

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending provider's order and **prior authorization**. Refer to [WAC 296-20-03001](#) for information on what to include when requesting authorization.

Home biofeedback device rentals are time limited and require **prior authorization**. Refer to [WAC 296-20-1102](#) for the insurers' policy on rental equipment.

Biofeedback treatment is limited to those procedures within the scope of practice of the licensed and approved biofeedback provider administering the service.

[WAC 296-21-280](#) limits provision of biofeedback to those who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also has authorization conditions, treatment limitations and reporting requirements for biofeedback services.

A qualified or certified biofeedback provider as defined in [WAC 296-21-280](#) who isn't licensed as a practitioner as defined in [WAC 296-20-01002](#), may not receive direct payment for biofeedback services. Services may be provided by paraprofessionals as defined in [WAC 296-20-015](#) under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

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.

The following contains the biofeedback codes for approved providers:

CPT [®] /HCPCS Code	Payable to:
90875	L&I approved biofeedback providers who are: clinical psychologists or psychiatrists (MD or DO).
90876	
90901 ⁽¹⁾	Any L&I approved biofeedback provider
90911 ⁽¹⁾	
E0746	DME or pharmacy providers (for rental or purchase). Use of the device in the office isn't separately payable for RBRVS providers.

(1) CPT[®] codes 90901 and 90911 are not time limited and only 1 unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. Use evaluation and management codes for diagnostic evaluation services.

ELECTRODIAGNOSTIC SERVICES

Covered electrodiagnostic testing services

The department or self-insurer **does cover** use of electrodiagnostic testing including nerve conduction studies and needle electromyography only when:

- Proper and necessary and
- Testing meets the requirements described in this policy.

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels. For the complete requirements for appropriate electrodiagnostic testing see <http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/electrodiagnostictesting.asp>.

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.

Physical therapists (PTs) who meet the requirements of Department of Health rules ([WAC 246-915-370](#)) may provide electroneuromyographic tests. PTs performing electrodiagnostic testing must provide documentation of proper DOH licensure to L&I Provider Accounts prior to performing and billing for these services. PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed. Please contact L&I Provider Accounts at (360) 902-5140 for information on where to send proper license documentation.

Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the AANEM recommended number of tests (see Table) may be reviewed for quality and 'proper and necessary'.

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

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. Review of the quality and appropriateness (proper and necessary) may occur when testing repeatedly exceeds AANEM recommendations.

Recommended Maximum Number of Studies by Indication (adapted from AANEM Table 1).

Indication	Needle EMG CPT® 95860- 95864, 95867- 95870	NCS CPT® 95900, 95903, 95904	Other EMG studies CPT® 95934, 95936, 95937		
	# of tests	Motor NCS with and without F- wave	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
Motor neuronopathy (eg, 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	

*Table recreated with written permission from the AANEM.

Non-covered electrodiagnostic testing services

- Testing which isn't proper and necessary per [WAC 296-20-01002](#).
In general, repetitive testing isn't considered proper and necessary except:
 - To document ongoing nerve injury, for example following surgery
 - If required for provision of an impairment rating
 - To document significant changes in clinical condition
- Testing by mobile diagnostic labs, in which the specialist physician isn't present to examine and test the patient.
- Testing with non-covered devices including portable, automated and 'virtual' devices not demonstrated equivalent to traditional lab-based equipment (eg, NC-stat®, Brevio).
- Testing determined to be outside of AANEM recommended guidelines without proper documentation supporting that it is proper and necessary.
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ELECTROCARDIOGRAMS (EKG)

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. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are **not payable with** office services.

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

EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

The insurer **doesn't cover** extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature. Additional information can be found at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/default.asp#s>

VENTILATOR MANAGEMENT SERVICES

The insurer **doesn't pay** for ventilator management services (CPT® codes 94002-94005, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider.

The insurer **pays** for either the ventilation management code or the E/M service, but not both. 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 not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

See [WAC 296-20-03005](#) for work-related exposure to an infectious disease. Immunization materials are payable when authorized.

CPT[®] codes 90471 and 90472 **are payable** in addition to the immunization materials code(s).

Add-on CPT[®] code 90472 may be billed for each additional immunization given.

An E/M code **isn't payable** in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a –25 modifier.

Information on bloodborne pathogens can be found at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Bloodbornepathogens.asp>

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes **are not paid**. The provider bills 1 of the injection codes and 1 of the antigen/antigen preparation codes.

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service.

Exception: Outpatient services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, services (CPT[®] codes 96360, 96361, 96365-96368) **are payable** to physicians, ARNPs, and PAs.

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.

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.

Refer to the [Home Infusion Services](#) section, page **135** for further information on home infusion therapy.

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the code definitions.

Billing instructions for nonpharmacy providers are located in [Injectable Medications](#), page **93** later in this section. Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the [Home Health Services](#) section, page **131** for further information.

The insurer **may cover** with **prior authorization**:

- Implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, E0785 and E0786).
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal.
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, Baclofen).

Placement of nonimplantable epidural or subarachnoid catheters for single or continuous injection of medications **is covered**.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are **not covered** (see [WAC 296-20-03002](#)).

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) are **not covered unless** they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (see [WAC 296-20-03014](#)).

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT® code 96372) **are payable** along with the appropriate HCPCS **J** code for the drug.

E/M office visit services provided on the same day as an injection **may be payable** if the services are separately identifiable.

Separate E/M services (CPT® codes 99212-99215) **must be billed** using a –25 modifier.

CPT® code 99211 **won't be paid** separately and, if billed with the injection code, providers will be **paid only** the E/M service and the appropriate HCPCS **J** code for the drug.

Providers must document the following in the medical record and in the remarks section of the bill:

- Name,
- Strength,
- Dosage and
- Quantity of the drugs administered

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 96373 and 96374) may be billed separately and **are payable** if they are not provided in conjunction with IV infusion therapy services (CPT® codes 96360, 96361, 96365-96368).

NOTE: Injections of narcotics or analgesics **aren't permitted** or paid in the outpatient setting except:

- On an emergency basis (see [WAC 296-20-03014](#))
- For pain management related to outpatient surgical procedures and dressing and cast changes
- For severe soft tissue injuries, burns or fractures.

Dry needling is considered a variant of trigger point injections with medications.

Dry needling 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. Dry needling of trigger points must be billed using CPT® codes 20552 and 20553. Dry needling follows the same rules as trigger point injections in [WAC 296-20-03001\(14\)](#).

The insurer **doesn't cover** acupuncture services (see [WAC 296-20-03002](#)). Additional coverage decision information can be found at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Acupuncture.asp>

Injectable Medications

Providers must use the **J** codes for injectable drugs that are administered during an E/M office visit or other procedure. The **J** codes are not intended for self-administered medications.

Miscellaneous Injectable Medication

When billing for a non-specific injectable drug the following must be noted on the bill and documented in the medical record:

- Name,
- Strength,
- Dosage and
- Quantity of drug administered or dispensed.

Distinct Injectable Medication

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. Divide the total strength of the injected drug by the strength listed in the manual to get the total billable units.

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 is made according to the published fee schedule amount, or the acquisition cost for the **covered** drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

Hyaluronic acid injections are **only allowed** for osteoarthritis of the knee. Other uses are considered experimental, and therefore won't be paid, see [WAC 296-20-03002\(6\)](#).

Hyaluronic acid injections must be billed with CPT® code 20610 and the appropriate HCPCS code.

HCPCS Code	Description	Maximum Fee
J7321	Hyalgan or Supartz inj	\$131.20
J7323	Euflexxa, inj	\$185.45
J7324	Orthovisc, inj	\$243.00
J7325	Synvisc or Synvisc-1, per mg	\$ 15.84

The correct side of body modifier (–RT or –LT) is required for authorization and billing. If bilateral procedures are required, both modifiers must be authorized and each billed as a separate line item.

See more information on hyaluronic acid injections at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/hyaluronicacid.asp>

Non-Injectable Medications

Providers may use distinct **J** codes that describe specific noninjectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The name, strength, dosage and quantity of the drug administered must be documented in the medical record and noted on the bill. Providers must bill their acquisition cost for these drugs. See the [Acquisition Cost Policy](#) in the Supplies, Materials and Bundled Services section, page **136** for more information. No payment will be made for pharmaceutical samples.

The **J** codes aren't intended for self-administered medications.

Miscellaneous oral or noninjectable medications administered during office procedures are considered bundled in the office visit. No separate payment will be made for these medications. The name, strength, dosage and quantity of drug administered or dispensed must be documented in the medical record.

The non-specific HCPCS codes listed below are bundled in the office visit.

HCPCS Code	Brief Description
A9150	Nonprescription drug
J3535	Metered dose inhaler drug
J7599	Immunosuppressive drug, noc
J7699	Noninhalation drug for DME
J8498	Antiemetic drug, rectal/suppository, nos
J8499	Oral prescript drug nonchemo
J8597	Antiemetic drug, oral, nos
J8999	Oral prescription drug chemo

No payment will be made for pharmaceutical samples.

OBESITY TREATMENT

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.

Services for all obesity treatment **require prior authorization**.

To be eligible for obesity treatment, the worker must be severely obese. Severe obesity for the purposes of providing obesity treatment is defined by L&I as a Body Mass Index (BMI) of 35 or greater.

The attending provider may 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, or
 - Participate in physical rehabilitation, or
 - Return to work.

An attending provider who believes a worker may qualify for obesity treatment should contact the insurer. The attending provider will need to advise the insurer of the worker's weight and level of function prior to the injury and how it has changed.

The attending provider must submit medical justification for obesity treatment, including tests, consultations or diagnostic studies that support the request.

The attending provider may request a consultation with a certified dietitian (CD) to determine if an obesity treatment program is appropriate for the worker.

Only CDs will be paid for nutrition counseling services. CDs may bill for authorized services using CPT[®] code 97802 or 97803. Both CPT[®] 97802 and 97803 are billed in 15 minute units.

CPT [®] Code	Limit	Maximum Fee per unit
97802	Initial visit, maximum of 4 units	\$ 52.02
97803	Maximum 2 units per visit with maximum of 3 visits	\$ 45.38

Providers practicing in another state that are similarly certified or licensed may apply to be considered for payment.

Prior to authorizing an obesity treatment program, the attending provider and worker are required to develop a treatment plan and sign an authorization letter. This authorization letter will serve as a memorandum of understanding between the insurer, the worker and the attending provider. The treatment plan will include:

- The amount of weight the worker must lose to undergo surgery.
- Estimated length of time needed for the worker to lose the weight.
- A diet and exercise plan, including a weight loss goal, approved by the attending provider as safe for the worker.
- Specific program or other weight loss method requested.
- The attending provider's plan for monitoring weight loss.
- Documented weekly weigh-ins.
- Group support facilitated by trained staff.
- Counseling and education provided by trained staff.
- No requirements to buy supplements or special foods.

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.
- Exercise programs or exercise equipment.

Upon approval of the obesity treatment plan, the attending provider's role is to:

- Examine the worker, monitor and document their weight loss every 30 days.
- 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.

To ensure continued authorization of the obesity treatment plan the worker must do each of the following:

- Lose **an average** of 1 to 2 pounds a week.
- Regularly attend weekly treatment sessions (meetings and weigh-ins).
- Cooperate with the approved obesity treatment plan.
- Be evaluated by the attending doctor at least every 30 days.
- Pay the joining fee and weekly membership fees up front and get reimbursed.

Send the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

The insurer doesn't pay the obesity treatment provider directly. The worker will be reimbursed for the obesity treatment program using the following codes:

Code	Description	Fee Limits
0440A	Weight loss program, joining fee, worker reimbursement	\$154.77
0441A	Weight loss program, weekly fee, worker reimbursement	\$30.96

The insurer authorizes obesity treatment for up to 90 days at a time as long as the worker does **all** of the above. The insurer stops authorizing obesity treatment when **any one** of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan. (The worker may continue the weight loss program for general health at their own expense).
- Obesity no longer interferes with recovery from the accepted condition. ([WAC 296-20-055](#) prohibits treatment of an unrelated condition once it no longer retards recovery from the accepted condition.)
- The worker isn't cooperating with the approved obesity treatment plan.
- The worker isn't losing weight at **an average** of 1 to 2 pounds each week.

IMPAIRMENT RATING EXAMINATION AND REPORT BY ATTENDING DOCTORS AND CONSULTANTS

Qualified attending providers (AP) may rate impairment of their own patients per [WAC 296-20-2010](#). See table below to determine if you are qualified to provide this service.

Impairment rating should occur during the closing exam. 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.

The AP can ask a consultant to perform the rating examination if the AP is unable or unwilling to perform the rating examination.

APs: See billing codes 1190M, 1191M and 1192M below.

Consultants: See billing codes 1194M and 1195M below.

Which providers may rate impairment?

Provider type - currently licensed in	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

Providers may only give ratings for areas of the body or conditions within their scopes of practice.

- Psychologists may not be an attending provider (except for Crime Victim's claims) and may not rate impairment for injured workers or victims of crime.
- Chiropractors performing impairment ratings must be on L&I's list of approved IME examiners.

For details on this topic, refer to the Medical Examiners' Handbook. To view a copy online go to <http://www.Lni.wa.gov/IPUB/252-001-000.pdf>

Attending providers who are permitted to rate their own patients don't need an IME provider account number and may use their existing provider account number.

For details on this topic, refer to the Attending Doctor's Handbook. To view a copy online go to <http://www.Lni.wa.gov/IPUB/252-004-000.pdf>

When do you perform the impairment rating?

Rate impairment when the worker has reached maximum medical improvement (MMI) or when requested by the insurer.

For what areas of the body do you rate impairment?

Rate impairment for medical conditions accepted under the claim.

Prior authorization is only required when:

- A psychiatric impairment rating is needed.
- An IME is scheduled.
 - For State Fund claims, use our secure, online Claim & Account Center to see if an IME is scheduled. To set up an account go to www.Claiminfo.Lni.wa.gov.
 - For Self-Insured claims, contact the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs, go to: <http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp>
 - For Crime Victims claims call 1-800-762-3716.

How do you rate impairment?

Use the appropriate rating system.

See the [Medical Examiners' Handbook](#) for an overview of systems for rating impairment.

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.
Physical Exam	Pertinent details of the physical examination performed (both positive and negative findings).
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.
Rating	An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example: <ul style="list-style-type: none">• The AMA Guidelines to the Evaluation of Permanent Impairment and the edition used, or• The Washington state category rating system – refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 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.

If there is no impairment, document that in your report. For more details and examples about rating impairment, see the [Medical Examiners' Handbook](#).

Use the most appropriate billing code from the following table:

Code	Description	Maximum Fee
1190M	Impairment rating by attending physician, limited, 1 body area or organ system. Use this code if there is only 1 body area or organ system that needs to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:	\$ 439.50

Code	Description	Maximum Fee
	<ul style="list-style-type: none"> • 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 as requested. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. <p>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.</p>	
1191M	<p>Impairment rating by attending physician, standard, 2-3 body areas or organ systems. Use this code if there are 2-3 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:</p> <ul style="list-style-type: none"> • 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 as requested. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. <p>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.</p>	\$ 493.56
1192M	<p>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:</p> <ul style="list-style-type: none"> • 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 as requested. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. <p>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.</p>	\$ 616.93
1194M	<p>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:</p> <ul style="list-style-type: none"> • 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 as requested. • Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. <p>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.</p>	\$ 493.56

Code	Description	Maximum Fee
1195M	<p>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:</p> <ul style="list-style-type: none"> 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 as requested. Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. <p>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.</p>	\$ 616.93
1198M	<p>Impairment rating, addendum report. Must be requested and authorized by the claim manager.</p> <ul style="list-style-type: none"> Addendum report for additional information which necessitates review of new records. Payable to attending physician or consultant. <p>This code isn't billable when the impairment rating report did not contain all the required elements. (See the Medical Examiners' Handbook for the required elements.)</p>	\$ 113.40

Limited, Standard and Complex Coding

The impairment rating 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. 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 Current Procedural Terminology (CPT®) book must be used to distinguish between limited, standard and complex impairment rating.

The following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity

The following organ systems are recognized:

- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

NOTE: Each extremity is counted once per extremity examined, when determining limited, standard or complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, 2 body areas would be counted.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

Limit on Total Scheduled Exams per Day

L&I has placed a limit of 12 independent medical examinations scheduled per examiner per day. 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
- 1131M IME, out-of-state exam
- 1134M, Late cancellation fee
- 1135M, Late cancellation fee, psychiatrist
- 1136M, IME, two claims included in evaluation
- 1137M, IME, three claims included in evaluation
- 1138M, IME four or more claims included in evaluation

IME Unique Billing Codes

Code	Description	Maximum Fee
1100M	IME, microfiche handling, initial 10 pages of fiche with referral. <ul style="list-style-type: none">• Payable only once per referral.• You may not bill this code if you are provided with a paper copy of the claim record.	\$ 58.82
1101M	IME, microfiche handling, per fiche page beyond 10 <ul style="list-style-type: none">• 1 unit equals 1 microfiche page.• Use code with associated units only once per referral.	\$ 5.89 (per fiche page)
1104M	IME, addendum report. Requested and authorized by claim manager. <ul style="list-style-type: none">• Addendum report for information not requested in original assignment, which necessitates review of records.• Not to be used for review of job analysis or review of diagnostic testing or study results ordered by the examiner.	\$ 113.40
1105M	IME Physical Capacities Estimate. Must be requested by the insurer. Bill under lead examiner's provider account number for multi-examiner exams	\$ 30.27

Code	Description	Maximum Fee
1108M	<p>IME, standard exam – 1-3 body areas or organ systems</p> <ul style="list-style-type: none"> • 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). • An appropriate exam and reporting of an injury or condition limited to 1-3 body areas or organ systems. • Records are reviewed and the report includes a detailed chronology of the injury or condition as described in the Medical Examiners' Handbook. • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. Impairment rating is performed if requested. • The IME 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). • Includes review of up to 2 job analyses. • L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient. • This code can be used by: Single examiners, leads on multi-examiner exams where findings from other examiners are combined into 1 report, & examiners on multi-examiner exams who perform separate file review, exam and standalone reports. <p>Additional examiners who are not leads: Use 1112M. **</p>	\$ 493.56
1109M	<p>IME, complex exam – 4 or more body areas or organ systems</p> <ul style="list-style-type: none"> • 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). • An appropriate exam and reporting of an injury or condition of 4 or more body areas or organ systems. • Records are reviewed and the report includes a detailed chronology of the injury or condition, as described in the Medical Examiners' Handbook. • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed if requested. • 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). • The IME report must contain the required elements noted in the Medical Examiners' Handbook. • Includes review of up to 2 job analyses. • L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the patient. • This code can be used by: Single examiners, leads on multi-examiner exams where findings from other examiners are combined into 1 report, & examiners on multi-examiner exams who perform separate file review, exam and standalone reports. <p>Additional examiners who are not leads: Use 1112M. **</p>	\$ 616.93
1111M	<p>IME, no-show fee, per examiner.</p> <ul style="list-style-type: none"> • Bill only if appointment time cannot be filled • Not payable for no-shows of IME related services (for example, neuropsychological evaluations, performance based PCEs). WAC 296-20-010 	\$ 210.03
1134M	<p>IME late cancellation fee, per examiner</p> <ul style="list-style-type: none"> • Bill only if appointment time cannot be filled and cancellation is within 3 business days of exam. Business days are Monday thru Friday. • Not payable for no-shows of IME related services (for example, neuropsychological evaluations). 	\$ 210.03
1112M	<p>IME, additional examiner for IME</p> <ul style="list-style-type: none"> • Use where input from more than 1 examiner is combined into 1 report. Includes: <ul style="list-style-type: none"> • 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. <p>Note: Lead examiner on IMEs with a combined report should bill a standard or complex exam code (1108M or 1109M).</p>	\$ 439.50

Code	Description	Maximum Fee
1118M	<p>IME by psychiatrist</p> <ul style="list-style-type: none"> Psychiatric diagnostic interview with or without direct observation of a physical exam. 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 includes a detailed chronology of the injury or condition, as described in the Medical Examiners' Handbook. L&I expects that these exams will typically involve at least 60 minutes of face-to-face time with the patient. <ul style="list-style-type: none"> Also includes impairment rating, if applicable. 	\$ 893.15
1120M	<p>IME, no-show fee, psychiatrist</p> <ul style="list-style-type: none"> Bill only if appointment time cannot be filled Not payable for no-shows of IME related services (for example, neuropsychological evaluations). WAC 296-20-010 	\$ 325.56
1135M	<p>IME late cancellation fee, psychiatrist</p> <ul style="list-style-type: none"> <i>Bill only if appointment time cannot be filled and cancellation is within 3 business days</i> of exam. Business days are Monday thru Friday. Not payable for no-shows of IME related services (for example, neuropsychological evaluations). 	\$ 325.56
1122M	<p>Impairment rating by an approved pain program</p> <ul style="list-style-type: none"> 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. See WAC 296-20-2010. The rating report must include at least the following elements as described in the Medical Examiners' Handbook: <ul style="list-style-type: none"> MMI (maximum medical improvement) Physical exam Diagnostic tests Rating Rationale 	\$ 493.56
1123M	<p>IME, communication issues</p> <ul style="list-style-type: none"> 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. Not payable with a no-show fee (1111M or 1120M). 	\$ 198.48
1124M	<p>IME, other, by report</p> <ul style="list-style-type: none"> Requires preauthorization and prepay review. For State Fund claims call Provider Review and Education at 360-902-6818. For self-insured claims contact the self-insured employer or third party administrator. 	By Report

Code	Description	Maximum Fee
1125M	<p>Physician travel per mile</p> <ul style="list-style-type: none"> Allowed when roundtrip exceeds 14 miles. Code usage is limited to extremely rare circumstances. Requires preauthorization and prepay review. For State Fund claims call Provider Review and Education at 360-902-6818. For self-insured claims contact the self-insured employer or third party administrator. 	\$ 4.84
1128M	<p>Occupational disease history.</p> <ul style="list-style-type: none"> Must be requested by insurer. Occupational carpal tunnel syndrome, noise-induced hearing loss, occupational dermatitis, and occupational asthma are examples of conditions which L&I considers occupational diseases. 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. 	\$ 183.56
1129M	<p>IME, extensive file review by examiner</p> <ul style="list-style-type: none"> 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. Not payable with 1111M or 1120M. Only the following document categories will be paid for unless the authorizing letter requests a review of ALL documents: <ul style="list-style-type: none"> Medical files History Report of Accident Re-open Application Other documents specified by claim manager or requestor Bill per examiner Bill for unique documents not duplicates. Payment will not be made for review of duplicate documents. <p>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.</p>	\$ 1.00
1130M	<p>IME, terminated exam</p> <ul style="list-style-type: none"> Bill for exam ended prior to completion. Requires file review, partial exam and report (including reasons for early termination of exam). 	\$ 351.59
1131M	IME, out-of-state exam	by report
1132M	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Report of Accident Re-open application History Medical files Other documents specified by claim manager or requestor <p>NOTE: This fee isn't payable if paper copies of records are provided.</p>	\$ 0.07 per printed page

Code	Description	Maximum Fee
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.	\$ 58.82
1139M	IME, no show fee for missed neuropsychological testing. <ul style="list-style-type: none"> • Must be scheduled or approved by department or self-insurer as part of an independent medical examination. Authority: 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 appointment cannot be filled. 	\$882.56
1140M	IME, no show fee for missed PCE. <ul style="list-style-type: none"> • Must be scheduled or approved by department or self-insurer as part of an independent medical examination. Authority: 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 appointment cannot be filled. 	\$282.31
Modifier -7N	X-rays and laboratory services in conjunction with an IME. <ul style="list-style-type: none"> • When X-rays, laboratory and other diagnostic tests are provided with an exam, identify the service(s) by adding the modifier – 7N to the usual procedure number. Procedure codes are listed in the L&I Fee Schedules, Radiology and Laboratory Sections. 	N/A

Multiple Claim Codes

1136M	IME, Two claims included in evaluation. <ul style="list-style-type: none"> • 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 should not be reported as a stand-alone code. • Bill once per examiner. NOTE: This must be pre-authorized by state fund claim manager or self-insured employer/third party administrator.	\$100.00
1137M	IME, Three claims included in evaluation. <ul style="list-style-type: none"> • 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 should not be reported as a stand-alone code. • Bill once per examiner. NOTE: This must be pre-authorized by state fund claim manager or self-insured employer/third party administrator.	\$200.00
1138M	IME, Four or more claims included in evaluation. <ul style="list-style-type: none"> • 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 should not be reported as a stand-alone code. • Bill once per examiner. NOTE: This must be pre-authorized by state fund claim manager or self-insured employer/third party administrator.	\$300.00

Billing State Fund (L&I) for In-State IMEs

For IMEs performed in Washington State, examiners need 1 IME provider account number for each payee they wish to designate.

An IME examiner not working through any IME firms will need just 1 IME number, which will also serve as their payee number.

HOW IME FIRMS MUST BILL FOR IMES CONDUCTED IN WASHINGTON STATE

The chart below shows which provider account number and/or National Provider Identifier (NPI) to use in 24J of the CMS 1500 form based on the IME service provided. The NPI must be registered with the department.

Use only the IME examiner’s provider account number/NPI for these codes:		Use only the IME firm provider account number/NPI for these codes:	The following codes may be billed by the IME examiner, the IME firm, or by the performing provider.
1028M	1118M	1100M	1124M
1038M	1120M	1101M	CPT® Code 90801
1048M	1123M	1132M	CPT® Codes 96101, 96102
1066M	1125M	1133M	CPT® Codes 96118, 96119
1104M 1105M	1128M		X-ray, diagnostic laboratory tests in conjunction with IME (Use modifier -7N.)
1108M	1129M		1045M
1109M	1130M		
1111M 1112M 1134M 1135M 1136M 1137M 1138M	CPT® Codes 99441-99443		

NOTE: On CMS-1500, IME firms may use their own provider account number (box 33b) and/or NPI (box 33a) as the “payee” although it isn’t required if the same provider account number /NPI is in box 24J.

Billing for Out-of-State IMEs

A separate provider account number is required for IMEs conducted outside of Washington State.

IME examiners must meet L&I's criteria for approved examiners.

IME examiners must be approved by L&I. To obtain the procedures and an IME provider application, go to <http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/IME/default.asp>.

When you submit your application include a copy of the doctor's license for the state where the exam will be conducted and current curriculum vitae (CV).

Firms will not be required to put the examiner provider account number on State Fund bills.

Bills for out-of-state IMEs must contain the IME firm's provider account number in box 33b of the CMS-1500 bill form.

Bill your usual and customary fees.

Use billing code 1131M for all services, **except** 1100M and 1101M, and the CPT[®] codes for neuropsychological evaluation and testing. Combine all 1131M charges into one line-item on your bill. Also use 1131M for activities occurring after the IME, such as addendums.

L&I and self insurers will reimburse 1131M by report.

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. 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.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity

The following **organ systems** are recognized:

- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Respiratory
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

NOTE: Each extremity is counted once per extremity examined, when determining standard or complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, 2 body areas would be counted.

General Information

Only doctors with an IME provider account number can bill IME codes. To obtain an application, go to <http://www.Lni.wa.gov/forms/pdf/245046af.pdf>

Or, for Crime Victims contact the Crime Victims Compensation Program Provider Registration desk at 360-902-5377.

For more information on becoming an approved IME provider or to perform impairment ratings, please see the *Medical Examiners' Handbook* at <http://www.Lni.wa.gov/IPUB/252-001-000.pdf>