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, 2019

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

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2019/

Table of contents

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.

Payment policy: Activity Coaching

Activity Coaching:

The Progressive Goal Attainment Program (PGAP®) is the standardized form of activity coaching supported by L&I. It consists of an assessment followed by up to 10 weekly individual sessions. Only L&I approved activity coaches will be paid. Providers of these services may include occupational therapists, physical therapists, and vocational rehabilitation counselors.

Services that can be billed

Billing code	Description	Unit limit	Unit Price
CPT 96150	Activity Coaching Initial Assessment	6 units per life of claim (1 unit = 15 min)	$41.43
CPT 96151	Activity Coaching Reassessment	5 units per day 10 units per life of claim (1 unit = 15 min)	$40.14
CPT 96152	Activity Coaching Intervention	4 units per day 40 units per life of claim (1 unit = 15 min)	$38.20
1160M	PGAP Workbook	1 per life of claim	$83.24

Activity Coaching – Telephone calls to worker legal representatives

Who must perform these services to qualify for payment

Telephone calls are payable to approved PGAP Activity Coaches only when they personally participate in the call.

Services that can be billed

These services are payable when providing outreach, education, and facilitating services with:

- Worker's legal representative identified in claim file.

Note: The insurer will pay for telephone calls if the coach 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.

Services that aren't covered

Telephone calls aren't payable if they are for:

- Authorization, scheduling or resolution of billing issues

Requirements for billing

Use the correct local billing codes and provide documentation as described below.

If the duration of the telephone call is…	And you are a PGAP activity coach, then bill local code
1-10 minutes	1725M
11-20 minutes	1726M
21-30 minutes	1727M

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.

This may be documented in a report and/or a session note.

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

When billing for locum tenens services, the locum tenens physician must use HCPCS billing code **modifier –Q6** (which is defined as, “Services furnished by a locum tenens physician”).

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 **$5.27** per mile.

Note: (Also see Prior authorization, above.)

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**