

Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules (MARFS), and Provider Bulletins. 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 MARFS, the Department of Labor and Industries' (L&I) rules and policies take precedence (WAC [296-20-010](#)). 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.

For more information on L&I WACs go to

<http://www.Lni.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp>

For more information on the Revised Code of Washington (RCW) go to

<http://search.leg.wa.gov/pub/textsearch/default.asp>

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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GENERAL INFORMATION

EFFECTIVE DATE

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2011.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to MARFS will be published on L&I's web site at <http://feeschedules.Lni.wa.gov/> under Fee Schedules/Updates & Corrections.

Additional fee schedule and policy information is published throughout the year in L&I's Provider Bulletins that are available at <http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp>

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

Listserv participants will receive via e-mail:

- Updates and changes to the Medical Aid Rules and Fee Schedules.
- A link to the new Provider Bulletins as soon as they are posted.
- Notices about courses, seminars, and new information available on L&I's website.

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

Washington State government payers coordinate fee schedule and payment policy development. Billing and payment requirements are as consistent as possible for providers.

The state government payers are:

- The Washington State Fund Workers' Compensation Program administered by the Department of Labor and Industries (L&I).
- The State Medicaid Program administered by the Medical Purchasing Administration within the Health Care Authority.

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.

PAYMENT REVIEW

All services rendered to workers' compensation claims are subject to audit by L&I. See RCW [51.36.100](#) and RCW [51.36.110](#).

HEALTH CARE PROVIDER NETWORKS

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. Workers are responsible for choosing their providers. RCW [51.04.030 \(2\)](#) allows the insurer to recommend to the worker particular health care 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.

MAXIMUM FEES NOT MINIMUM FEES

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

RCW [51.04.030 \(2\)](#) 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.

BECOMING A PROVIDER

Health care providers can use the same L&I provider number to bill for treating State Fund injured workers and crime victims. New providers can sign up for both programs at the same time using one provider application.

WORKERS' COMPENSATION PROGRAM

A provider must have an active L&I provider account number in order to treat Washington workers and receive payment for medical services. For State Fund claims, this proprietary account number is necessary for L&I to accurately set up its automated billing systems. Once the L&I provider account number is established, and the federally-issued National Provider Identifier (NPI) is registered with L&I, either number can be used on bills and correspondence submitted to L&I. 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.

Providers can apply for:

- L&I provider account numbers by completing the Provider Account Application and W-9 (form F248-011-000). *These forms are available at <http://www.becomeprovider.Lni.wa.gov> or can be requested by contacting L&I's Provider Accounts section or the Provider Hotline.*
- NPIs at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> .

Contact Information

Provider Accounts

Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
360-902-5140

Provider Hotline

1-800-848-0811

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

KEEP YOUR PROVIDER ACCOUNT UPDATED

Keep us informed of your account changes to prevent payment delays by completing a Provider Accounts Change Form (form F245-365-000) available at <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1650> . Providers with active L&I provider accounts are listed on Find-a-Doctor (FAD) at <http://www.Lni.wa.gov/ClaimsIns/Claims/FindaDoc/Default.asp> unless they indicate on their application they don't wish to be included on FAD. Accurate information helps ensure smooth communication between you, L&I, workers and employers.

For self-insured workers' compensation claims contact the insurer directly for provider account number requirements. For assistance in locating self-insurers go to:

<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

CRIME VICTIMS COMPENSATION PROGRAM

A provider treating crime victims must apply for a provider account number. The Provider Application and W-9 (form F800-053-0000) are available on L&I's web site at <http://www.becomeprovider.Lni.wa.gov> or can be requested by contacting L&I's Provider Accounts section or the Provider Hotline.

Provider resources for the Crime Victims Compensation Program are available on L&I's web site at <http://www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp>. Providers with active Crime Victims Compensation Program accounts are listed on Find-a-Doctor for Crime Victims at <https://fortress.wa.gov/lni/fad/FADCSearch.aspx> unless they indicate on their application they don't wish to be included on Find-a-Doctor.

Contact Information

Crime Victims Compensation Program

Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

SELF-INSURANCE

Self-insured employers (SIE) 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\(1\)](#)).
- Health care providers should send their bills, reports, requests for authorization etc., directly to the SIE/TPA.
- For a list of SIE/TPAs go to:
<http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

SIEs use the Self Insurance Accident Report (SIF2).

- The SIF2 is the form used to assign the claim number.
- Only the SIE and the worker complete the SIF2.
- Employers: To order a supply of SIF2s go to:
<http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2466>

Provider's Initial Report (PIR) forms are supplied to providers to assist injured workers of SIEs in filing claims.

- The PIR is used in the same way the Report of Accident (ROA) form is used for State Fund covered workers.
- Only the provider and the worker complete the PIR.
- Providers: To order a supply of PIRs go to:
<http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2467>

The Self-Insurance (SI) Program of L&I regulates the SIEs. 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 section's adjudicator assigned to the claim will handle the request.
- For disputes related to billing codes, fees, and/or payment policies, the SI section's Medical Compliance Consultant will handle the request.

BILLING INSTRUCTIONS AND FORMS

WHO TO BILL

State Fund Claims begin with the letters **B, C, F, G, H, J, K, L, M, N, P, X,** or **Y** 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. U. S. 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.

Federal claims begin with **A13** or **A14**. Questions and billing information about federal claims should be directed to the U.S. Department of Labor at (206) 398-8100 or (206) 398-8200 or their web site at <http://www.dol.gov/owcp/>.

BILLING PROCEDURES

Billing procedures are outlined in WAC [296-20-125](#).

BILLING MANUALS AND BILLING INSTRUCTIONS

The [General Provider Billing Manual \(publication F248-100-000\)](#) and L&I's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. Providers can download these manuals on L&I's web site at <http://www.Lni.wa.gov/FormPub/> or request these publications from L&I's Provider Accounts section or the Provider Hotline. (See the Becoming a Provider section above for contact information.)

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
- Meeting your Provider Account Representatives

Additional information on the workshops is available at <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/Workshop/default.asp>.

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 allows greater control over the payment process eliminating entry time and allowing L&I to process payments faster than paper billing. It reduces billing errors and decreases the costs of bill processing. See Cost Comparison Estimator at <http://www.Lni.wa.gov/ClaimsIns/Files/providers/EstimatorFinal042009.xls>

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

- Free on-line billing form.
Note: No specific software/clearinghouse required.
- Upload bills using your software.
Note: The department doesn't supply billing software for electronic billing.
- Use an intermediary/clearinghouse

Your correspondence and reports may be faxed to L&I. Fax numbers can be found on page **15** or L&I's web site at <http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/How/default.asp>.

For additional information on electronic billing, go to:

www.ElectronicBilling.Lni.wa.gov

Or contact the Electronic Billing Unit at:

Electronic Billing

Phone: (360) 902-6511

Fax: (360) 902-6192

E-mail: ebulni@LNI.wa.gov

BILLING FORMS

Providers must use L&I's current billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other L&I publications, complete the "Medical Forms Request" (Form F208-063-000) (located under Contact Information on the MARFS CD or on L&I's web site at <http://www.Lni.wa.gov/Forms/pdf/208063a0.pdf> and send it to L&I's warehouse (address listed on the form). You may also download many forms from L&I's web site at <http://www.Lni.wa.gov/FormPub/>.

GENERAL BILLING TIPS



This symbol is placed next to billing tips throughout the policy sections to facilitate billing correctly.

ADJUSTMENT VS. SUBMITTING A NEW BILL TO THE STATE FUND

- When an entire bill is denied, you need to submit a new bill to be paid for your services.
- When part of the bill is paid, you must submit an adjustment for the services which weren't paid. Additional information on adjustments is available at

<http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp> .

FAILURE TO ATTEND SCHEDULED APPOINTMENT

Workers are expected to attend scheduled appointments. When a worker fails to show for an appointment:

- Per WAC [296-20-010\(5\)](#) "No fee is payable for missed appointments unless the appointment is for an examination arranged by L&I or self-insurer."
- Workers are advised that a no-show appointment may be grounds for a non-cooperation order.
- Providers are to notify the claim manager immediately when an injured worker fails to show for an appointment.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Submitting State Fund bills, reports and correspondence to the correct addresses helps L&I pay you promptly.

Please don't fax bills. You may fax correspondence and reports to the FAX Numbers listed in this section.

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

Item	FAX Numbers	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease – Accident Report F242-130-000	ROAs ONLY (360) 902-6690 (800) 941-2976	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, Activity Prescription Forms, reports and chart notes for State Fund Claims and claim related documents other than bills.	(360) 902-4567	Department of Labor & Industries 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
UB-04 Forms CMS 1500 Forms Retraining & Job Modification Bills Home Nursing Bills Miscellaneous Bills Pharmacy Bills Compound Prescription Bills 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

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. This 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 batched and scanned when time is available.

Do's

These tips can help L&I process your documents promptly and accurately.

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

Don'ts

Please **don't**:

- Use colored paper, particularly hot or intense colors.
- Use thick or textured paper.
- Send carbonless paper.
- Use any highlighter markings.
- Place information within shaded areas.
- Use italicized text.
- Use paper with black or dark borders, especially on the top border.
- Staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment, and can help you avoid repeated requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' individual records to verify the level, type and extent of services provided to workers. The insurer may 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. No additional amount is payable for documentation required to support billing.

Providers can submit forms with a signature stamp or an electronic signature from the medical provider. The insurer **won't pay** for forms unless they are signed by the provider or authorized representative.

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 sections of this document (MARFS) and in WAC [296-20-06101](#). The insurer may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix G**.

Amendment of Medical Records

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

Changes to the medical record legally amended prior to bill submission may be considered in determining the validity of the services billed. 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 department.

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation or clinical services. A **late entry, addendum or correction** to the medical record must bear the current date of that entry and be signed by the person making the addition or change.

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 bear the current date, be added as soon as possible, 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".
- 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,
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional documentation as much as possible.

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.
- Document the current date and time.
- Identify any sources of information used to support the addendum.

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

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

Correction of electronic medical records should follow the same principles of tracking the information.

Falsified Documentation

Deliberately falsifying medical records is a felony offense and is viewed seriously when encountered (RCW [51.48.290](#), [51.48.250](#)). Some examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. You must include subjective and objective findings, records of clinical assessment (diagnoses), reports, interpretations of X-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years (See WAC [296-20-02005](#)).

Providers are required to keep all X-rays for a minimum of 10 years (See WACs [296-20-121](#) and [296-23-140](#)).

DOCUMENTATION REQUIREMENTS WHEN REFERRING WORKER OUTSIDE OF LOCAL COMMUNITY FOR CARE

Whenever it is necessary to refer an injured worker for specialty care or 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.**

CHARTING FORMAT

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, and Plan and progress) format.

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:

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 undergo.

R Restrictions to recovery

- Describe the physical limitations (temporary and permanent) that prevent 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?

SOAP-ER CHARTING FORMAT

Office/chart/progress notes and 60-day reports should include the SOAP contents:

S Worker's Subjective complaints

What the worker states, or what the employer, coworker or significant other (family, friend) reports, about the illness or injury. Refer to WAC [296-20-220 \(i\)](#).

O Objective findings

What is directly observed and noticeable by the medical provider. This includes factual information, for example, physical exam – skin is red and edematous, lab tests – positive for opiates, X-rays – no fracture. Refer to WAC [296-20-220 \(i\)](#).

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. Refer to WAC [296-20-010\(7\)](#) and WAC [296-20-01002](#) (Chart notes).

Add **ER** to the SOAP contents to document work status information.

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of L&I's hospital inpatient payment methods. See the [Facility Services section](#), page 188, or refer to Chapter [296-23A](#) WAC for more information.

Self-insurers (see WAC [296-23A-0210](#))

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

All Patient Diagnosis Related Groups (AP DRG) (See WAC [296-23A-0200](#))

L&I uses All Patient Diagnosis Related Groups (AP DRG) to pay for most inpatient hospital services.

Per Diem

L&I uses statewide average per diem rates for 5 AP DRG categories:

- Chemical dependency
- Psychiatric
- Rehabilitation
- Medical
- Surgical

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

Percent of Allowed Charges (POAC)

L&I uses a POAC payment method:

- For some hospitals exempt from the AP DRG payment method
- As part of the outlier payment calculation for hospitals paid by the AP DRG

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of L&I's payment methods for hospital outpatient services. Refer to Chapter [296-23A](#) WAC and the Facility Services section for more information.

Self-insurers (see WAC [296-23A-0221](#))

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.

Ambulatory Payment Classifications (APC) (See WAC [296-23A-0220](#))

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

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.

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,
- The Professional Services Fee Schedule or
- By L&I contract.

Out-of-State Hospital Payment Methods

See WAC [296-23A-0230](#) for out-of-state hospital outpatient, inpatient, and professional services payment methods.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (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. Refer to Chapter [296-23B](#) WAC in the Medical Aid Rules and the Facility Services section for more information.

By Report

Insurers pay for some covered services on a by report basis as defined in WAC [296-20-01002](#). Fees for by report services may be based on the value of the service as determined by the report.

Maximum Fees

L&I establishes rates for some services that are not priced with other payment methods.

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.

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, Transitional Care Units and Critical Access Hospitals 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.

PROFESSIONAL PROVIDER PAYMENT METHODS

Refer to Chapters [296-20](#), [296-21](#) and [296-23](#) WAC and the Professional Services section for more information.

Resource Based Relative Value Scale (RBRVS)

Insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of **R** in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

Insurers pay for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

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 column of the Professional Services Fee Schedule.

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 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 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 of **C** in the Professional Services Fee Schedule.

The Crime Victims Compensation Program doesn't contract for these services.

By Report

Insurers pay for some covered services on a by report basis as defined in

WAC [296-20-01002](#). 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 of **N** in the Professional Services Fee Schedule and BR in other fee schedules.

Program Only

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

- Centers for Occupational Health Education
- Orthopedic and Neurological Surgeon Quality Pilot

BILLING CODES AND MODIFIERS

L&I's fee schedules use the federal HCPCS and agency unique local codes.

NOTE: There are no descriptions for CPT[®] codes and only partial descriptions of HCPCS or CDT codes in the fee schedule. Providers must bill according to the full text descriptions published in the CDT-3[®], CPT[®] and HCPCS books. These can be purchased from private sources. Refer to WAC [296-20-010\(1\)](#) for additional information.

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 3 categories of CPT[®] codes:

- **CPT[®] Category I** codes are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, not newly emerging technologies. They consist of 5 numbers (for example, 99201).
- **CPT[®] Category II** codes are optional and used to facilitate data collection for tracking performance measurement. They consist of 4 numbers followed by an **F** (for example, 0001F).
- **CPT[®] Category III** codes are temporary and used to identify new and emerging technologies. They consist of 4 numbers followed by a **T** (for example, 0001T).

HCPCS Level I modifiers are the CPT[®] modifiers that are developed, updated and copyrighted by the AMA. These are used to indicate that a procedure or service has been altered without changing its definition. They consist of 2 numbers (for example, -22). **L&I doesn't accept the 5 digit modifiers.**

HCPCS Level II codes are updated by the Center for Medicare & Medicaid Services (CMS).

HCPCS codes are used to identify:

- Miscellaneous services
- Supplies
- Materials
- Drugs
- Professional services

These codes begin with 1 letter, followed by 4 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).

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered. They consist of 2 letters (for example, -AA) or 1 letter and 1 number (for example, -E1).

Local codes are used to identify unique services or supplies. They consist of 4 numbers followed by 1 letter (except F and T). For example, 1040M must be used to code completion of the Report of Accident and Providers Initial Report forms. L&I will modify local code use as national codes become available.

Local modifiers are used to identify modifications to services. They consist of 1 number and 1 letter (for example, -1S). L&I will modify local modifier use as national modifiers become available.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	CPT® Category II	CPT® Category III	HCPCS	L&I Unique Local Codes
Source	AMA / CMS	AMA / CMS	AMA / CMS	AMA / CMS	L&I
Code Format	5 numbers	4 numbers followed by F	4 numbers followed by T	1 letter followed by 4 numbers	4 numbers followed by 1 letter (not F or T)
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter followed by 1 number	1 number followed by 1 letter
Purpose	Professional services, pathology and laboratory tests	Tracking codes to facilitate data collection for tracking performance measurement	Temporary codes for new and emerging technologies	Miscellaneous services, supplies, materials, drugs and professional services	L&I unique services, materials and supplies

CURRENT PROVIDER BULLETINS

Provider Bulletins are temporary communications that give official notification of new or revised rules, laws, coverage decisions, policies, and/or programs that haven't been previously published.

Current Provider Bulletins are available on L&I's web site at

<http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp>.

NOTE: If a Provider Bulletin isn't listed on L&I's web site, it is no longer current or available. Its content was incorporated into coverage decisions, payment policies, and fee schedules.

CURRENT COVERAGE DECISIONS FOR MEDICAL TECHNOLOGIES & PROCEDURES

The following coverage decisions were made by the Office of the Medical Director. See L&I's web site at <http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/default.asp> for more information.

Coverage Decisions for Medical Technologies & Procedures This information is current as of March 16, 2011.

Topic	Covered by workers compensation?			No
	Yes			
	With proper documentation	Only with pre-authorization	On a case-by-case basis	
Acupuncture				X
AquaMED (or dry hydrotherapy)	X			
Artificial disc replacement		X		
Autologous blood injections				X
Autologous chondrocyte implantation (ACI)		X		
Bloodborne pathogens	X			
Bone cements for use during kyphoplasty and vertebroplasty				X
Bone growth stimulators		X		
Bone morphogenic proteins (BMP) for long bone nonunions and spinal fusions		X		
Botulinum toxin		X		

Covered by workers compensation?				
Topic	Yes			No
	With proper documentation	Only with pre-authorization	On a case-by-case basis	
Brevio® Nerve Conduction Testing System				X
Cervical traction devices	X			
Ctrac™ for CTS wrist splint				X
Discography		X		
Dry needling		X		
Duragesic			X	
Electrical Stimulation for Chronic Wounds		X		
Electrodiagnostic Sensory Nerve Conduction Threshold (sNCT)				X
Electrodiagnostic Testing	X			
Epidural adhesiolysis		X		
ERMI Flexionator and Extensionater				X
Extracorporeal Shockwave Therapy (ESWT)				X
Fibromyalgia				X
Futures Unlimited	X			
Hyaluronic acid		X		
IDET (Intradiscal heating)				X
Implantable Drug Delivery Systems			X	
Influenza Claims		X		
Low level laser therapy				X
Knee Arthroscopy (for osteoarthritis of the knee)				X
MedX lumbar extension machine	X			
Meniscal allograft transplantation		X		
Microprocessor-controlled prosthetic knees				X
NC-stat® Nerve Conduction System-NeuroMetrix®				X
Neuromuscular electrical stimulators (NMES)	X (clinical use)	X (home use)		
Otto Bock Vacuum Assisted Socket System				X
Percutaneous Discectomy for Disc Herniation				X
Percutaneous Neuromodulation Therapy for low back pain				X
Posterior Lumbar Interbody Fusion (PLIF)		X		
Powered Traction Devices for Intervertebral Decompression	X			
Quantitative Sensory Testing (QST)				X
Smoking cessation		X		
Spinal Cord Stimulation				X
Standing, Weight-bearing, Positional & Upright™ MRI				X
Transcutaneous, Interferential and Percutaneous Electrical Nerve Stimulators (TENS)				X
Thermal shrinkage for instability				X
Tinnitus Retraining Therapy				X
UniSpacer				X
Wound VAC			X	
X-STOP® interspinous process device				X