organization, children's, and state-run psychiatric hospitals will be paid at 100% of allowed charges for outpatient hospital services.</p>	<p>Military, veteran's administration, health maintenance organization, children's, and state-run psychiatric hospitals will be paid at 100% of allowed charges for inpatient hospital services.</p>

AMENDATORY SECTION (Amending WSR 99-07-004, filed 3/4/99, effective 4/4/99)

WAC 296-31-080 How do providers bill for services? (1)

Neither the department nor the claimant is required to pay for provider services which violate the mental health treatment rules, fee schedule or department policy.

(2) All fees listed are the maximum fees allowable. Providers must bill their usual and customary fee for each service. If this is less than our fee schedule rate, you must bill us at the lesser rate. The department will pay the lesser of the billed charge or the fee schedule's maximum allowable.

The provider is prohibited from charging the claimant for any difference between the provider's charge and our allowable amount.

(3) Regardless of who completes the bill form, you are responsible for the completeness and accuracy of the description of services and of the charges billed.

(4) All bills submitted to the department must:

(a) Be itemized on forms approved by us.

For example: Physicians, psychologists, advanced registered nurse practitioners and master level mental health counselors may use our form or the (~~(national standard HCFA 1500)~~) current Health Insurance Claim Form (as defined by the National Uniform Claim Committee). Hospitals use the (~~(UB 92)~~) current National Uniform Billing Form (as defined by the National Uniform Billing Committee) for institution services and the (~~(national standard HCFA 1500)~~) current Health Insurance Claim Form (as defined by the National Uniform Claim Committee) for professional services.

(b) Refer to the crime victims compensation program mental health (~~(treatment rules and fees booklet for procedure code listings and)~~) billing instructions for detailed billing ((instructions)) information. Billings must be submitted in accordance with (~~(this publication)~~) these instructions. Procedure codes and fees are available on the crime victims compensation web site or by contacting the crime victims program.

(5) The following supporting documentation must be maintained and, if applicable, submitted when billing for services:

(a) Intake evaluation;

(b) Progress reports;

(c) Consultation reports;

(d) Special or diagnostic study reports;

(e) Independent assessment or closing exam reports;

(f) BR (by report) describing why a service or procedure is too unusual, variable, or complex to be assigned a value unit;

(g) The claimant's or patient's (if patient is other than claimant) private or public insurance information;

For example: When services provided are for survivors of

homicide victims.

(6) The claim number must appear in the appropriate field on each bill form. Reports and other correspondence must have the claim number in the upper right hand corner of each page.

(7) You may rebill us if your bill is not reported on your remittance advice within sixty days. Unless the information on the original bill was incorrect, a rebill should be identical. Rebills must be submitted for services denied if a claim is closed or rejected and subsequently reopened or allowed.

(8) We will adjust charges when appropriate. We must provide you with a written explanation as to why a billing was adjusted. A written explanation is not required if the adjustment was made solely to conform to our maximum allowable fees. Any inquiries regarding adjustment of charges must be received in the required format within ninety days from the date of payment.

AMENDATORY SECTION (Amending WSR 05-09-063, filed 4/19/05, effective 7/1/05)

WAC 296-20-010 General information. (1) The following rules are promulgated pursuant to RCW 51.04.020 and 51.04.030. The department or self-insurer may purchase necessary physician and other provider services according to the fee schedules. The fee schedules shall be established in consultation with interested persons and updated at times determined by the department in consultation with those interested persons. Prior to the establishment or amendment of the fee schedules, the department will give at least thirty calendar days notice by mail to interested persons who have made timely request for advance notice of the establishment or amendment of the fee schedules. To request advance notice of the establishment or amendment of the fee schedules, interested persons must contact the department at the following address:

Department of Labor and Industries
Health Services Analysis
Interested Person's Mailing List for the Fee Schedules
P.O. Box 44322
Olympia, WA 98504-4322

As an alternative, interested persons may subscribe to the L&I medical provider news listserv. To subscribe, go to the department's web site at www.lni.wa.gov and click on the link "Provider billing & payment." Look for the icon that says "Get E-mail Updates" and click on it.

The department or self-insurer will require the current version of the federal Health Care Common Procedure Coding System (HCPCS) Level I (or CPT) and II codes on January 1, of each new year. CPT refers to the American Medical Association's Physicians' Current Procedural Terminology codes.

The adoption of these codes on an annual basis is designed to reduce the administrative burden on providers and lead to more accurate reporting of services. However, the inclusion of a service, product or supply within these new codes does not necessarily imply coverage, reimbursement or endorsement, by the department or self-insurer. The department will make coverage and reimbursement decisions for these new codes on an individual basis.

If there are any services, procedures or narrative text contained in the new HCPCS Level I and II codes that conflict with the medical aid rules or fee schedules, the department's rules and policies take precedence.

Copies of the HCPCS Level I and II codes are available for public inspection. These documents are available in each of the department's service locations.

Copies of the HCPCS Level II codes may be purchased from:

The Superintendent of Documents
United States Government Printing Office
Washington, DC 20402
(202) 783-3238

Copies of the Level I (or CPT) codes may be purchased from:

The American Medical Association
Chicago, Illinois 60601
(800) 621-8335

In addition to the sources listed above, both the Level I and II codes may be purchased from a variety of private sources.

(2) The fee schedules are intended to cover all services for accepted industrial insurance claims. All fees listed are the maximum fees allowable. Practitioners shall bill their usual and customary fee for services. **If a usual and customary fee for any particular service is lower to the general public than listed in the fee schedules, the practitioner shall bill the department or self-insurer at the lower rate.** The department or self-insurer will pay the lesser of the billed charge or the fee schedules' maximum allowable.

(3) The rules contained in the introductory section pertain to all practitioners regardless of specialty area or limitation of practice. Additional rules pertaining to specialty areas will be found in the appropriate section of the medical aid rules.

(4) The methodology for making conversion factor cost of living adjustments is listed in WAC 296-20-132. The conversion factors are listed in WAC 296-20-135.

(5) No fee is payable for missed appointments unless the appointment is for an examination arranged by the department or self-insurer.

(6) When a claim has been accepted by the department or self-insurer, no provider or his/her representative may bill the worker for the difference between the allowable fee and the usual and customary charge. Nor can the worker be charged a fee, either for interest or completion of forms, related to services rendered for the industrial injury or condition. Refer to chapter 51.04 RCW.

(7) Practitioners must maintain documentation in claimant medical or health care service records adequate to verify the level, type, and extent of services provided to claimants. A health care practitioner's bill for services, appointment book, accounting records, or other similar methodology do not qualify as appropriate documentation for services rendered. Refer to chapter 296-20 WAC and department policy for reporting requirements.

(8) Except as provided in WAC 296-20-055 (Limitation of treatment and temporary treatment of unrelated conditions when retarding recovery), practitioners shall bill, and the department or self-insurer shall pay, only for proper and necessary medical care required for the diagnosis and curative or rehabilitative treatment of the accepted condition.

(9) When a worker is being treated concurrently for an

unrelated condition the fee allowable for the service(s) rendered must be shared proportionally between the payors.

(10) Correspondence: Correspondence pertaining to state fund and department of energy claims should be sent to: Department of Labor and Industries, Claims Administration, P.O. Box 44291, Olympia, Washington 98504-4291.

Accident reports should be sent to: Department of Labor and Industries, P.O. Box 44299, Olympia, Washington 98504-4299.

Send all provider bills (~~(by type (UB-92))~~) and adjustments to: Department of Labor and Industries, P.O. Box (~~(44266)~~) 44269, Olympia, Washington (~~(98504-4266)~~) 98504-4269.

~~((Adjustments, Home Nursing, Retraining, Job Modification, and Miscellaneous to: Department of Labor and Industries, P.O. Box 44267, Olympia, Washington 98504-4267.~~

~~Pharmacy to: Department of Labor and Industries, P.O. Box 44268, Olympia, Washington 98504-4268.~~

~~HCFA-1500 to: Department of Labor and Industries, P.O. Box 44269, Olympia, Washington 98504-4269.)~~

State fund claims have six digit numbers or a letter and five digits preceded by a letter other than "S," "T," or "W."

All correspondence and billings pertaining to *crime victims* claims should be sent to Crime Victims Division, Department of Labor and Industries, P.O. Box 44520, Olympia, Washington 98504-4520.

Crime victim claims have six digit numbers preceded by a "V" or five digit numbers preceded by "VA," "VB," "VC," "VH," "VJ," or "VK."

All correspondence and billings pertaining to self-insured claims should be sent directly to the employer or the service representative as the case may be.

Self-insured claims are six digit numbers or a letter and five digits preceded by an "S," "T," or "W."

Communications to the department or self-insurer must show the patient's full name and claim number. If the claim number is unavailable, providers should contact the department or self-insurer for the number, indicating the patient's name, Social Security number, the date and the nature of the injury, and the employer's name. A communication should refer to one claim only. Correspondence must be legible and reproducible, as department records are microfilmed. Correspondence regarding specific claim matters should be sent directly to the department in Olympia or self-insurer in order to avoid rehandling by the service location.

(11) The department's various local service locations should be utilized by providers to obtain information, supplies, or assistance in dealing with matters pertaining to industrial injuries.