

Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in Provider Bulletins.

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 CPT[®] and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence ([WAC 296-20-010](#)). All policies in this document apply to workers or crime victims receiving benefits from the State Fund, the Crime Victims Compensation Program and self-insurers unless otherwise noted.

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.

Copyright Information

Physicians' Current Procedural Terminology (CPT®) 5-digit codes, descriptions, and other data only are copyright 2010 American Medical Association. All Rights Reserved.

No fee schedules, basic units, relative values or related listings are included in CPT.

AMA does not directly or indirectly practice medicine or dispense medical services.

AMA assumes no liability for data contained or not contained herein.

CPT® is a registered trademark of the American Medical Association.

This document is also on L&I's Internet site

<http://feeschedules.Lni.wa.gov/>

Updates to this manual can be found on L&I's web site

<http://feeschedules.Lni.wa.gov/>

Updates to this manual are also announced on the Medical Provider e-News listserv. Individuals may join the listserv at

<http://www.Lni.wa.gov/Main/Listservs/Provider.asp>.

PROFESSIONAL SERVICES TABLE OF CONTENTS

General Information	33
Covered Services.....	33
Physician Assistants	33
Units of Service.....	33
Unlisted Codes.....	33
Washington RBRVS Payment System and Policies	34
Basis for Calculating RBRVS Payment Levels	34
Site of Service Payment Differential	35
Evaluation and Management Services (E/M)	37
New and Established Patient	37
Medical Care in the Home or Nursing Home	37
Prolonged Evaluation and Management	37
Using the –25 Modifier	38
Split Billing	38
Standby Services	39
Case Management Services	40
Care Plan Oversight	44
Teleconsultations and other Telehealth Services	44
End Stage Renal Disease (ESRD).....	45
Surgery Services	46
Global Surgery Policy	46
Pre, Intra, or Postoperative Services.....	47
Minor Surgical Procedures.....	47
Standard Multiple Surgery Policy	48
Bilateral Procedures Policy	48
Endoscopy Procedures Policy.....	49
Microsurgery	51
Spinal Injection Policy	52
Registered Nurses as Surgical Assistants.....	54
Procedures Performed in a Physician’s Office.....	54
Miscellaneous	54
Anesthesia Services	57
Noncovered and Bundled Services	57
Certified Registered Nurse Anesthetists.....	57
Medical Direction of Anesthesia (Team Care)	57
Anesthesia Services Paid with Base and Time Units	59
Anesthesia Add-On Codes.....	60
Anesthesia Services Paid with RBRVS	61
Radiology Services	62
Definitions.....	62
X-ray Services.....	62
Consultation Services	63
Contrast Material.....	65
Nuclear Medicine	65

Physical Medicine Services	66
General Information	66
Physical Medicine and Rehabilitation (Physiatry)	66
Nonboard Certified/Qualified Physical Medicine Providers	66
Physical and Occupational Therapy	66
Physical Capacities Evaluation	68
Massage Therapy	69
Work Hardening	73
Osteopathic Manipulative Treatment.....	75
Electrical Nerve Stimulators	76
Chiropractic Services	78
Psychiatric Services	84
Providers of Psychiatric Services	84
Psychiatrists as Attending Physicians	84
Noncovered and Bundled Services	85
Psychiatric Consultations and Evaluations	85
Case Management Services	85
Individual Insight Oriented Psychotherapy	85
Use of CPT® Evaluation and Management Codes for Office Visits	86
Pharmacological Evaluation and Management.....	86
Neuropsychological Testing	86
Group Psychotherapy Services	87
Narcosynthesis and Electroconvulsive Therapy	87
Other Medicine Services	88
Biofeedback.....	88
Electrodiagnostic Services	88
Electrocardiograms (EKG)	90
Extracorporeal Shockwave Therapy (ESWT)	Error! Bookmark not defined.
Ventilator Management Services	90
Medication Administration	91
Obesity Treatment	95
Impairment Rating by Attending Doctors and Consultants	97
Independent Medical Examinations.....	101
Naturopathic Physician	108
Pathology and Laboratory Services	109
Panel Tests.....	109
Repeat Tests	111
Drug Screens	111
Specimen Collection and Handling.....	112
Stat Lab Fees	112
Testing For and Treatment of Bloodborne Pathogens	114
Pharmacy	116
Pharmacy Fee Schedule.....	116
Coverage Policy.....	116
Obtaining Authorization for Nonpreferred Drugs.....	117
NCPDP V5.1 Payer Sheet.....	117
Emergency Contraceptives and Pharmacist Counseling	119
Infusion Therapy Services.....	119
Third Party Billing for Pharmacy Services	118

Durable Medical Equipment	120
Rental or Purchase Requirements	120
Oxygen Equipment	122
Repairs and Maintenance	123
Prosthetic and Orthotic Services	123
Bundled Codes	124
Dental Services	126
Preexisting Conditions	126
Billing Rules	126
Treatment Plan Submission	127
Prior Authorization Review	127
Self-insurers Treatment Plan Procedures.....	128
Documentation and Record Keeping Requirements.....	129
Home Health Services	131
Attendant Services.....	131
Home Health Services	134
Home Infusion Therapy Services	135
Supplies, Materials and Bundled Services	135
Acquisition Cost Policy.....	136
Casting Materials	136
Miscellaneous Supplies.....	136
Catheterization.....	137
Surgical Trays and Supplies Used in the Physician's Office	137
Surgical Dressings Dispensed for Home Use.....	137
Hot and Cold Packs or Devices.....	139
Ambulance Services	140
General Information	140
Vehicle and Crew Requirements	140
Payment Policies for Ambulance Related Services	140
Ambulance Services Fee Schedule.....	142
Audiology and Hearing Services	143
Authorization Requirements	143
Authorized Hearing Aids	143
Payment for Audiology Services	144
Repairs and Replacement.....	146
Documentation Requirements.....	148
Advertising Limits.....	149
Billing Requirements	149
Authorized Fees.....	150
Fee Schedule.....	151
Interpretive Services	153
Policy Application.....	153
Covered and Noncovered Services.....	153
Credential Requirements	154
Prior Auth Requirements.....	156
Fees.....	158
Billing Information	158
Documentation Requirements.....	161
Standards of Conduct	162
Other Services	167
After Hours Services	167

Medical Testimony and Depositions	167
Nurse Case Management	169
Reports and Forms	171
Copies of Medical Records	172
Provider Mileage	173
Review of Job Offers and Job Analyses	173
Vehicle, Home and Job Modifications	174
Vocational Services	177
Billing Codes by Referral Type	177
Other Billing Codes	178
Fee Caps	180
Additional Requirements	181

GENERAL INFORMATION

COVERED SERVICES

L&I makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a **covered** benefit.

Procedure codes listed as **not covered** in the fee schedules aren't **covered** for the following reasons:

1. The treatment isn't safe or effective; or is controversial, obsolete, investigational or experimental.
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
3. The procedure or service is payable under another code.

The insurer may pay for procedures in the first 2 categories above on a case-by-case basis. The health care provider must:

- Submit a written request and
- Obtain approval from the insurer prior to performing any procedure in these categories.

The request must contain:

- The reason,
- The potential risks and expected benefits,
- The relationship to the accepted condition and
- Any additional information about the procedure that may be requested by the insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections [-01505](#), [-02700](#) through [-02850](#), [-030](#), [-03001](#), [-03002](#) and [-1102](#).

UNITS OF SERVICE

Payment for billing codes that don't specify a time increment or unit of measure is limited to 1 unit per day. For example, only 1 unit is payable for CPT[®] code 97022 regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that doesn't have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter [296-20](#) WAC (including the definition section) and to the fee schedules for additional information.

PHYSICIAN ASSISTANTS

Physician assistants (PAs) must be certified and have valid individual L&I provider account numbers to be paid for services. PAs must bill for services using their provider account numbers. PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of MARFS. For example, to bill for Assistant at Surgery, the PA would use modifier –80, –81 or –82 as appropriate.

Physician assistants may sign any documentation required by the department. Consultations and impairment ratings services related to workers' compensation benefit determinations aren't payable to physician assistants as specified in [RCW 51.28.100](#) and [WAC 296-20-01501](#).

Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee. For more information about physician assistant services and payment, see [WAC 296-20-12501](#) and [WAC 296-20-01501](#).

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

L&I uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. These services have a fee schedule indicator (FSI) of R in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on:

- Relative value units (RVUs),
- Geographic adjustment factors for Washington State and
- A conversion factor.

The maximum fee for a procedure is obtained by multiplying the adjusted RVU by the conversion factor. The maximum fees are published as dollar values in the Professional Services Fee Schedule.

Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

- The work,
- Practice expense and
- Liability insurance (malpractice expense).

A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4. Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU described below.

The conversion factor is published in [WAC 296-20-135](#). It has the same value for all services priced according to the RBRVS. L&I may annually adjust the conversion factor by a process defined in [WAC 296-20-132](#).

Two state agencies, L&I and Department of Social and Health Services (DSHS), use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2011 Medicare Physician Fee Schedule Database (MPFSDB), which was published by CMS in the January 11, 2011 *Federal Register*. The *Federal Register* can be accessed online at <http://www.gpoaccess.gov/fr/index.html> or can be purchased from the U.S. government in hard copy, microfiche or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents or <http://bookstore.gpo.gov/>
PO Box 371954
Pittsburgh, PA 15250-7954

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2011 are:

- 100.4% of the work component RVU,
- 102.2% of the practice expense RVU and
- 77.4% of the malpractice RVU.

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor,
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth,
3. Multiply the rounded sum by L&I's RBRVS conversion factor (published in [WAC 296-20-135](#)) and round to the nearest penny.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy. The insurer will pay professional services at the RBRVS rates for facility and nonfacility settings based on where the service was performed. Therefore, it is important to **include a valid 2-digit place of service code on your bill**.

The maximum fees for facility and nonfacility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the insurer makes 2 payments, one to the professional provider and another to the facility. The payment to the facility includes:

- Resource costs such as labor,
- Medical supplies and
- Medical equipment.

To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for professional services in facility settings.

Professional services billed with the following place of service codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgery center
25	Birth center
26	Military treatment facility
31	Skilled nursing facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
99	Other unlisted facility
(none)	(Place of service code not supplied)

Billing Tip

Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Services Paid at the RBRVS Rate for Nonfacility Settings

When services are provided in nonfacility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for nonfacility settings.

Professional services will be paid at the RBRVS rate for nonfacility settings when the insurer doesn't make a separate payment to a facility. The following place of service codes will be paid at the rate for nonfacility settings:

Place of Service Code	Place of Service Description
01	Pharmacy
03	School
04	Homeless shelter
09	Correctional facility
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
16	Temporary lodging
17	Walk-in retail health clinic
20	Urgent care facility
32	Nursing facility
33	Custodial care facility
49	Independent clinic
50	Federally qualified health center
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
57	Nonresidential substance abuse treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory

Billing Tip

When the insurer doesn't make a separate payment directly to the provider of the professional service, the facility will be paid for the service at the RBRVS rate for nonfacility settings. Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

DOCUMENTATION AND BILLING

The history, examination and decision making are the key components in determining the level of E/M service to bill. Providers must use one of the following guidelines to determine the appropriate level of service.

The *1995 Documentation Guidelines for Evaluation & Management Services* available at www.cms.hhs.gov/MLNProducts/Downloads/1995dq.pdf

or

The *1997 Documentation Guidelines for Evaluation and Management Services* available at www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf

Chart notes must contain documentation that justifies the level of service billed.

NEW AND ESTABLISHED PATIENT

L&I uses the CPT® definitions of new and established patients. If a patient presents with a work related condition and meets the definition in a provider's practice as

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

MEDICAL CARE IN THE HOME OR NURSING HOME

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

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

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and 1 of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99304-99310
99357	99356 and 1 of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact are bundled and aren't payable in addition to other E/M codes. Refer to the above CMS websites for more information.

A report is required when billing for prolonged evaluation and management services. See Appendix G for additional information.

USING THE –25 MODIFIER

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

Modifier –25 must be reported in the following circumstances to be paid:

- Same patient, same day encounter, and
- Same or separate visit, and
- Same provider, and
- Patient condition required a “significant separately identifiable E/M service above and beyond the usual pre and post care” related with the procedure or service.
- Scheduling back-to-back appointments doesn’t meet the criteria for using the –25 modifier.

Example 1:

A worker goes to an osteopathic physician’s office to be treated for back pain. The physician:

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

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

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

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

Example 2:

A worker goes to a physician’s office for a scheduled follow up visit for a work related injury. During the examination, the physician determines that the worker’s condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection was not scheduled previously as part of the E/M visit.

The physician gives the injection during the visit. This is a significant separately identifiable procedure performed at the time of the E/M service. For the same time and date of service, the physician may bill the appropriate:

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

Example 3:

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

The provider sees the patient for a second office visit. Since the 2 visits were completely separate, both E/M services may be billed.

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

TREATING 2 SEPARATE CONDITIONS/SPLIT BILLING POLICY

If the worker is treated for 2 separate conditions at the same visit, the charge for the service must be divided equally between the payers. If evaluation and treatment of the 2 injuries increases the complexity of the visit, a higher level E/M code might be billed. If this is the case, CPT® guidelines must be followed and the documentation must support the level of service

billed. A physician would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day (see the Example 3 above). **Scheduling back-to-back appointments doesn't meet the criteria for using the -25 modifier.**

Separate chart notes and reports must be submitted when there are 2 different claims. The claims may be from injuries sustained while working for 2 different employers and the employers only have the right to information about injuries they are responsible for.

Billing Tip

List all workers' compensation claims treated in Box 11 of the CMS-1500 form when submitting paper bills to L&I and in the remarks section when submitting electronic claims. L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition, providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

Example 1:

A worker goes to a provider to be treated for a work related shoulder injury and a separate work related knee injury. The provider treats both work related injuries. For State Fund claims, the provider bills L&I for 1 visit listing both workers' compensation claims in Box 11 of the CMS-1500 form. L&I will divide charges equally to the claims. For self-insured claims, contact the SIE or their TPA for billing instructions.

Example 2:

A worker goes to a provider's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident. The provider would bill 50% of his usual and customary fee to L&I or the SIE and 50% to the insurance company paying for the motor vehicle accident. L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

STANDBY SERVICES

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

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

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30 minute period downward. A report is required when billing for standby services.

CASE MANAGEMENT SERVICES

Team Conferences

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

- An interdisciplinary team of health professionals
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- L&I medical consultants
- SIEs/TPAs
- Physical and occupational therapists and speech-language pathologists

Billing codes

Patient status	CPT® code (Physicians)	CPT® code (Nonphysicians)
Patient present	Appropriate level E&M	99366
Patient not present	99367	99368

Multiple units of 99366, 99367 and 99368 may be billed for conferences exceeding 30 minutes:

Duration of conference	Units billed
Up to 30 minutes	1 unit
Up to 60 minutes	2 units

Physical and Occupational Therapists

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

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

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

To be paid for the conference the therapists must:

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

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

Telephone Calls

Telephone calls are payable to the attending provider, consultant, psychologist or other provider only when they personally participate in the call. These services are payable when discussing or coordinating care or treatment with:

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

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

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

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

ARNPs, PAs, psychologists, PTs and OTs must bill using nonphysician codes.

Telephone calls for authorization, resolution of billing issues or ordering prescriptions **aren't payable**.

Duration	CPT® code (Physicians)	CPT® code (Nonphysicians)
1-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968

Documentation Requirements

Documentation for case management services (team conferences and telephone calls) must include:

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

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

Team conference documentation must also include a goal-oriented, time-limited treatment plan covering:

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

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

Online Communications and Consultations

Electronic online communications (e-mail) with the worker are payable only when personally made by the attending provider, consultant, psychologist or physical or occupational therapist who has an existing relationship with the worker.

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

- The American Medical Association
- The Federation of State Medical Boards
- The eRisk Working Group for Healthcare

Services payable for communications with workers include:

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

Services not payable include:

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

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

- L&I staff
- Vocational rehabilitation counselors
- Case managers
- L&I medical consultants
- TPAs
- Employers

Documentation Requirements

Documentation for electronic communications must include:

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

Provider and CPT® code	Nonfacility fee	Facility fee
Physician - 99444	\$43.17	\$40.95
Nonphysician - 98969	\$43.17	\$40.95

CARE PLAN OVERSIGHT

The insurer allows separate payment for care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to 1 per attending provider, per patient, per 30 day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30 day period are considered part of E/M services and **aren't** separately payable.

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

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

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS AND OTHER TELEHEALTH SERVICES

L&I adopted a modified version of CMS's policy on teleconsultations and other telehealth services. Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient and consultant.

Coverage of Teleconsultations

Teleconsultations **are covered** in the same manner as face-to-face consultations (refer to [WACs 296-20-045](#) and [-051](#)), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in [WAC 296-20-01002](#) or a PhD Clinical Psychologist. A consulting DC must be an approved consultant with L&I; and
- The **referring provider** must be 1 of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The exam of the patient must be under the control of the consultant; and
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who isn't the attending must consult with the attending provider before making the referral.

Coverage of other Telehealth Services

Other procedures and office visits that are covered include:

- Follow up visits after the initial consultation
- Psychiatric intake and evaluation
- Individual psychotherapy
- Pharmacologic management
- End stage renal disease (ESRD) services
- Team conferences

Payment of Teleconsultations and other Telehealth Services

Providers

Teleconsultations and telehealth services are paid in the same manner as face-to-face visits. The insurers will pay according to the following criteria:

- Providers must append a **GT** modifier to 1 of the appropriate services listed in the table below.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the insurer.

Providers may bill these services:
Consultation codes
Office or other outpatient visits
Psychiatric intake and assessment
Individual psychotherapy
Pharmacologic management
End stage renal disease (ESRD) services
Team conferences

Originating Facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment. Bill for these services with HCPCS code:

Q3014 \$34.19

The insurer will only pay for a professional service by the referring provider if it is a separately identifiable service provided on the same day as the telehealth service.

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

Telemedicine Services Not Covered

Procedures and services **not covered** include:

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

END STAGE RENAL DISEASE (ESRD)

L&I follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99307-99310) **aren't payable** on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

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

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

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the Fol-Up column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- The following services:
 - Dressing changes;
 - Local incisional care and removal of operative packs;
 - Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
 - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes;
 - Change and removal of tracheostomy tubes; and
 - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

NOTE: Casting materials **aren't** part of the global surgery policy and are paid separately.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the patient; identified by modifiers –56, –54 and –55)
- Assistant surgeon (identified by modifiers –80, –81 and –82)
- 2 surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT® codes, unless modifier –22, –24, –25, –57, –58, –78 or –79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99304-99310	92012-92014
99218-99220	99315-99318	
99231-99239	99334-99337	
99291-99292	99347-99350	

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (for example, they aren't payable for scheduled hospital admissions).

Codes that are considered bundled **aren't payable** during the global surgery follow-up period.

Services and Supplies Not Included in the Global Surgery Policy

- The initial consultation or evaluation by the surgeon to determine the need for surgery.
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care.
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications.
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Distinct surgical procedures during the postoperative period which aren't re-operations or treatment for complications (A new postoperative period begins with the subsequent procedure.)
- Treatment for postoperative complications which requires a return trip to the operating room.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunotherapy management for organ transplants.
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the provider.

PRE, INTRA OR POSTOPERATIVE SERVICES

The insurer will allow separate payment when different providers perform the preoperative, intraoperative or postoperative components of the surgery. The modifiers (-54, -55 or -56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another provider for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both providers.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the postoperative period and modifier -24 is used, or
- The provider who performs the procedure is seeing the patient for the first time an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier -25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

Modifier -57, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

Modifier -57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

- **100%** of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.
- **50%** of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

More than 5 procedures require documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the patient on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures.
- Other modifier policies.
- Standard multiple surgery policy.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as 2 line items. Modifier –50 must be applied to the second line item. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum. Bilateral procedures are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.



Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (nonfacility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	\$678.47		\$678.47 ⁽¹⁾
2	64721-50	\$678.47	\$339.24 ⁽²⁾	\$339.24
Total Allowed Amount in Nonfacility Setting:				\$1017.71 ⁽³⁾

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
- (3) Represents total allowable amount.

Example: Bilateral Procedure and Multiple Procedures

Line Item	CPT® Code/Mod	Max Payment (nonfac setting)	Bilateral Applied	Multiple Applied	Allowed Amount
1	63042	\$2,068.61			\$2,068.61 ⁽¹⁾
2	63042-50	\$2,068.61	\$1,034.31 ⁽²⁾		\$1,034.31
					subtotal \$3,102.92 ⁽³⁾
3	22612-51	\$2,543.98		\$1,271.99 ⁽⁴⁾	\$1,271.99
Total Allowed Amount in Nonfacility Setting:					\$4,374.91 ⁽⁵⁾

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
- (3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.
- (4) The third line item billed with modifier –51 is paid at 50% of the maximum payment.
- (5) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, endoscopy will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, Endoscopy Families.

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. The endoscopy procedure with the highest dollar value is 100% of the fee schedule value.
2. For subsequent endoscopy procedures, payment is the difference between the family member and the base fee.
3. When the fee for the family member is less than the base fee, the payment is \$0.00 (see Example 2).
4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group. If more than 1 endoscopic group or other nonendoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4).

Multiple endoscopies that aren't related (Each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example 1: 2 Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base ⁽¹⁾	29805	\$ 751.52	\$ 000.00 ⁽²⁾	
1	29822	\$ 918.64	\$ 167.12 ⁽⁴⁾	\$ 167.12 ⁽⁵⁾
2	29826	\$ 1,068.06	\$ 1,068.06 ⁽³⁾	\$ 1,068.06 ⁽⁵⁾
Total Allowed Amount in Nonfacility Setting:				\$ 1,235.18 ⁽⁶⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Payment isn't allowed for a base code when a family member is billed.
- (3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
- (4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
- (5) Amount allowed under the endoscopy policy.
- (6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only 1 family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member with Fee Less than Base Procedure

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base ⁽¹⁾	43235	\$488.65		
1	43241	\$ 253.22	\$ 000.00 ⁽²⁾	
2	43251	\$ 359.16	\$ 359.16 ⁽³⁾	\$ 359.16 ⁽⁴⁾
Total Allowed Amount in Nonfacility Setting:				\$ 359.16 ⁽⁵⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
- (3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to \$0.00.
- (4) Allowed amount under the endoscopy policy.
- (5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

Example 3: 2 Surgical Procedures Billed with an Endoscopic Group (highest fee)

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	\$ 260.65		\$ 130.33 ⁽⁵⁾
2	11406	\$ 481.46		\$ 240.73 ⁽⁵⁾
Base ⁽¹⁾	29830	\$ 724.95		
3	29835	\$ 808.52	\$ 83.57 ⁽³⁾	\$ 83.57 ⁽⁴⁾
4	29838	\$ 946.87	\$ 946.87 ⁽²⁾	\$ 946.87 ⁽⁴⁾
Total Allowed Amount in Nonfacility Setting:				\$ 1401.50 ⁽⁶⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
- (3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
- (4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
- (5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
- (6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: 1 Surgical Procedure (highest fee) Billed with an Endoscopic Group

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	23412	\$ 1,370.22		\$ 1,370.22 ⁽⁴⁾
Base ⁽¹⁾	29805	\$ 751.52		
3	29826	\$ 1,068.06	\$ 316.54 ⁽³⁾	\$ 158.27 ⁽⁵⁾
4	29824	\$ 1,078.02	\$1,078.02 ⁽²⁾	\$ 539.01 ⁽⁵⁾
Total Allowed Amount in Nonfacility Setting:				\$ 2,067.50 ⁽⁶⁾

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
- (3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
- (4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
- (5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
- (6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

CPT® code 69990 isn't payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 can't be billed with CPT® code 31535 because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT® Code	CPT® Code	CPT® Code	CPT® Code
15756-15758	26551-26554	31561	63075-63078
15842	26556	31571	64727
19364	31526	43116	64820-64823
19368	31531	43496	65091-68850
20955-20962	31536	49906	
20969-20973	31541-31546	61548	

SPINAL INJECTION POLICY

Injection procedures are divided into 4 categories; injection procedures that:

1. Require fluoroscopy.
2. Injections that include fluoroscopy or CT guidance in their descriptions.
3. May be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they aren't performed at a certified or accredited facility.
4. Don't require fluoroscopy.

Definition of Certified or Accredited Facility

L&I defines a certified or accredited facility as a facility or office that has certification or accreditation from 1 of the following organizations:

1. Medicare (CMS - Centers for Medicare and Medicaid Services)
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Accreditation Association for Ambulatory Health Care (AAAHC)
4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
5. American Osteopathic Association (AOA)
6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT® Code	CPT® Fluoroscopy Codes ^{(1),(2)}
62268	77002, 77012, 76942
62269	77002, 77012, 76942
62281	77003, 72275
62282	77003, 72275
62284	77003, 77012, 76942, 72240, 72255, 72265, 72270
62290	72295
62291	72285
62292	72295
62294	77002, 77003, 77012, 75705
62310	77003, 72275
62311	77003, 72275
62318	77003, 72275
62319	77003, 72275

- (1) One of these fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.
- (2) Only 1 of these codes may be billed for each injection.

Spinal Injection Procedures that Include Fluoroscopy, Ultrasound or CT in the Description

Paravertebral facet joint injections now include fluoroscopic or CT guidance as part of the description. Fluoroscopic, ultrasound or CT guidance can't be billed separately.

CPT® Code	CPT® Code
64479	0213T
64480	0214T
64483	0215T
64484	0216T
64490	0217T
64491	0218T
64492	0228T
64493	0229T
64494	0230T
64495	0231T

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a provider with privileges to perform the procedure at that facility. The provider must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code
62310
62311
62318
62319

Spinal Injection Procedures that Don't Require Fluoroscopy

CPT® Code
62270
62272
62273

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection ⁽³⁾	-26 Component of Professional Services Fee Schedule
	Radiology	-26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	-TC Component of Professional Services Fee Schedule
Hospital ⁽¹⁾	Injection	APC or POAC
	Radiology ⁽²⁾	APC or -TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	-TC Component is a bundled service

- (1) Payment method depends on a hospital's classification.
- (2) Radiology codes may be packaged with the injection procedure.
- (3) A separate payment for the injection **won't be made** when computed tomography is used for imaging unless documentation demonstrating medical necessity is provided.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application.

1. A photocopy of her/his valid and current registered nurse license, and
2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is 90% of the allowed fee that would be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Procedures performed in a provider's office are paid at nonfacility rates that include office expenses. Modifier –SU denotes the use of facility and equipment while performing a procedure in a provider's office. Services billed with an –SU modifier aren't covered.

Providers' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter [296-23B WAC](#) for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies CPT® code 35400 is limited to only 1 unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The insurer **may cover** autologous chondrocyte implant (ACI) when all of the guidelines are met. ACI requires **prior authorization**.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have received training through Genzyme Biosurgery and
- Have performed or assisted with 5 ACI procedures or
- Perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

The appropriate CPT® code for the implant is 27412. Use CPT® code 29870 for harvesting the chondrocytes.

If the procedure is authorized, the insurer will pay US Bioservices for Carticel® (autologous cultured chondrocytes). For more information, go to

<http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/autoChondImplant.asp>

Bone Morphogenic Protein

The insurer **may cover** the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at 1 level from L4-S1.

CPT® codes used depend on the specific procedure being performed.

All of the criteria and guidelines must be met before the insurer will authorize the procedures. For more information, go to

<http://www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonemorphogenics.asp>

In addition, lumbar fusion guidelines must be met. For more information, go to <http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/TreatGuide/default.asp>

Bone Growth Stimulators

The insurer, with **prior authorization**, pays for bone growth stimulators for specific conditions when proper and necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, and
- Implanted electrical stimulators that supply a direct current to the bone.

For more information, go to

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

Billing Codes for Bone Growth Stimulators

Billing Code	Description	Prior Auth.
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal application	Required
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal application	Required
E0749	Osteogenesis stimulator, electrical (surgically implanted)	Required
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Required

Botulinum Toxin

The insurer covers botulinum toxin injections (Botox[®]: BTX-A, Myobloc[®]: BTX-B) **with prior authorization** for the following indications when it is proper and necessary:

- Blepharospasm
- Primary axillary hyperhidrosis
- Cervical dystonia (spasmodic torticollis)
- Strabismus
- Hemifacial spasm
- Torsion dystonia (idiopathic/symptomatic)
- Laryngeal or spasmodic dysphonia
- Torticollis, unspecified
- Orofacial dyskinesia
- Writer's cramp
- Oromandibular dystonia

Patients must have failed conservative treatment such as other medications and physical therapy before Botox will be authorized.

Noncovered Indications

The insurer won't authorize payment for BTX injections for other off-label indications.

Criteria for Additional Injections

The insurer may authorize 1 subsequent injection session administered 90 days after the initial session if the first BTX session produced an adequate, functional response. Providers must submit documents describing the patient's response to BTX following a session of injections. No more than 2 injections per individual will be authorized due to risk of antibody development and decrease in response.

For more information, go to

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

Closure of Enterostomy

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Epidural Adhesiolysis

The insurer, with **prior authorization**, pays for epidural adhesiolysis using the 1 day protocol but doesn't pay for the 3 day protocol. Epidural adhesiolysis is also known as percutaneous lysis of epidural adhesions, epidural decompressive neuroplasty, and Racz neurolysis. Workers must meet the following criteria:

- The worker has experienced acute low back pain or acute exacerbation of chronic low back pain of no more than 6 months duration.
- The provider intends to conduct the adhesiolysis in order to administer drugs closer to a nerve.
- The provider documents strong suspicion of adhesions blocking access to the nerve.
- Adhesions blocking access to the nerve have been identified by Gallium MRI or Fluoroscopy during epidural steroid injections.

For more information, go to

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

Meniscal Allograft Transplantation

The insurer, with **prior authorization**, may cover meniscal allograft transplantation when all of the guidelines are met.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have performed or assisted with 5 meniscal allograft transplants or
- Perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants.

For more information, go to

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/Meniscal.asp>

ANESTHESIA SERVICES

Anesthesia payment policies are established by L&I with input from the Reimbursement Steering Committee (RSC) and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NONCOVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The insurer doesn't cover anesthesia assistant services.

Noncovered Procedures

Anesthesia isn't payable for procedures that **aren't covered** by L&I. Refer to **Appendix D** for a list of noncovered procedures.

Patient Acuity

Patient acuity doesn't affect payment levels. Payment for CPT[®] codes 99100, 99116, 99135 and 99140 is considered bundled and isn't payable separately. CPT[®] physical status modifiers (–P1 to –P6) and CPT[®] 5-digit modifiers aren't accepted.

Payment for Anesthesia

Payment for anesthesia services will only be made to anesthesiologists and certified registered nurse anesthetists.

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier –47 (anesthesia by surgeon) are considered bundled and aren't payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

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

Refer to [WAC 296-23-240](#) for licensed nursing rules and [296-23-245](#) for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to L&I's CMS-1500 billing instructions (publication F248-094-000).

Billing Tip

CRNA services shouldn't be reported on the same CMS-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

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

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

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

In addition, physicians directing anesthesia:

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

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

Documentation Requirements for Team Care

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

Billing for Team Care

When billing for team care situations:

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

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services.
(Refer to [Anesthesia Payment Calculation](#) in the Anesthesia Services Paid with Base and Time Units section, page 60)
- The maximum payment to the physician is 50% of the maximum payment for solo physician services.
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

Anesthesia Teaching Physicians

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

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

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

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

Anesthesia Base Units

Most of L&I's anesthesia base units are the same as the units adopted by CMS. L&I differs from the CMS base units for some procedure codes based on input from the ATAG. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.



List only the time in minutes on your bill. Don't include the base units. They are automatically added by L&I's payment system.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. Except for modifier –99, these modifiers aren't valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® 5-digit modifiers and physical status modifiers (P1 through P6) **aren't** paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	Modifier	Brief Description	Notes
Anesthesiologists and CRNAs	–99	Multiple modifiers	Use this modifier when 5 or more modifiers are required. Enter –99 in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

For Use By	Modifier	Brief Description	Notes
Anesthesiologists	–AA	Anesthesia services performed personally by anesthesiologist	
	–QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services.
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*	–QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
	–QZ	CRNA service: without medical direction by a physician ⁽¹⁾	Maximum payment is 90% of the maximum allowed for physician services.

(1) Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services.

Anesthesia Payment Calculation

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

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

The anesthesia conversion factor is published in [WAC 296-20-135](#). For services provided on or after July 1, 2010, the anesthesia conversion factor is \$47.85 per 15 minutes (\$3.19 per minute). Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by \$3.19.

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

Example: CPT® code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. Base units x 15 = 3 x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x \$3.19 = \$334.95

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes must be billed with a primary anesthesia code. There are 3 anesthesia add-on CPT® codes: 01953, 01968 and 01969.

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

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

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT® code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 4 percent	01951	None
5 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs aren't paid with anesthesia base and time units. These services include:

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

Modifiers

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

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.



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

E/M Services Payable with Pain Management Procedures

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

- It is the patient's initial visit to the provider who is performing the procedure, or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service. (see Using the -25 modifier)

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in [WAC 296-20-03001](#). Refer to [Medication Administration](#) in the Other Medicine Services section; page **91** for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	Maximum of 6 injections per acute episode are allowed.
Facet injections	Maximum of 4 injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other nonscheduled medications and trigger point dry needling ⁽¹⁾	Maximum of 6 injections per patient are allowed.

- (1) Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. L&I doesn't cover acupuncture services ([WAC 296-20-03002](#)). Dry needling of trigger points should be billed using trigger point injection codes. Dry needling follows the same rules as trigger point injections in [WAC 296-20-03001](#) (14).

RADIOLOGY

X-RAY SERVICES

Requirements and Definitions

Attending health care providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain.
- PA and lateral chest films to determine cause for dyspnea.

All imaging studies must be of adequate technical quality to rule out radiologically-detectable pathology

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the study).

If only the technical component of a radiology service is performed, the modifier -TC must be used, and only the technical component fees are allowable.

If only the professional component of a radiology service is performed, the modifier -26 must be used, and only the professional component fees are allowable.

Repeat X-rays

The insurer **won't pay** for excessive or unnecessary X-rays. Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Number of Views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT[®] description for that service.

For example, the following CPT[®] codes for radiologic exams of the spine are payable as outlined below:

CPT [®] Code	Payable
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Incomplete Full Spine Studies

A full spine study is a radiologic exam of the entire spine; anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic and lumbar spine). An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. Incomplete full spine studies in which 5 views are obtained are payable at the maximum fee schedule amount for CPT[®] code 72010. Incomplete full spine studies in which 4 views are taken are payable at one-half the maximum fee schedule amount for CPT[®] code 72010 and must be billed with a -52 modifier to indicate reduced services.

-RT and -LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) don't affect payment. They may be used with CPT[®] radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving
 - Extremities,
 - Pelvis,
 - Vertebral column or
 - Skull
- Chest or abdominal films that don't involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable X-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s). R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table.

HCPCS Code	Modifier	Patients Served	Description	Fee
R0070		1	Transport portable X-ray	\$164.84
R0075	-UN	2	Transport portable X-ray	\$ 82.43
R0075	-UP	3	Transport portable X-ray	\$ 54.95
R0075	-UQ	4	Transport portable X-ray	\$ 41.21
R0075	-UR	5	Transport portable X-ray	\$ 32.97
R0075	-US	6 or more	Transport portable X-ray	\$ 27.48

Custody

X-rays must be retained for 10 years. See WACs [296-20-121](#) and [296-23-140\(1\)](#).

RADIOLOGY CONSULTATION SERVICES

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?
- Does this disc protrusion shown on MRI look new or preexisting?

CPT[®] code 76140 **isn't covered**. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier -26. The insurer won't pay separately for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the X-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed. Payment for a radiological consultation will be made at the established professional component (modifier -26) rate for each specific radiology service. A written report of the consultation is required.

RADIOLOGY REPORTING REQUIREMENTS

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier -26 or as part of the global service. Documentation refers to charting of justification, findings, diagnoses, and test result integration. Any provider who produces and interprets his/her own imaging studies, and any radiologist who overreads imaging studies must produce a report of radiology findings to bill for the professional component.

The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, and date of procedure
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc)
- Specific views (eg, AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc, as applicable)
- Brief sentence summarizing history and/or reason for the study. Examples:
 - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
 - "Neck pain radiating to upper extremity; rule out disc protrusion."
- Description of, or listing of, imaging findings:
 - Advanced imaging reports should follow generally accepted standards to include relevant findings related to the particular type of study.
 - Radiology reports on plain films of skeletal structures should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings.
 - Radiology reports on chest plain films should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine).

NOTE: Chart notes such as "x-rays are negative" or "x-rays are normal" don't fulfill the reporting requirements described in this section and the insurer won't pay for the professional component in these circumstances.

- Impressions

Imaging impressions summarize and provide significance for the imaging findings described in the body of the report. Examples include:

- For a skeletal plain film report that described normal osseous density and contours and no joint abnormalities, the impression could be "No evidence of fracture, dislocation, or gross osseous pathology."
- For a skeletal plain film report that described reduced bone density and thinned cortices, the impression could be "Osteoporosis, compatible with the patient's age."
- For a chest report that described vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be "Emphysema."

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes. Examples include:

- "Imaging rules out fracture, so rehab can proceed."
- "Flexion/extension plain films indicate hypermobility at C4/C5, and spinal manipulation will avoid that region."
- "MRI identifies disc protrusion at L4/L5, and a conservative course of inversion therapy will begin."

CONTRAST MATERIAL

Separate payment will be made for contrast material for imaging studies. Providers may use either high osmolar contrast material (HOCM) or low osmolar contrast material (LOCM). The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart. Use the following codes to bill for contrast material:

- LOCM: Q9951, Q9965 – Q9967
- HOCM: Q9958 - Q9964



HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml. Bill 1 unit per ml. Code A9525 **isn't** valid for contrast material.

NUCLEAR MEDICINE

The standard multiple surgery policy applies to the following radiology codes for nuclear medicine services.

CPT® Code
78306
78320
78802
78803
78806
78807

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient,
 - On the same day,
 - By the same physician or
 - By more than 1 physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Physical and occupational therapy services must be ordered by the worker's:

- Attending doctor
- Nurse practitioner or
- By the physician assistant for the attending doctor.

Who May Bill For Physical Medicine Services

Board Certified Physical Medicine and Rehabilitation (Physiatry) Physicians

Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may provide physical medicine services.

- They use CPT[®] codes 97001 through 97799 and 95831 through 95852 to bill for their services.
- CPT[®] code 64550 may also be used but is payable only once per claim (see [WAC 296-21-290](#)).

Licensed Physical Therapists

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the supervision of a licensed physical therapist (see [WAC 296-23-220](#)).

Licensed Occupational Therapists

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapy assistant serving under the direction of a licensed occupational therapist (see [WAC 296-23-230](#)).

Nonboard Certified/Qualified Physical Medicine Providers

Special payment policies apply for attending doctors who aren't board qualified or certified in physical medicine and rehabilitation:

- They **won't be paid** for CPT[®] codes 97001-97799.
- They may perform physical medicine modalities and procedures described in CPT[®] codes 97001-97750 if their scopes of practice and training permit it, but must bill local code 1044M for these services.
- Local code 1044M is limited to 6 units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.
- After 6 units, the patient must be referred to a licensed, physical or occupational therapist or physiatrist for such treatment except when the attending provider practices in a remote location. Refer to [WAC 296-21-290](#) for more information.

1044M Physical medicine modality (ies) and/or procedure(s) by attending provider who isn't board qualified or certified in physical medicine and rehabilitation. Limited to 6 units except when provider practices in a remote area. \$ 43.06

Who Won't Be Paid For Physical Medicine Services

- Physical or occupational therapist students
- Physical or occupational therapist assistant students
- Physical or occupational therapist aides
- Athletic trainers

PHYSICAL AND OCCUPATIONAL THERAPY

Billing Codes

Physical and occupational therapists must use the appropriate CPT[®] and HCPCS codes 64550, 95831-95852, 95992, 97001-97799 and G0283, with the exceptions noted later in the Noncovered and Bundled Codes section. They must bill the appropriate **covered** HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the [Supplies, Materials and Bundled Services](#) section, page **136**. If more than 1 patient is treated at the same time use CPT[®] code 97150. Refer to the Physical Medicine [CPT[®] Codes Billing Guidance](#) section, page **70** for additional information.

Noncovered and Bundled Codes

The following physical medicine codes aren't covered:

CPT [®] Code
97005
97006
97033

The following are examples of bundled items or services:

- Application of hot or cold packs.
- Ice packs, ice caps and collars.
- Electrodes and gel.
- Activity supplies used in work hardening, such as leather and wood.
- Exercise balls.
- Therataping.
- Wound dressing materials used during an office visit and/or physical therapy treatment.

Refer to the appendices for complete lists of noncovered and bundled codes.

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to 1 unit per day:

CPT [®] Code	CPT [®] Code
97001	97018
97002	97022
97003	97024
97004	97026
97012	97028
97014	97150
97016	

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see [WAC 296-23-220](#) and [WAC 296-23-230](#) \$ 118.07

The daily maximum applies to CPT® codes 64550, 95831-95852 and 97001-97799 and HCPCS code G0283 when performed for the same claim for the same date of service. If physical, occupational, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type.

If the worker is treated for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition, therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

The daily maximum allowable fee doesn't apply to:

- Performance based physical capacities examinations (PCEs),
- Work hardening services,
- Work evaluations or
- Job modification/prejob accommodation consultation services.

PHYSICAL AND OCCUPATIONAL THERAPY EVALUATIONS

Use CPT® codes 97001 through 97004 to bill for physical and occupational therapy evaluations and reevaluations. Use CPT® codes 97001 and 97003 to report the evaluation by the physician or therapist to establish a plan of care. Use CPT® codes 97002 and 97004 to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. CPT® codes 97002 and 97004 have no limit on how frequently they can be billed.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists. The evaluation must be provided as a 1-on-1 service.

1045M Performance-based physical capacities evaluation with report and summary of capacities \$ 705.78
(Limit of 1 per 30 days)

POWERED TRACTION THERAPY

Powered traction devices **are covered** as a physical medicine modality.

The insurer **won't pay** any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. For more information go to

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

WOUND CARE

Debridement

Therapists must bill CPT® 97597, 97598 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies used in the office are bundled and aren't separately payable.

Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier –1S. See the [Supplies, Materials and Bundled Services](#) section, page 136 for more information.

Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is **covered** for the following chronic wound indications:

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

Prior authorization is required if electrical stimulation for chronic wounds is requested for use on an outpatient basis using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy.
- In addition to electrical stimulation, standard wound care must continue.
- In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Use HCPCS code G0281 to bill for electrical stimulation for chronic wounds. For more information go to

<http://www.ini.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecStimofChronicWounds.asp>

MASSAGE THERAPY

Massage is a **covered** physical medicine service when performed by a licensed massage therapist ([WAC 296-23-250](#)) or other covered provider whose scope of practice includes massage techniques.

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **won't pay** massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is paid at 75% of the maximum daily rate for physical and occupational therapy services and the daily maximum allowable amount is \$ 88.55

The following are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices and
- Lubricants (For example, oils, lotions, emollients).

Refer to [WAC 296-23-250](#) for additional information.



Document the amount of time spent performing the treatment. Your documentation must support the units of service billed.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

Timed Codes

Some physical medicine services (e.g. ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as 'timed services' and are billed using 'timed codes'.

Timed codes can be identified in CPT® by the code description. The definition will include words such as 'each 15 minutes'.

Providers **must document** in the daily medical record (chart note and flow sheet, if used):

- the amount of time spent for each time based service performed
- the specific interventions or techniques performed, including:
- frequency and intensity (if appropriate), and
- intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (e.g. flow sheets, chart notes, and reports.)



Documenting a range of time (e.g. 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

The number of units you can bill is determined by the time spent performing each 'timed service', and is constrained by the total number of minutes spent performing these services on a given day. Add together the minutes spent performing each individual time based service to obtain the total minutes spent performing time based services, and use the table below to obtain the number of units that can be billed for these services.

Units Reported	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

NOTE: The above schedule of times doesn't imply that any minute until the 8th should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

For example, if you perform 10 minutes of CPT® 97110 (therapeutic exercises) and 12 minutes of CPT® 97140 (manual therapy), you have performed 22 minutes of 'timed code' services. This equates to 1 unit of service that can be billed. Since the most time was spent performing manual therapy, bill 1 unit of 97140.

Examples

The following charts are examples of how the required elements of interventions can be documented. These examples aren't reflective of a complete medical record for the patient's visit. The other elements of reporting (SOAP) must also be documented.

Example 1

Time	Procedural Intervention	Specific Intervention	Purpose
20'	Therapeutic Exercise	Left leg-Straight Leg Raises X 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting
15'	Neuromuscular Reeducation	One leg stance 45 seconds left, 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead
10'	Cold Pack	Applied to left knee	Decrease edema

Total timed intervention: 35 minutes

Total treatment time: 45 minutes

The total treatment time spent performing timed services is 35 minutes. A maximum of 2 units of timed services can be billed. **Correct billing of these services is:**

- 97110 (therapeutic exercise) X 1 unit; and
- 97112 (neuromuscular reeducation) X 1 unit

Example 2

Time	Procedural Intervention	Specific Intervention	Purpose
8'	Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm ² ; 100% right forearm	Increase joint mobility
8'	Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation
10'	Therapeutic Exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping

Total timed intervention: 18 minutes

Total treatment time: 26 minutes

The total treatment time spent performing timed services is 18 minutes. A maximum of 1 unit of timed service can be billed. **Correct billing of these services is:**

- 97110 (therapeutic exercise) X 1 unit; and
- 97022 (whirlpool) X 1 unit

Prohibited Pairs

A therapist can't bill any of the following pairs of CPT[®] codes for outpatient therapy services provided simultaneously to 1 or more patients **for the same time period**.

- Any 2 CPT[®] codes for “therapeutic procedures” requiring direct, 1-on-1 patient contact.
- Any 2 CPT[®] codes for modalities requiring “constant attendance” and direct, 1-on-1 patient contact.
- Any 2 CPT[®] codes requiring either constant attendance or direct, 1-on-1 patient contact—as described above—. For example: any CPT[®] codes for a therapeutic procedure with any attended modality CPT[®] code.
- Any CPT[®] code for therapeutic procedures requiring direct, 1-on-1 patient contact with the group therapy CPT[®] code. For example: CPT[®] code 97150 with CPT[®] code 97112.
- Any CPT[®] code for modalities requiring constant attendance with the group therapy code. For example: (CPT[®] code 97150 with CPT[®] code 97035)
- Any untimed evaluation or reevaluation code with any other timed or untimed CPT[®] codes, including constant attendance modalities, therapeutic procedures and group therapy.

DETERMINING WHAT TIME COUNTS TOWARDS TIMED CODES

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services aren't to be counted in determining the treatment service time. In other words, the time counted as “intraservice care” begins when the therapist or physician (or a physical therapy or occupational therapy assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (For example, on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. The time the patient spends not being treated because of the need for toileting or resting shouldn't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

More information about L&I's Physical, Occupational and Massage Therapy policies is also available on L&I's web site at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/default.asp>

WORK CONDITIONING AND WORK HARDENING

Work Conditioning

Work Conditioning is an intensive, work-related, goal-oriented conditioning program designed specifically to restore function for work. These programs are reimbursed as outpatient occupational and physical therapy under the daily fee cap. See [WAC 296-23-220](#) and [WAC 296-23-230](#).

Guidelines:

- Frequency: at least 3 times per week and no more than 5 times per week
- Duration: No more than 8 weeks for 1 set. 1 set equals up to 20 visits.
- An additional 10 visits may be approved upon review of progress
- Plan of Care: Goals are related to:
 - increasing physical capacities;
 - return to work function; and
 - establishing a home program allowing the individual to progress and/or maintain function after discharge.
- Documentation: Includes return to work capacities which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances
- Treatment: May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
 - Physical and occupational therapy visits accumulate separately and both are allowed on the same date of service.
 - Billing reflects active treatment. Examples include CPT 97110, 97112, 97530, 97535, and 97537.

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker. Work hardening programs require prior approval by the worker's attending physician and **prior authorization** by the claim manager.

Only L&I approved work hardening providers will be paid for work hardening services.

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on L&I's web site at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/default.asp>

This information is also available by calling the work hardening program reviewer at (360) 902-4480.

The work hardening evaluation is billed using local code 1001M. Treatment is billed using CPT® codes 97545 and 97546. These codes are subject to the following limits:

Work hardening programs are authorized for up to 4 weeks.

Code	Description	Unit limit (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	\$ 117.02
97545	Initial 2 hours per day	20 units per program; max. 1 unit per day per worker (1 unit = 2 hours)	\$ 133.37
97546	Each additional hour	70 units per program; add-on, won't be paid as a stand-alone procedure per worker per day. (1 unit = 1 hour)	\$ 62.53

Program extensions

Program extensions must be authorized in advance by the claim manager and are based on documentation of progress and the worker's ability to benefit from the program extension up to 2 additional weeks. Additional units available for extended programs

Code	Description	6 week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial 2 hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes 97545 and 97546 takes into consideration that some work occurs outside of the time the client is present (team conference, plan development, etc.).

Time spent in treatment conferences **isn't covered** as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using procedure codes 97545 and 97546.

Billing for additional services

The provision of additional services during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

Billing for less than 2 hours of service in 1 day (97545)

Services provided for less than 2 hours on any day don't meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. For example, the worker arrives for work hardening but is unable to fully participate that day. Services should be billed using CPT® codes that appropriately reflect the services provided. This should be considered as an absence in determining worker compliance with the program. The standard for participation continues to be a minimum of 4 hours per day, increasing each week to 7-8 hours per day by week 4.

Billing less than 1 hour of 97546

After the first 2 hours of service on any day, if less than 38 minutes of service are provided the -52 modifier must be billed. For that increment of time, procedure code 97546 must be billed as a separate line item with a -52 modifier and the charged amount prorated to reflect the reduced level of service. For example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged Amt	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	-52	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Only 1 unit of 97545 (first 2 hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

Example: The occupational therapist (OT) is responsible for the work simulation portion of the worker's program, which lasted 4 hours. On the same day, the worker performed 2 hours of conditioning/aerobic activity that the physical therapist (PT) is responsible for. The 6 hours of services could be billed in 1 of 2 ways.

Option 1		
PT	1 unit 97545	2 hours
OT	4 units 97546	4 hours
	Total hours billed	6 hours

Option 2		
OT	1 unit 97545 +	2 hours
	2 units 97546	2 additional hours
PT	2 units 97546	2 hours
	Total hours billed	6 hours

Billing for evaluation and treatment on the same day – multiple disciplines

If both the OT and the PT need to bill for 1 hour of evaluation and 1 hour of treatment on the same date of service, the services must be billed as follows:

Provider	Service	Bill As:
OT	1 hour evaluation	1 unit 1001M
PT	1 hour evaluation	1 unit 1001M
OT (or PT)	1 hour treatment	1 unit 97545 with modifier -52 (billed amount proportionate to 1 hour)
PT (or OT)	1 hour treatment	1 unit 97546

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT® code 97140 **isn't covered** for osteopathic physicians.

For OMT services body regions are defined as:

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Rib cage
- Abdomen and viscera regions
- Lower and upper extremities

These codes ascend in value to accommodate the additional body regions involved. Therefore, only 1 code is payable per treatment. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

OMT includes pre- and post-service work (For example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the -25 modifier.

The insurer **won't pay** for E/M codes billed on the same day as OMT without the -25 modifier. The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of E/M in addition to OMT services on the same day.

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers may bill professional services for application of stimulators with the CPT® physical medicine codes when it is within the provider's scope of practice. Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code 1044M.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described as follows.

Electrical Stimulator Devices for Home Use or Surgical Implantation

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Prior authorization is required
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
L8680	Implantable neurostimulator electrode	Not covered
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.
E0761	Nontherm electromgntc device	Covered
E0762	Trans elec jt stim dev sys	Not covered
E0764	Functional neuromuscular stimulator	Prior authorization is required
E0765	Nerve stimulator for tx n&v	Not covered
E0769	Electric wound treatment dev	Not covered

Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5120	Skin barrier wipes box per 50	
A6250	Skin seal protect moisturizer	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

Transcutaneous electrical nerve stimulation (TENS), interferential current therapy (IFC) and percutaneous neuromodulation therapy (PNT) devices for use outside of medically supervised facility settings **aren't covered** for State Fund, Self-Insured and Crime Victims claims. This includes home use, purchase or rental of durable medical equipment (DME) and supplies. Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

On October 30, 2009, the State Health Technology Clinical Committee (HTCC) met in an open public meeting to review the evidence for Electrical Nerve Stimulation (ENS), including TENS, IFC and PNT, as treatments for acute and chronic pain. Based on a review of the best available evidence of safety, efficacy and cost-effectiveness, the committee's determination is that ENS is noncovered for use outside of medically supervised facilities. Purchase or rental of TENS, IFC, and PNT equipment and supplies isn't covered. The determination was made final by the HTCC on November 20, 2009. Complete information on this HTCC determination is available at: <http://www.hta.hca.wa.gov>.

CHIROPRACTIC SERVICES

Chiropractic physicians must use the codes listed in this section to bill for services. In addition, they must use the appropriate CPT[®] codes for radiology, office visits and case management services and HCPCS codes for miscellaneous materials and supplies.

CHIROPRACTIC EVALUATION AND MANAGEMENT

Chiropractic physicians may bill the first 4 levels of new and established patient office visit codes. L&I uses the CPT[®] definitions for new and established patients. If a provider has treated a patient for any reason within the last 3 years, the person is considered an established patient. Refer to a CPT[®] book for complete code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is **payable only once** for the initial visit.
- An established patient E/M office visit code isn't payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or that occur more than 60 days after the first date you treat the worker require **prior authorization**.
- Modifier –22 isn't payable with E/M codes for chiropractic services.
- Established patient E/M codes are **not payable** in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section for policies about the use of E/M office visit codes with chiropractic care visit codes.

Case Management

Refer to [Case Management Services](#), page 40 in the Evaluation and Management section for information on billing for case management services telephone calls, team conferences, and secure e-mail). These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first 4 levels of CPT[®] office consultation codes. L&I periodically publishes:

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

The most recent policy, list of approved consultants and how to become a chiropractic consultant is available on the L&I web at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/BySpecialty/ChiroSvcs.asp>

Physical Medicine Treatment

Local code 1044M (physical medicine modality (ies) and/or procedure(s) by attending provider not board qualified/certified in Physical Medicine & Rehabilitation (PM&R)) may be billed up to 6 units per claim (not per attending provider), except when the provider practices in a remote area. Refer to the previous section [Non-Board Certified/Qualified Physical Medicine](#) providers, page 66 for more information. Documentation of the visit must support billing for this procedure code.

CPT[®] physical medicine codes 97001-97799 are not payable to chiropractic physicians.

Powered Traction Devices

Powered traction devices are **covered** as a physical medicine modality under existing physical medicine payment policy. The insurer will not pay any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments, or surgery. This policy applies to all FDA-approved powered traction devices. When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider. Nonboard certified/qualified physical medicine providers must use 1044M. Therapy is **limited to 6 units per claim** except when the provider practices in a remote area.

Only 1 unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied. For additional information see "[Powered Traction Therapy](#)", page **68** in the Physical Medicine section of this document.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. L&I defines complementary and preparatory services as interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service. Examples of patient education or counseling include discussion about:

- Lifestyle
- Diet
- Self-care and activities of daily living
- Home exercises

CHIROPRACTIC CARE VISITS

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. CPT® codes for chiropractic manipulative treatment (98940-98943) **aren't covered**. L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop the local codes that are covered for chiropractic services. The codes account for these components of treating workers:

- Professional management (clinical complexity), and
- Technical service (manipulation and adjustment)

Local codes for chiropractic care visits:

2050A	Level 1: Chiropractic Care Visit (straightforward)	\$ 41.20
2051A	Level 2: Chiropractic Care Visit (low complexity)	\$ 52.76
2052A	Level 3: Chiropractic Care Visit (moderate complexity)	\$ 64.29

Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to visit complexity include:

- The current occupational condition(s)
- Employment and workplace factors
- Nonoccupational conditions that may complicate care of the occupational condition
- Chiropractic intervention(s) provided (including the number of body regions manipulated)
- Care planning and patient management
- Response to care

NOTE: The number of body regions being adjusted is only one of the factors that may contribute to visit complexity. It isn't the only factor as it is in the CPT® chiropractic manipulation treatment (CMT) codes.

Payment Policies for Chiropractic Care Visits

- **Only 1** chiropractic care visit code is payable per day.
- Extremities are considered as one body region and are **not billed separately**.
- Office visits in excess of 20 visits or that are more than 60 days after the first treatment date require **prior authorization** per [WAC 296-20-03001\(1\)](#).
- Modifier –22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). Submit a report detailing the nature of the unusual service and the reason it was required. Payment will vary based on the review findings. This modifier isn't **payable** when used for noncovered or bundled services (for example: application of hot or cold packs).

Use of Chiropractic Care Visit Codes with E/M Office Visit Codes

Chiropractic care visit codes (local codes 2050A-2052A) are payable in addition to E/M office visit CPT® codes (99201-99204, 99211-99214) **only when all of the following conditions are met:**

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



When a patient requires reevaluation for an existing claim:

- Either an established patient E/M code **or**
- A chiropractic care local code (2050A-2052A) is payable **and**
- Modifier –25 isn't applicable in this situation.

Selecting the Level of Chiropractic Care Visit Code

The following table outlines the treatment requirements, presenting problems and face-to-face patient time involved in the 3 levels of chiropractic care visits. Clinical decision making complexity is the primary component in selecting the level of the visit. L&I defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of the CPT® book.

If the clinical decision-making is...	and the typical number of body regions* manipulated is...	and the typical face-to-face time with patient or family is...	Then the appropriate billing code is:
Straightforward	Up to 2	Up to 10-15 minutes	Level 1 (2050A)
Low complexity	Up to 3 or 4	Up to 15-20 minutes	Level 2 (2051A)
Moderate complexity	Up to 5 or more	Up to 25-30 minutes	Level 3 (2052A)

* Body regions for chiropractic services are defined as:

- Cervical (includes atlanto-occipital joint)
- Thoracic (includes costovertebral and costotransverse joints)
- Lumbar
- Sacral
- Pelvic (includes sacro-iliac joint)
- Extraspinal: Any and all extraspinal manipulations are considered to be **one region**.
Extraspinal manipulations include:
 - Head (including temporomandibular joint, excluding atlanto-occipital)
 - Lower extremities
 - Upper extremities

- Rib cage (excluding costotransverse and costovertebral joints)

Chiropractic Care Visit Examples

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES	
Level 1 Chiropractic Care Visit (Straightforward)	Patient: 26-year-old male. Injury: Lifting a box at work. Presenting Problems: Mild, lower back pain for several days after injury. Treatment: Manipulation/ adjustment of the lumbar region, anterior thoracic mobilization and lower cervical adjustment.
Level 2 Chiropractic Care Visit (Low complexity)	Patient: 55-year-old male, follow-up visit. Injury: Slipped and fell near the bottom of a stairwell while carrying a printer at work. Presenting Problems: Ongoing complaints of neck pain and lower back pain. Today, worker reports new sensation of periodic tingling in right foot. He was off work for 2 days. Treatment: Discussion of need to minimize lifting and getting assistance with heavier objects. Worker receives 5 minutes of myofascial release prior to adjusting the cervical, thoracic and lumbar regions.
Level 3 Chiropractic Care Visit (Moderate complexity)	Patient: 38-year-old female. Injury: Moving heavy archive boxes at work over a 3-day period. Presenting Problems: Headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right-sided foot drop. She tried to return to light duty last week, but was unable to sit for very long and went home. She is obese and mentioned in her history that she might have borderline diabetes. Worker reports she tried to do the stretching prescribed during her last visit but they hurt so she did not do them. Treatment: Reviewed MRI report with the worker. She receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

CHIROPRACTIC INDEPENDENT MEDICAL EXAMS

Chiropractic physicians must be approved examiners by the department prior to performing independent medical exams (IMEs) or impairment ratings. Before applying for approval, chiropractic physicians must meet the following requirements:

- Complete two years as an approved chiropractic consultant and
- Complete an impairment rating course approved by the department;

The above mentioned course is offered as part of the Chiropractic Consultant Program. For more information refer to

<http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/Chiropractic/default.asp> or the [*Medical Examiners' Handbook*](#) (publication F252-001-000).

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668>.

Attending chiropractic physicians who are approved IME examiners may:

- Perform impairment ratings on their own patients or
- Refer to an approved examiner for a consultant impairment rating. See page 97, later in this section.

CHIROPRACTIC RADIOLOGY SERVICES

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the policies described in the [Radiology Services](#) section, page **62**.

When medically necessary, X-rays immediately prior to and following the initial chiropractic adjustment **are allowed** without prior authorization. X-rays subsequent to the initial study require **prior authorization**.

Only chiropractic physicians that are on L&I's list of approved radiological consultants may bill for X-ray consultation services. To qualify, a chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I.

SUPPLIES

See the [Supplies, Materials and Bundled Services](#) section, page **136** to find information about billing for supplies.

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply to workers covered by the State Fund and self-insured employers (see [WAC 296-21-270](#)). Refer to the Medical Treatment Guideline for Psychiatric and Psychological Evaluation at

<http://www.Lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/PsychEval.pdf> for information on:

- Treatment guidelines
- Psychiatric conditions
- Reporting requirements
- Diagnosis of a psychiatric condition
- Identifying barriers that hinder recovery from an industrial injury
- Formulation of a psychiatric treatment plan
- Assessment of psychiatric treatment and recommendations

For information on psychiatric policies applicable to the Crime Victims' Compensation Program, refer to <http://www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp> and Chapter [296-31](#) WAC.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by a psychiatrist (MD or DO), a psychiatric Advanced Registered Nurse Practitioner (ARNP), or a licensed clinical PhD or PsyD psychologist (see [WAC 296-21-270](#)).

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

Psychiatric ARNPs are paid at 90% of the values listed in the fee schedule.

Psychiatric evaluation and treatment services provided by social workers, and other master's level counselors, **are not covered** even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

Staff supervised by a psychiatrist, psychiatric ARNPs, or licensed clinical psychologist may administer psychological testing; however, the psychiatrist, or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS OR PSYCHIATRIC ARNPs AS ATTENDING PROVIDERS

A psychiatrist or psychiatric ARNP can only be a worker's attending provider when the insurer has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist or psychiatric ARNP may certify a worker's time loss from work if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychiatric ARNP may not rate permanent partial disability.

Psychologists cannot be the attending provider and may not certify time loss from work or rate permanent partial disability per [WAC 296-20-01002](#) (Doctor).

NONCOVERED AND BUNDLED PSYCHIATRIC SERVICES

The following services **aren't covered**:

CPT® Code	CPT® Code
90802	90845
90810-90815	90846
90823-90829	90849
90857	

The following services are bundled and **aren't payable separately**:

CPT® Code
90885
90887
90889

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

Prior authorization is required for all psychiatric care referrals (see [WAC 296-21-270](#)). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the E/M consultation codes or the psychiatric diagnostic interview exam code.

When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code 90801. CPT® code 90801 is limited to 1 occurrence every 6 months, per patient, per provider.

Refer to [WAC 296-20-045](#) and [WAC 296-20-051](#) for more information on consultation requirements.

Telephone psychology services are **not covered**. Refer to the [Teleconsultation and Other Telehealth Services](#) section, page **44** for further details.

CASE MANAGEMENT SERVICES

Psychiatrists, psychiatric ARNPs, and clinical psychologists may only bill for case management services (telephone calls, team conferences and secure e-mail) when providing consultation or evaluation.

For payment criteria and documentation requirements, see [Case Management Services](#) in the Evaluation and Management section, page **40**.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into:

- Services with an E/M component, and
- Services without an E/M component.

Coverage of these services is different for psychiatrists and psychiatric ARNPs, and clinical psychologists.

Psychiatrists and psychiatric ARNPs may bill individual insight oriented psychotherapy codes (CPT® 90804-90809, 90816-90819, 90821-90822) either with or without an E/M component.

Psychotherapy with an E/M component may be billed when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation,
- Drug management,
- Writing physician orders,
- Interpreting laboratory or other medical tests.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes without an E/M component. They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license.

Further explanation of this policy and CMS's response to public comments are published in *Federal Register* Volume 62 Number 211, issued on October 31, 1997. This is available on line at <http://www.gpoaccess.gov/fr/index.html>.



To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, don't bill more than 1 unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR PSYCHIATRIC OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists and psychiatric ARNPs may **only** bill the E/M codes for office visits on the same day psychotherapy is provided **if** it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized. The provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs. If a pharmacological evaluation and psychotherapy are conducted on the same day, then the psychiatrist or psychiatric ARNP bills the appropriate psychotherapy code with an E/M component.

In this case, the psychiatrist or psychiatric ARNP must not bill the individual psychotherapy code and a separate E/M code (CPT® codes 99201-99215). Payment **isn't allowed** for psychotherapy and pharmacological management services performed on the same day, by the same provider, for the same patient.

HCPCS code M0064 isn't **payable with**:

- CPT® code 90862
- CPT® E/M office visit or
- Consultation codes (CPT® codes 99201-99215, 99241-99255).

HCPCS code M0064 is described "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders."

It is paid only if these described conditions are accepted or treatment is temporarily allowed by the insurer.

NEUROPSYCHOLOGICAL TESTING

The following codes may be used when performing neuropsychological evaluation. Reviewing records and/or writing/submitting a report is included in these codes and may not be billed separately.

CPT® Code	May be billed:
90801	Once every 6 months per patient per provider.
96101 and 96102	Up to a combined 4 hour maximum. In addition to CPT® codes 96118 and 96119.
96118 and 96119	Per hour up to a combined 12 hour maximum.

The psychologist is responsible to release test data to the insurer. Test data includes the injured worker's test results, raw test data, records, written/computer-generated reports, global scores or individuals scale scores, and test materials such as test protocols, manuals, test items, scoring keys or algorithms, and any other materials considered secure by the test developer or publisher.

The term *test data* also refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment is authorized on a case-by-case basis only. If authorized, the worker may participate in group therapy as part of the individual treatment plan. The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT[®] definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

CPT[®] codes 90865 and 90870 require **prior authorization**. Authorized services are payable only to psychiatrists.

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.
-

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	IME by psychiatrist <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	IME, no-show fee, psychiatrist <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	IME late cancellation fee, psychiatrist <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	Impairment rating by an approved pain program <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	IME, communication issues <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	IME, other, by report <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>

or go to

<http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/IME/default.asp>

To receive e-mail updates on IMEs, subscribe to the ListServ at

<http://www.lni.wa.gov/Main/Listservs/IME.asp>

NATUROPATHIC PHYSICIANS

Naturopathic physicians should use the local codes listed in this section to bill for office visit services, CPT[®] codes 99367 and 99441-99444 to bill case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Refer to [Case Management Services](#), page 40 in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed including consultations. Refer to WAC [296-23-205](#) and [296-23-215](#) for additional information.

INITIAL VISITS

2130A	Routine examination, history, and/or treatment (routine procedure), and submission of a report	\$51.50
2131A	Extended office visit including treatment – report required	\$77.26
2132A	Comprehensive office visit including treatment – report required in addition to the report of accident	\$103.03

FOLLOW-UP VISITS

2133A	Routine office visit including evaluation and/or treatment	\$41.22
2134A	Extended office visit including treatment – report required	\$77.26

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT® codes								
80048	80069	82247	82374	82550	82977	84100	84295	84478
80051	80076	82248	82435	82565	83615	84132	84450	84520
80053	82040	82310	82465	82947	84075	84155	84460	84550

Calculating Payment for Automated Tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Calculate the payment according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- The total number of remaining unduplicated automated tests is counted.

See the following table to determine the payable fee based on the total number of unduplicated automated tests performed.

Number of Tests	Fee
1 Test	Lower of the single test or \$10.26
2 Tests	\$10.26
3 –12 Tests	\$12.59
13 –16 Tests	\$16.81

Number of Tests	Fee
17 – 18 Tests	\$18.83
19 Tests	\$21.80
20 Tests	\$22.48
21 Tests	\$23.20
22 –23 Tests	\$23.91

Calculating Payment for Panels with Automated and NonAutomated Tests

When panels are comprised of both automated multichannel tests and individual nonautomated tests, they are priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual nonautomated test(s).

For example CPT® code 80061 is comprised of 2 automated multichannel tests and 1 non-automated test. As shown below, the fee for 80061 is **\$27.31**.

CPT® 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: \$ 10.26
Nonautomated: CPT® 83718	N/A	Nonautomated: \$ 16.13
Maximum Payment:		\$ 26.39

Calculating Payment for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how to calculate the maximum payment when panel codes 80050, 80061 and 80076 are billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES			INDIVIDUAL TESTS	Test Count	Max Fee
	80050	80061	80076			
Automated Tests	82040 84075		82040 ⁽¹⁾	82977 83615	19 Unduplicated Automated Tests	\$ 21.80
	82247 84132		82247 ⁽¹⁾			
	82310 84155		82248			
	82374 84295	82465	84075 ⁽¹⁾			
	82435 84450	84478	84155 ⁽¹⁾			
	82565 84460		84450 ⁽¹⁾			
	82947 84520		84460 ⁽¹⁾			
Nonautomated Tests	84443					\$32.98
	85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009					\$15.32
		83718				\$16.13
				84439		\$17.23
				85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 ⁽¹⁾		\$ 0.00
MAXIMUM PAYMENT:						\$ 103.46

(1) DUPLICATED TESTS

DRUG SCREENS

The insurer will pay for drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver and confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

Codes that can be billed

Effective 1/1/2011 the department will pay for drug screening using the following CPT® and HCPCS codes:

- 80100, Drug screen, qualitative; multiple drug classes chromatographic method, each procedure.
- 80102, Drug confirmation, each procedure.
- G0431, Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class.
- G0434, Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter.

Payment limits

- 80100 and 80102 are only payable to laboratories that don't require a CLIA certificate of waiver.
- G0431 is limited to one unit per day per patient encounter for laboratories with a CLIA certificate of waiver. Laboratories that don't require a CLIA certificate of waiver may bill more than one unit per day per patient encounter.
- G0434 is limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.

Codes that are not covered

Effective 1/1/2011 the following CPT codes are not covered by the insurer:

- 80101
- 80104

REPEAT TESTS

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters.

Test(s) normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

The medical necessity for repeating the test(s) must be documented in the patient's record.

Modifier -91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests section.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed as follows:

- The fee is payable only to the provider who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:
 - A throat culture,
 - Pap smear or
 - A routine capillary puncture for clotting or bleeding time.

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

Billing Tip

Use CPT[®] code 36415 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT[®] or HCPCS codes.

Travel **won't be paid** to nursing home or skilled nursing facility staff that performs specimen collection.

Travel **will be paid** in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- The provider personally draws the specimen, and
- The trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.

Billing Tip

Use HCPCS code P9603 to bill for actual mileage (1 unit equals 1 mile). HCPCS code P9604 isn't **covered**.

Handling and conveyance **won't be paid**, (for example, shipping or messenger or courier service of specimen(s)). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are considered to be integral to the process and are bundled into the total fee for testing service.

STAT LAB FEES

Usual laboratory services **are covered** under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to 1 STAT charge per episode (not once per test).

Tests ordered STAT should be limited to only those needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT® Code	CPT® Code	CPT® Code	CPT® Code
80047	81003	84100	85384
80048	81005	84132	85396
80051	82003	84155	85610
80069	82009	84157	85730
80076	82040	84295	86308
80100	82055	84302	86367
80156	82150	84450	86403
80162	82247	84484	86880
80164	82248	84512	86900
80170	82310	84520	86901
80178	82330	84550	86902
80184	82374	84702	86920
80185	82435	84704	86921
80188	82550	85004	86922
80192	82565	85007	86923
80194	82803	85025	86971
80196	82945	85027	87205
80197	82947	85032	87210
80198	83615	85046	87281
81000	83663	85049	87327
81001	83874	85378	87400
81002	83880	85380	89051

HCPCS Code	Abbreviated Description
G0306	Complete CBC, auto w/diff
G0307	Complete CBC, auto
G0431	Drug screen, single class
G0434	Drug screen, multi drug class

TESTING FOR AND TREATMENT OF BLOODBORNE PATHOGENS

The insurer may pay for post-exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease. Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim at a later date.

The exposed worker must apply for benefits (submit an accident report form) before the insurer can pay for testing and treatment.

Covered Testing Protocols

Testing for Hepatitis B, C and HIV should be done at the time of exposure and at 3, 6, and 12 months post exposure. The following test protocols are **covered**:

Hepatitis B (HBV)

- HbsAg (hepatitis B surface antigen).
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen).
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C (HCV)

- Enzyme Immunoassay (EIA).
- Recombinant Immunoblot Assay (RIBA).
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are **covered** services if HCV is an accepted condition on a claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR).
- Branched-chain DNA (bDNA).
- Genotyping.
- Liver biopsy.

HIV

There are 2 blood tests needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, and
- A Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test.
- EIA test.
- Western Blot test.
- Immunofluorescent antibody.

The following tests are **covered** services if HIV is an accepted condition on a claim:

- HIV antiretroviral drug resistance testing.
- Blood count, kidney, and liver function tests.
- CD4 count.
- Viral load testing.

Post-exposure Prophylaxis for HBV

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate.

Post-exposure Prophylaxis for HIV

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. **Prior authorization isn't required.**

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count and
- Renal and hepatic chemical function tests

Covered Bloodborne Pathogen Treatment Regimens

Chronic hepatitis B (HBV)

- Interferon alfa-2b.
- Lamivudine.

Hepatitis C (HCV) – acute

- Mono therapy.
- Combination therapy.

HIV/AIDS: Covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS). These guidelines are available on the web at <http://aidsinfo.nih.gov/>.

Treating a Reaction to Testing or Treatment of an Exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to **covered** treatment for a probable exposure.

BLOODBORNE PATHOGEN BILLING CODES

Diagnostic Test/Procedure

CPT® Code	CPT® Code
47100	86803
83890	86804
83894	87340
83896	87390
83898	87521
83902	87522
83912	87901
86689	87903
86701	87904
86704	
86706	

Treatment Related Procedures

CPT® Code	CPT® Code
78725	99201-99215
86360	99217-99220
87536	
80076	
90371	
90746 (adult)	
90772-90779	

PHARMACY SERVICES

PHARMACY FEE SCHEDULE

This fee schedule applies to pharmacy providers only. It doesn't apply to medical providers administering or dispensing drugs in the office. Payment for drugs and medications, including all oral nonlegend drugs, will be based on the pricing methods described below. Refer to [WAC 296-20-01002](#) for definition of Average Wholesale Price (AWP).

Drug Type	Payment Method
Generic	AWP less 50% (+) \$ 4.50 professional fee
Single or multisource brand	AWP less 10% (+) \$ 4.50 professional fee
Brand with generic equivalent (Dispense as Written only)	AWP less 10% (+) \$ 4.50 professional fee
Compounded prescriptions	Allowed cost of ingredients (+) \$4.50 professional fee (+) \$4.00 compounding time fee (per 15 minutes)

Orders for over-the-counter nonoral drugs or nondrug items must be written on standard prescription forms. Price these on a 40% margin.

Prescription drugs and oral or topical over-the-counter medications are nontaxable ([RCW 82.08.0281](#)).

COVERAGE POLICY

The outpatient formulary can be found in [Appendix F](#), page 259 at the end of this document or at <http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/default.asp>

Preferred Drug List

L&I uses a subset of the Washington State Preferred Drug List (PDL). A current list of the drug classes that are part of the workers' compensation benefit and on the PDL is available at <http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/PDL.asp>.

Endorsing the Preferred Drug List

Providers may endorse the PDL by:

- Registering online at <http://www.rx.wa.gov/tip.html> or
- Filling out and returning a registration form available at <http://www.rx.wa.gov/tip.html> or
- By calling Benefit Control Methods at 866-381-7879 or 866-381-7880

Endorsing Practitioner and Therapeutic Interchange Program

Endorsing practitioners may indicate Dispense as Written (DAW) on a prescription for a nonpreferred drug on the PDL and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates substitution permitted on a prescription for a nonpreferred drug on the PDL, the pharmacist will interchange a preferred drug for the nonpreferred drug and a notification will be sent to the prescriber.

Therapeutic interchange **won't** occur when the prescription is a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug as exempted by law. See [WAC 296-20-01002](#) for definitions relating to the Therapeutic Interchange Program:

- Endorsing practitioner
- Refill

- Therapeutic alternative
- Therapeutic interchange

Due to federal regulations, therapeutic interchange will not take place when the prescription is for a schedule II nonpreferred drug. However, L&I will honor the prescription if an endorsing practitioner indicates DAW for a schedule II nonpreferred drug.

Exception: Fentanyl patch (Duragesic) **won't** be routinely covered. For exception criteria see

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

COVERAGE FOR BUPRENORPHINE OR BUPRENORPHINE/NALOXONE

The department may cover buprenorphine (Subutex[®]) or buprenorphine/naloxone (Suboxone[®]) for a limited time to aid in opioid weaning, but doesn't provide coverage for maintenance of opioid dependency or for off-label uses.

Prior authorization is required for buprenorphine and buprenorphine/naloxone products. The requesting provider must:

- Provide documentation of a time-limited opioid taper plan and
- Have a current DATA 2000 waiver to prescribe buprenorphine and buprenorphine/naloxone.

To verify whether a provider has a valid DATA waiver, use the Buprenorphine Locator at

http://buprenorphine.samhsa.gov/bwns_locator/dr_facilitylocator.doc.htm

Authorization is limited to 30 days. An additional 30 days is available if requested and progress on the opioid taper has been documented.

OBTAINING AUTHORIZATION FOR NONPREFERRED DRUGS

The table lists what providers should do to obtain authorization for **nonpreferred** drugs.

Outpatient drug formulary	Endorsing provider	Nonendorsing provider
Preferred Drug List	Write DAW for nonpreferred drugs	Contact the PDL Hotline (888) 443-6798
Remainder of drug classes	Contact the PDL Hotline (888) 443-6798	Contact the PDL Hotline (888) 443-6798

The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm (Pacific Time).

Filling prescriptions after hours

If a pharmacy receives a prescription for a nonpreferred drug when authorization cannot be obtained, the pharmacist may dispense an emergency supply of the drug by entering a value of 6 in the DAW field. L&I **must authorize** additional coverage for the nonpreferred drug.

NOTE: An emergency supply is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

Retaining prescriptions

[WAC 296-20-02005](#) (Keeping of records) requires that records must be maintained for audit purposes for a minimum of 5 years.

NCPDP V5.1 PAYER SHEET

L&I uses version 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system. The current version is available online at

<http://www.Lni.wa.gov/ClaimsIns/Files/Providers/PayerSheet.pdf>

INITIAL PRESCRIPTION DRUGS OR “FIRST FILLS”

L&I **will** pay pharmacies or reimburse workers for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance. Refer to [WAC 296-20-01002](#) for definitions of initial prescription drug and initial visit.

L&I **won't** pay:

- For refills of the initial prescription before the claim is accepted,
- For new prescription written after the initial visit but before the claim is accepted or
- If it is a federal or self-insured claim. ***Pharmacies should bill the appropriate federal or self-insured employer.***

If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

Payment for “first fills” shall be based on L&I’s fee schedule including but not limited to screening for drug utilization review (DUR) criteria, preferred drug list (PDL) provisions, 30-day supply limit and formulary status. Your bill must be received by L&I within 1 year of the date of service. For additional information and billing instructions, go to <http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Billing/default.asp#3> or see the Pharmacy Prescription Billing Instructions manual.

THIRD PARTY BILLING FOR PHARMACY SERVICES

Pharmacy services billed through a third party pharmacy biller **will be paid** using the pharmacy fee schedule **only when**:

- A valid L&I claim exists; and
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I; and
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

L&I pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement
- Allow third party pharmacy billers to route bills on their behalf,
- Agree to follow L&I rules, regulations and policies and
- Ensure that third party pharmacy billers use L&I’s online POS system and
- Review and resolve all online POS system edits using a **licensed pharmacist** during the dispensing episode.

Third party pharmacy billers **can’t resolve** POS edits. Third Party Pharmacy Supplemental Agreements can be obtained either through the third party pharmacy biller or by contacting Provider Accounts at (360) 902-5140. The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I. For more information refer to the Pharmacy Services website at <http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/default.asp>.

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, and
- The ECP and/or counseling service is sought by the worker, and
- The claim manager authorizes payment for the ECP and/or the counseling, and
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code S9445.

INFUSION THERAPY

Services

These services require **prior authorization** by the insurer. The insurer will only pay home health agencies and/or independent registered nurses for infusion therapy services and/or therapeutic, diagnostic, vascular injections.

Supplies

Only pharmacies and DME suppliers, including IV infusion companies, may be paid for infusion therapy supplies. **Prior authorization is required** for supplies (including infusion pumps) and must be billed with HCPCS codes. See [WAC 296-20-1102](#) for information on the rental or purchase of infusion pumps. Implantable infusion pumps are **not routinely covered**.

Exception: When a spinal cord injury is the accepted condition the insurer may pay for an implantable pump for Baclofen. See [WAC 296-20-03014\(6\)](#).

Drugs

Infusion therapy drugs, including injectable drugs, are **payable only to pharmacies**. Drugs must be authorized and billed with NDC codes or UPC codes if NDC codes are not available.

DURABLE MEDICAL EQUIPMENT (DME)

Pharmacies and DME providers must bill their “usual and customary” charge for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax, and fitting fees **aren’t payable separately**. Include these charges in the total charge for the supply. See [WAC 296-20-1102](#) for information on the rental or purchase of DME.

PURCHASING OR RENTING DME

Required Modifiers –NU or –RR

A modifier is always required on all HCPCS codes that are used to purchase or rent DME.

- NU for a new purchase or
- RR for a rental.

The HCPCS Section of the Professional Services Fee Schedule lists the HCPCS E codes and the HCPCS K codes that require either –NU or –RR. Look in the HCPCS/CPT® code column of the fee schedule for the appropriate modifier. There is also a column in fee schedule that designates the HCPCS code as requiring prior authorization. There is no need to obtain prior authorization if the code doesn’t require it.

DME codes fall into one of 3 groups relative to modifier usage. DME that is:

- Only purchased (only –NU modifier allowed).
- Only rented (only –RR modifier allowed).
- Either purchased or rented (either –NU or –RR modifier allowed).

Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, for example –LT, –RT, etc., in conjunction with the mandatory modifiers if appropriate (up to 4 modifiers may be used on any 1 HCPCS code).

Exceptions:

- K0739: Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes doesn’t require a modifier.
- K0740: Repair or no routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes.

L&I **won’t** purchase used equipment.

Self-insured employers **may purchase** used equipment.

DME Purchase

Purchased DME must have the –NU modifier. The new purchase codes and their modifier can be found in the HCPCS Section of the [Professional Services Fee Schedule](#). Purchased DME belongs to the worker.

DME Rental

DME that is rented must have the –RR modifier. The rental codes and their modifier can be found in the HCPCS Section of the Professional Services Fee Schedule.

Rental payments will not exceed 12 months. At the 12th month of rental, the equipment is **owned by the worker**. The insurer may review rental payments at 6 months and decide to purchase the equipment at that time. The purchased DME belongs to the worker.

The maximum allowable rental fee is based on a per month period. Rental of 1 month or less is equal to 1 unit of service.

Exceptions:

- E0935 and E0936, continuous passive motion exercise device for use on knee only and continuous passive motion exercise device for use other than knee respectively are rented on a per diem basis up to 14 days with 1 unit of service equaling 1 day.
- E1800-E1818, E1825-E1840, extension/flexion device. These devices are rented for 1 month. If needed beyond 1 month, a claims manager's authorization is required.



If the equipment is being rented for 1 day, use the same date for the first and last dates of service. If the equipment is being rented for more than 1 day, use the actual first and last dates of service. Errors will result in suspension and/or denial of payment of the bill and any subsequent bills. Some equipment will only be rented by the insurer.

During the authorized rental period, the DME belongs to the provider. When the equipment is no longer authorized, the DME will be returned to the provider. If the unauthorized DME isn't returned to the provider within 30 days, the provider can bill the worker for charges related to DME rental, purchase and supplies that accrue after DME authorization is denied by the insurer.

DME Purchase after Rental

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

- The provider will retrieve the rental equipment and replace it with the new DME item.
- The provider should bill the usual and customary charge for the new replacement DME item. The HCPCS code billed will require a –NU modifier.
- L&I will pay the provider the new purchase price for the replacement DME item in accordance with the established maximum fee.
- Self-insurers may purchase the equipment and receive rental credit toward the purchase.

DME, Miscellaneous, E1399

HCPCS code E1399 will be paid by report.

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

OXYGEN AND OXYGEN EQUIPMENT

L&I primarily rents oxygen equipment and will no longer rent to purchase.

Types of Oxygen Systems

Stationary systems: Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems and oxygen concentrators.

- Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders. Large H cylinders weigh approximately 200 pounds and provide continuous oxygen at 2 liters per minute for 2.5 days.
- Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas but takes up less space and can be more easily transferred to a portable tank. A typical liquid oxygen system weighs approximately 120 pounds and provides continuous oxygen at 2 liters per minute for 8.9 days. Certain liquid oxygen systems can provide oxygen at the same rate for 30 days or more.
- Oxygen concentrators are electric devices that extract oxygen from ambient air and deliver oxygen at 85% or greater at concentration of up to 4 liters per minute. A back-up oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

Portable systems: Portable oxygen systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.

- Small gas cylinders, such as the E cylinder, are available as portable systems. The E cylinder weighs 12.5 pounds alone, 22 pounds with a rolling cart.
- Portable systems sometimes referred to as ambulatory systems are lightweight (less than 10 pounds) and can be carried by most patients. Small gas cylinders are available that weigh 4.5 pounds.
- Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights. The smallest weighs 3.4 pounds with a conserver and provides oxygen at 2 liters per minute for 10 hours.

Oxygen System Fees

Stationary: Fee schedule payments for stationary oxygen system rentals are all-inclusive. One monthly fee is paid for a stationary oxygen system. This fee includes payment for the equipment, contents (if applicable), necessary maintenance and accessories furnished during a rental month.

If the worker owns a stationary oxygen system, payment will be made for contents of the stationary gaseous (E0441) or liquid (E0442) system.

Portable: Fee schedule payments for portable oxygen system rentals are all-inclusive. One monthly fee is paid for a portable oxygen system. This fee includes payment for the equipment, contents, necessary maintenance and accessories furnished during a rental month.

If the worker owns a portable oxygen system, payment may be made for the portable contents of the gaseous (E0443) or liquid (E0444) portable system.

The fee for oxygen contents (stationary or portable) is billed once a month, not daily or weekly. One unit of service is equal to 1 month of rental.

Oxygen Concentrators

Fee schedule payments for oxygen concentrators are all-inclusive. One monthly fee is paid for an oxygen concentrator. This fee includes payment for the equipment rental, necessary

maintenance and accessories furnished during a rental month.

Oxygen Accessories

Accessories include but aren't limited to:

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

These are included in the payment for rented systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when they are used with a patient owned system.

REPAIRS AND NONROUTINE SERVICE

Rented Equipment Repair

Repair, nonroutine service and maintenance are included as part of the monthly rental fee on DME. No additional payment will be provided. This excludes disposable and nonreusable supplies.

Purchased Equipment Repair

Repair, nonroutine service and maintenance on purchased equipment that is out of warranty will be paid by report.

In those cases where damage to a piece of DME is due to worker:

- Abuse,
- Neglect or
- Misuse

The repair or replacement is the responsibility of the worker. Replacement of lost or stolen DME is also the responsibility of the worker.

K0739, K0740 should be billed per each 15 minutes. Each 15 minutes should be represented by one unit of service in the 'Units' field.

For example, 45 minutes for a repair or nonroutine service of equipment requiring a skilled technician would be billed with 3 units of service.

PROSTHETIC AND ORTHOTIC SERVICES

The insurer will only pay for custom fabricated prosthetic and orthotic devices that are manufactured by providers specifically licensed to produce them. These providers include licensed prosthetists, orthotists, occupational therapists, certified hand specialists and podiatrists.

Refer to the "license required" field in the fee schedule to determine if an orthotic or prosthetic device is in this category.

WARRANTIES

A copy of the original warranty is required on each repair service completed. For State Fund claims, send a copy to:

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

For self-insured claims, send a copy to the SIE/TPA.

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

Write the claim number in the upper right-hand corner of the warranty document.

Payment will be denied if no warranty is received or if the item is still under warranty.

DME Item Type	Required Warranty Coverage
DME purchased new, excluding disposable and nonreusable supplies	Limited to the manufacturer's warranty
Rented DME	Complete repair and maintenance coverage is provided as part of the monthly rental fee
E1230 Power operated vehicle (3- or 4-wheel nonhighway) "Scooter"	Minimum of 1 year or manufacturer's warranty whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	Minimum of 1 year of manufacturer's warranty whichever is greater
HCPCS codes K0004, K0005 and E1161	Lifetime warranty on side frames and cross braces

For further information on miscellaneous services and appliances, see [WAC 296-23-165](#)

BUNDLED CODES

Covered HCPCS codes listed as **bundled** in the fee schedules are payable to pharmacy and DME providers because there is no office visit or procedure associated with these provider types into which supplies can be bundled.

HOT AND COLD PACKS OR DEVICES

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

Hot or cold therapy durable medical equipment (DME) **isn't covered**.

Exception: HCPCS code A9273, ice caps or collars are **covered** for DME providers only. Hot water bottles, heat and / or cold wraps aren't covered.

[WAC 296-20-1102](#) prohibits payment for heat devices for home use including heating pads. These devices are either bundled or **not covered**.

AUTHORIZATION REQUIREMENTS

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

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

Prior authorization **is required** for:

- Prosthetics, surgical appliances and other special equipment described in [WAC 296-20-03001](#), Treatment requiring authorization.
- Replacement of specific items on closed claims per [WAC 296-20-124](#), Rejected and closed claims.

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

For more information, contact the Provider Hotline at 1-800-848-0811 or 360-902-6500 (from Olympia).

Contact the self-insured employer or their third party administrator for prior authorization on self-insured claims. <http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

DENTAL SERVICES

Dental providers licensed in the state in which they practice may be paid for performing dental services ([WAC 296-20-110](#) and [WAC 296-23-160](#)).

This policy pertains to bills submitted for dental services.

PRE-EXISTING CONDITIONS

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

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker ([WAC 296-20-110](#)). It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that will not be covered.

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

To avoid delays in treatment, please exclude information regarding treatment that isn't directly related to the injury.

WHO CAN BILL

Dental providers including:

- Dentists
- Oral and Maxillofacial surgeons
- Orthodontists
- Denturists
- Hospitals
- Dental clinics

BILLING RULES

Provider Number

You must have an L&I provider account number to treat and be paid for services provided to injured workers ([WAC 296-20-015](#)). You can find more information about becoming an L&I provider at <http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp>

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>

BILLING INSTRUCTIONS

Billing Forms

To bill for workers' compensation claims, dentists should use L&I's Statement for Miscellaneous Services form. To bill for Crime Victims Compensation (CVC) claims, dentists should use CVC's Statement for Crime Victims Miscellaneous Services. Forms can be found at <http://www.lni.wa.gov/FormPub/BySubject.asp>.

Failure to use L&I's most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the code, materials used and the injured tooth number(s). When using Current Dental Terminology (CDT[®]) codes, please include the "D" in front of the code billed to avoid delays in claim/bill processing.

Bills must be submitted within one year from the date the service is rendered ([WAC 296-20-125](#)).

AUTHORIZATION AND TREATMENT PLAN REQUIREMENTS

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and CVC claims
- Self-insured employer or their third party administrator

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

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

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

To obtain authorization for a treatment plan the following are required:

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

Please include:

- Procedure code.
- Tooth number.
- Tooth surface.
- Charge amount.

Don't use a billing form to submit your treatment plan.

TREATMENT PLAN SUBMISSION

Claim services requiring prior authorization require a treatment plan. The dentist should outline the extent of the dental injury and the treatment plan ([WAC 296-20-110](#)).

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

PRIOR AUTHORIZATION REVIEW

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to restorative, endodontic, prosthodontic, prosthetic, implant, orthodontics, surgery and anesthesia procedures.

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

To avoid delays in authorization of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number

State the condition of the mouth and involved teeth including:

- Missing teeth, existing caries and restorations.
- Condition of involved teeth prior to the injury (caries, periodontal status).

Mail State Fund **treatment plans** to:
Department of Labor & Industries
PO Box 44291
Olympia, Washington 98504-4291

State Fund treatment plans (**not billing** info) may be faxed to:
(360) 902-4567

Mail CVC claim **treatment plans** to:
Department of Labor & Industries
PO Box 44520
Olympia, Washington 98504-4520

Mail self-insured treatment plans to the SIE/TPA.
<http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

DOCUMENTATION AND RECORDKEEPING REQUIREMENTS

Chart Notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service ([WAC 296-20-010](#)). Legible copies of office notes are required for all initial and follow-up visits ([WAC 296-20-06101](#)).

Acceptance of a Claim

If you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. You initiate the State Fund claim or CVC claim for your patient when you send an accident report to L&I.

The State Fund Report of Industrial Injury or Occupational Disease (Accident Report) (ROA) form can be ordered at:

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599> or call 1-800-LISTENS or 1-360-902-4300.

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

Attending Provider

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

Your responsibility as the AP includes:

- Documenting employment issues in the injured worker's chart notes, including:
 - A record of the worker's physical and medical ability to work, and
- Information regarding any rehabilitation that the worker may need to undergo.
- Restrictions to recovery,
- Any temporary or permanent physical limitations, and
- Any unrelated condition(s) that may delay recovery must also be documented.

For ongoing treatment, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format. Information on the format can be found in the Charting Format section, page **19** of this document.

L&I'S REVIEW OF DENTAL SERVICES

L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but aren't limited to, review of the injured worker's dental records.

HOME HEALTH SERVICES

Home Health Services include attendant care, home health, home care, infusion therapy, and hospice. All of these services require **prior authorization**. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

ATTENDANT CARE SERVICES

Attendant care services provide assistance in the home for personal care and activities of daily living. Attendant care services must be provided by an agency that is licensed, certified or registered to provide home health or home care services. Attendant care agencies must have registered nurse (RN) supervision of care givers providing care to a worker. In addition to prior authorization, attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services. RN supervision services aren't paid separately and are included in the hourly fee as business overhead. Attendants for workers may be:

- Registered aides
- Certified nurse's aides
- Licensed practical nurses
- RNs

The agency providing services must be able to provide the type of attendant care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

The agency can't bill for more than 12 hours per day for any one caregiver. The agency can't bill for care during the time the caregiver is sleeping.

All RN evaluation reports must be submitted to the insurer within 15 days of the initial evaluation and then annually or when the worker's condition changes and necessitates a new evaluation. Documentation to support daily billing must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift
- Name, initials, and title of each caregiver
- Specific care provided and who provided the care.

The insurer will notify the provider in writing if current approved hours are modified or changed. Refer to [WAC 296-20-091](#) and [WAC 296-23-246](#) for additional information.

The insurer will determine the maximum hours and type of authorized attendant care required based on the nursing assessment of the worker's personal care needs. Personal care may include but isn't limited to:

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

Attendant care services may be terminated or not authorized if:

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

Attendant Service Codes

Code	Description	Fee
S9122	Attendant in the home provided by a home health aide or certified nurse assistant per hour	\$26.01
S9123	Attendant in the home provided by a registered nurse per hour	\$56.57
S9124	Attendant in the home provided by licensed practical nurse per hour	\$41.29

Bundled Codes and DME

Attendant care agencies may bill for wound care and medical treatment supplies. Covered HCPCS codes which are listed as bundled in the fee schedule are separately payable to home attendant care service providers for supplies used in the worker's home.

When caregivers are providing wound care, prior authorization and a prescription from the treating provider is required to bill for infection control supplies (HCPCS code S8301). An invoice for the supplies must be submitted with the bill.

Noncovered Services

Social work services **aren't covered**, except as part of home hospice care.

Chore services and other services that are only needed to meet the worker's environmental needs **aren't covered**. The following services are examples of chore services.

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

Workers must not be left unattended during approved service hours. Attendant care providers may not bill for services the attendant performs in the home while the worker is away from the home.

Attendant care services won't be covered when a worker is in the hospital or a nursing facility unless the worker's industrial injury causes a special need that the hospital or nursing facility can't provide and attendant care is specifically authorized to be provided in the hospital or nursing facility.

The agency can bill workers for hours not approved by the insurer if worker is notified in advance that they are responsible for payment.

Spouse Attendant Care

Spouses who aren't employed by an agency, who provided insurer approved attendant services to the worker prior to October 1, 2001, and who met criteria in the year 2002, may continue to bill for spouse attendant care (per [WAC 296-23-246](#)).

Spouse attendants may bill up to 70 hours per week. Spouse attendants won't be paid during sleeping time. Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation which must be performed yearly. If the worker requires more than 70 hours per week of attendant care, the insurer can approve a qualified agency to provide the additional hours of care. The insurer will determine the maximum amount of additional care based on an RN evaluation.

Spouse Attendant Code

Code	Description	Fee
8901H	Spouse attendant in the home per hour	\$12.78

Travel Not Related To Medical Care

A worker who qualifies for attendant care and is planning a long distance trip must inform the insurer of the plans and request specific authorization for coverage during the trip. The insurer **won't cover** travel expenses of the attendant or authorize additional care hours. The worker must coordinate the trip with the appropriate attendant care agencies. Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

Respite Attendant Care

The insurer can approve short term agency attendant care services for a spouse or family member who provides either paid or unpaid attendant care when respite (relief) care is required. Respite care must be pre-authorized by the insurer.

A nursing evaluation (see Nursing Evaluations) will be conducted to determine the level of care and the maximum hours of service required if a current nursing assessment isn't available. The insurer will notify the agency in writing when services are approved. The agency providing respite care must meet L&I criteria as a provider of home health services.

If in-home attendant care can't be arranged with an agency, a temporary stay in a residential care facility can be approved by the insurer.

The insurer will notify the provider in writing if current approved hours are modified or changed. Spouses won't be paid for respite care.

Nursing Evaluations

An independent nurse evaluation requested by the insurer may be billed under Nurse Case Manager or Home Health Agency RN codes, using their respective codes.

HOSPICE SERVICES

In-home hospice services must be preauthorized and may include chore services. The following code applies to in-home hospice care:

Code	Description	Fee
Q5001	Hospice care, in the home, per diem	By report

For hospice services performed in a facility, please refer to Nursing Home, Residential and Hospice Care Services in the Facility Section.

HOME HEALTH SERVICES

The insurer will pay for aide, RN, physical therapy (PT), occupational therapy (OT), and speech therapy services provided by a licensed home health agency when services become proper and necessary to treat a worker's accepted condition. Home health services require prior authorization. Home health services are for intermittent or short term treatment or therapy for a medical condition. Home health services must be requested by a physician.

Services require an initial evaluation by the RN or PT/OT and a written report must be submitted to the insurer within 15 days of the evaluation.

Payment for continued treatment will require documentation of the worker's needs and progress and renewed authorization at the end of an approved treatment period. The worker is expected to be present and ready for the home health nurse or therapist treatment. Non-cooperation can result in termination of services.

Home health services may be terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

Documentation

Home health care providers must submit the initial assessment, attending provider's treatment plan and/or orders and home care treatment plan within 15 days of beginning the service.

Providers must submit documentation to the insurer to support daily billing that includes:

- Begin and end time of each caregiver's shift
- Name, initials, and title of each caregiver
- Specific care provided and who provided the care

Updated plans must be submitted every 30 days thereafter.

Home Health Codes

Code	Description	Fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day.	\$37.32
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day.	\$38.69
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day.	\$38.69
G0154	Services of skilled nurse RN/LPN in the home. 15 min units.	\$38.69
G0156	Services of home health aide in the home. 15 min units. Maximum of 96 units per day.	\$6.50
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units.	\$38.69

Bundled Codes and DME

Home health and home infusion services may bill appropriate HCPCS codes for wound care and medical treatment supplies. Covered HCPCS codes listed as bundled in the fee schedule are separately payable to home health and home care providers for supplies used during the home health visit. See [WAC 296-20-01002](#) for the definition of bundled services. Durable medical equipment may require specific authorization prior to purchase.

HOME INFUSION SERVICES

Home infusion services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home. Skilled nurses contracted by the home infusion service provide education of the worker and family, evaluation and management of the infusion therapy, and care for the infusion site.

Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition. Prior authorization is required for home infusion nurse services, drugs, and any supplies, regardless of who is providing services. Home infusion services can be authorized independently or in conjunction with home health services.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with National Drug Code (NDC) codes or Universal Product Code (UPC) codes if no NDC codes are available.

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes. See [WAC 296-20-1102](#) for additional information.

NOTE: Home health agencies must have prior authorization and use the RN G0154 visit code when administering home injections or nutritional parenteral solutions only.

Medical Supply companies and home infusion pharmacies may use the appropriate HCPCS code to bill for parenteral solutions, total parental nutrition (TPN), or enteral formula nutrition with prior authorization. Home infusion codes may be billed for initial establishment of nutritional therapy for the worker when services have been authorized.

Home Infusion Codes

Code	Description	Fee
99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit.	\$149.32
99602	Skilled RN visit for each additional hour per visit.	\$62.79

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of an **accepted** condition. Supplies include, but aren't limited to:

- Drugs administered in a provider's office
- Medical and surgical supplies
- Prefabricated orthotics.

Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services. The insurer won't pay CPT® code 99070, which represents miscellaneous supplies and materials provided by the physician.

Under the fee schedules, some services and supply items are considered bundled into the cost of other services (associated office visits or procedures) and won't be paid separately. See [WAC 296-20-01002](#) for the definition of bundled codes.

Supplies used in the course of an office visit are considered bundled and aren't payable separately.

Fitting fees are bundled into the office visit or into the cost of any DME and aren't payable separately.

Billing Tip

NOTE: Bundled codes contain the word bundled in the dollar value column in the Professional Services Fee schedule. Refer to **Appendices B and C** for lists of bundled services and supplies.

ACQUISITION COST POLICY

NOTE: This policy doesn't apply to hospital bills. Refer to the Facilities Section for the [hospital acquisition](#) cost policy, page **190190**.

Supply codes without a fee listed **will be paid** at their acquisition cost.

The total acquisition cost should be billed as 1 charge. The acquisition cost equals:

- The wholesale cost plus
- Shipping and handling plus
- Sales tax.

For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but isn't required.

Wholesale invoices for all supplies and materials must be kept in the provider's office files for a minimum of 5 years.

A provider must submit a hard copy of the wholesale invoice to the insurer when billing for a supply item that costs \$150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Billing Tip

Sales tax and shipping and handling charges aren't paid separately, and must be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills but isn't required.

CASTING MATERIALS

Bill for casting materials with HCPCS codes Q4001-Q4051. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

MISCELLANEOUS SUPPLIES

The following supplies must be billed with HCPCS Code E1399:

- Therapy putty and tubing
- Anti-vibration gloves

Bills coded with E1399 will be reviewed for payment and must meet the following criteria:

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

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter when performed in a provider's office and used to treat a temporary obstruction. Payment for the service isn't allowed when the procedure is performed on the same day or during the postoperative period of a major surgical procedure that has a follow up period.

For catheterization to obtain specimen(s) for lab tests, see the [Pathology and Laboratory Services](#) section, page 109.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

L&I follows CMS's policy of bundling HCPCS codes for surgical trays and supplies used in a physician's office.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. No separate payment is allowed.

Primary and secondary surgical dressings dispensed for home use are payable at acquisition cost when **all** of the following conditions are met:

- They are dispensed to a patient for home care of a wound and
- They are medically necessary and
- The wound is due to an accepted, work-related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as:

- Telfa
- Adhesive strips for wound closure
- Petroleum gauze

Secondary Surgical Dressings

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. Examples include items such as: adhesive tape, roll gauze, binders, and disposable compression material. They don't include items such as elastic stockings, support hose and pressure garments. These items must be billed with the appropriate HCPCS.

Providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item. Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and won't be paid.

HOT AND COLD PACKS OR DEVICES

The application of hot or cold packs is bundled for all providers.

Hot or cold therapy durable medical equipment (DME) **isn't covered**.

Exception: E0230, Ice cap or collar, is **covered** for DME providers only.

[WAC 296-20-1102](#) prohibits payment for heat devices for home use including heating pads.

These devices are either bundled or **not covered** (see **Appendices B, C and D and the Durable Medical Equipment section**).

AMBULANCE SERVICES

GENERAL INFORMATION

The ambulance services payment policies are primarily based on the current Medicare payment policies for ambulance services modified to meet the needs of Washington State's workers.

VEHICLE AND CREW REQUIREMENTS

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

Key sections of this WAC are identified below:

1. General
 - [WAC 246-976-260](#) Licenses required
2. Ground Ambulance Vehicle Requirements
 - [WAC 246-976-290](#) Ground ambulance vehicle standards
 - [WAC 246-976-300](#) Ground ambulance and aid vehicles--Equipment
 - [WAC 246-976-310](#) Ground ambulance and aid vehicles--Communications equipment
 - [WAC 246-976-390](#) Verification of trauma care services
3. Air Ambulance Services
 - [WAC 246-976-320](#) Air ambulance services
4. Personnel
 - [WAC 246-976-182](#) Authorized care
 - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines

PAYMENT POLICIES FOR AMBULANCE RELATED SERVICES

Emergency Transport

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated. Payment is based on the level of medically necessary services provided, not simply on the vehicle used.

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

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

Proper Facilities

The insurer pays the provider for ambulance services to the nearest place of proper treatment. To be a place of proper treatment, the facility must be generally equipped to provide the needed medical care for the worker. A facility isn't considered a place of proper treatment if no bed is available when inpatient medical services are required.

Multiple Patient Transportation

The insurer pays the appropriate base rate for each worker transported by the same ambulance. When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported. The provider must use HCPCS Modifier GM (Multiple Patients on 1 Ambulance Trip) for the appropriate mileage billing codes. The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

Nonemergency Transport

Nonemergency transportation by ambulance is appropriate if:

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

Bed-confined criteria:

- The worker is unable to get up from bed without assistance, and
- The worker is unable to ambulate, and
- The worker is unable to sit in a chair or wheelchair.

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

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

Workers may not arrange nonemergency ambulance transportation. Only medical providers may arrange for nonemergency ambulance transportation.

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

Arrival of Multiple Providers

When multiple providers respond to a call for services, only the provider that furnishes the transport of the worker(s) is eligible to be paid for the services provided. No payment is made to the other provider(s).

Mileage

The insurer pays for mileage (ground and/or air) based on loaded miles only, for example, from the pickup of the worker(s) to their arrival at the destination. The destination is defined as the nearest place of proper treatment.

AMBULANCE SERVICES FEE SCHEDULE

HCPCS Code	Description	Fee Schedule
A0425	Ground mileage, per statute mile	\$12.81 per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	\$633.83
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	\$657.87
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	\$346.24
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	\$554.00
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	\$5,652.91
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	\$6,572.32
A0433	Advanced Life Support, Level 2 (ALS 2)	\$952.18
A0434	Specialty care transport (SCT)	\$1,125.31
A0435	Fixed wing air mileage, per statute mile	\$31.47 per mile
A0436	Rotary wing air mileage, per statute mile	\$73.11 per mile
A0999	Unlisted ambulance service	By report restrictions: (1) Reviewed to determine if a more appropriate billing code is available; and (2) Reviewed to determine if medically necessary

AUDIOLOGY AND HEARING SERVICES

The following policies and requirements apply to all hearing aid services and devices except for CPT® codes.

SELF-INSURERS

SIEs that have entered into contracts for purchasing hearing aid related services and devices may continue to use them. (See [WAC 296-23-165](#) section 1(b).) SIEs that don't have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this section.

AUTHORIZATION REQUIREMENTS

Initial and Subsequent Hearing Related Services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies and accessories in accordance with [WAC 296-20-03001](#) and [WAC 296-20-1101](#). The insurer won't pay for hearing devices provided prior to authorization.

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

The authorization process for State Fund claims may be initiated by calling the claim manager or the State Fund's Provider Hotline at 1-800-848-0811 (in Olympia call 902-6500).

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

Trial Period

A 30-day trial period is the standard established by [RCW 18.35.185](#). During this time, the provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids aren't damaged). Follow up hearing aid adjustments are bundled into the dispensing fee. If hearing aids are returned within the 30-day trial period, the provider must refund the hearing aid and dispensing fee.

Types of Hearing Aids Authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). The decision will be based on recommendations from physicians, ARNPs, licensed audiologists, or fitter/dispensers. Based on current technology, the types of hearing aids purchased for most workers are digital or programmable in the ear (ITE), in the canal (ITC), and behind the ear (BTE).

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

L&I won't purchase used or repaired equipment.

Hearing Aid Quality

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards. All manufacturers and assemblers must hold a valid FDA certificate.

Masking Devices for Tinnitus

In cases of accepted tinnitus, the department or self-insurer may authorize masking devices. If masking devices are dispensed without hearing aids, providers will bill using code E1399. When dispensed as a component of a hearing aid, providers will bill using code V5267. Providers must bill masking devices at their acquisition cost. Refer to the Acquisition Cost

Policy on page [136](#) for more detail. If masking devices are dispensed without hearing aids, the provider may also bill the appropriate dispensing fee code for monaural or binaural devices.

Special Authorization for Hearing Aids and Masking Devices over \$900 per Ear

If the manufacturer's invoice cost of any hearing aid or masking device exceeds \$900 per ear including shipping and handling, special authorization is required from the claim manager.

Exception: The cost of BTE ear molds doesn't count toward the \$900 for special authorization. Initial BTE ear molds may be billed using V5264, and replacements may be billed using V5014 with V5264.

Authorized Testing

Testing to fit a hearing aid may be done by a licensed audiologist, fitter/dispenser, qualified physician, or qualified ARNP. The provider must obtain **prior authorization** for subsequent testing. The insurer doesn't pay for testing after a claim has closed unless related to fitting of replacement hearing aids.

The insurer doesn't cover annual hearing tests.

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

Required Documentation

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

- Report of Accident
- Occupational Disease Employment History Hearing Loss (F262-013-000; F262-013-111 continuation)
- Occupational Hearing Loss Questionnaire (F262-016-000)
- Valid audiogram
- Medical report
- Hearing Services Worker Information (F245-049-000)
- Authorization to Release Information (F262-005-000)

PAYMENT FOR AUDIOLOGY SERVICES

The insurer **doesn't pay** any provider or worker to fill out the Occupational Disease Employment History Hearing Loss form or Occupational Hearing Loss Questionnaire.

A physician or ARNP may be paid for a narrative assessment of work-relatedness to the hearing loss condition. Refer to the *Attending Doctors Handbook* table on Other Miscellaneous Codes and Descriptions.

The insurer **will pay** for the cost of battery replacement for the life of an authorized hearing aid. No more than 1 box of batteries (40) will be paid within each 90-day period.

NOTE: Sending workers batteries that they have not requested, and for which they don't have an immediate need, is in violation of L&I's rules and payment policies.

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

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

Hearing Aid Parts and Supplies Paid at Acquisition Cost

Parts and supplies **must be billed** and **will be paid** at acquisition cost including volume discounts (manufacturers' wholesale invoice). **Don't bill** your usual and customary fee.

- Supply items for hearing aids include tubing, wax guards, and ear hooks. These can be billed within the warranty period.
- Parts for hearing aids include switches, controls, filters, battery doors, and volume control covers. These can be billed as replacement parts only, but not within the warranty period.
- Shells ("ear molds" in HCPCS codes) and other parts can be billed separately at acquisition cost. The insurer **doesn't cover** disposable shells.

Hearing aid extra parts, options, circuits and switches, (for example, T-coil and noise reduction switches), can only be billed when the manufacturer doesn't include these in the base invoice for the hearing aid.

Batteries

Only 1 box of batteries (40) is authorized within each 90 day period. Providers must document the request for batteries by the worker and must maintain proof that the worker actually received the batteries.

NOTE: Sending workers batteries that they haven't requested and for which they don't have an immediate need is in violation of L&I's rules and payment policies.

Worker Responsible for Devices That Aren't Medically Necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given and wants to purchase different hearing aids, the worker then becomes totally responsible for the purchase of the hearing aid, batteries, supplies and any future repairs.

Worker Responsible for Some Repairs, Losses, Damages

Workers are responsible to pay for repairs and batteries for hearing aids not authorized by the insurer.

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

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

REPAIRS AND REPLACEMENTS

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

Warranties

Hearing aid industry standards provide a minimum of a 1 year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than 1 year, the manufacturer's warranty will apply.

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

The warranty should include the make, model and serial number of the individual hearing aid.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is **covered** under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid without charge.

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

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

- The warranty begins on the date the hearing aid is dispensed to the worker
- For repairs, the warranty begins when the hearing aid is returned to the worker

Repairs

Prior authorization is required for all billed repairs.

The insurer will repair hearing aids and devices when needed due to normal wear and tear.

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

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

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

For prior authorization of in-office repairs or repairs by the manufacturer or an all-make repair company, providers must submit a written estimate of the repair cost to the Provider Hotline or the SIE claim manager.

Replacement

The insurer doesn't provide an automatic replacement period.

Replacement requests must be sent directly to the insurer.

Documentation that a hearing aid isn't repairable may be submitted by licensed audiologists, fitter/dispensers, all-make repair companies or FDA certified manufacturers. Documentation to support a hearing aid as not repairable must be verified by:

- All-make repair companies or
- FDA certified manufacturers/repair facilities

If only 1 of the binaural hearing aids isn't repairable and if, in the professional's opinion both hearing aids need to be replaced, the provider must submit written, logical rationale for the claim manager's consideration.

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

- At its discretion, the insurer may replace hearing aids in other circumstances
- Replacement is defined as purchasing a hearing aid for the worker according to L&I's current guidelines
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer **won't pay** for new hearing aids when only new ear shell(s) are needed.
- The insurer **won't replace** a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on-the-job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident.
- The insurer **won't replace** hearing aids based solely on changes in technology.
- The insurer **won't pay** for new hearing aids for hearing loss resulting from: noise exposure that occurs outside the workplace; nonwork related diseases and conditions, **or** the natural aging process

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

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

Linear Non-programmable Analog Hearing Aid Replacement Policy

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

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

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with non-linear digital or analog hearing aid is authorized.

Providers must use modifier *RP* with the appropriate hearing aid HCPCS code to be paid for the replacement aid. The *RP* modifier is required to help the insurer track utilization of the replacement hearing aids.

Who Can Bill

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

Authorization Requirements

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

For State Fund claims

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

For Self-Insured claims

Contact the SIE/TPA for prior authorization. For a list of SIEs/TPAs:

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

Authorization Documentation and Recordkeeping Requirements

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

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

DOCUMENTATION AND RECORD KEEPING REQUIREMENTS

Documentation to Support Initial Authorization

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

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

Documentation to Support Repair

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

Documentation to Support Replacement

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

- The name and credential of the person who inspected the hearing aid, and
- Date of the inspection, and
- Observations, for example, a description of the damage, and/or information on why the

device can't be repaired or should be replaced.

Correspondence with the Insurer

The insurer may deny payment of the provider's bill if the following information has not been received.

- Original or unaltered wholesale invoices from the manufacturer are required to show the acquisition cost and must be retained in the provider's office records for a minimum of 5 years. The insurer **won't accept** invoices printed from email or the internet.
- A hard copy of the original or unaltered manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part or supply costs \$150.00 or more, or upon the insurer's request
- **NOTE:** Electronic billing providers must submit a hard copy of the original or unaltered manufacturer's wholesale invoice with the make, model and serial number for individual hearing aids within 5 days of bill submission.

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

For State Fund claims, providers are required to send warranty information to:

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

For self-insured claims, send warranty information to the SIE/TPA. Contact list is available at <http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp>

ADVERTISING LIMITS

L&I can deny a provider's application to provide services or suspend or revoke an existing provider account if the provider participates in false, misleading, or deceptive advertising, or misrepresentations of industrial insurance benefits. See [RCW 51.36.130](#) and [WAC 296-20-015](#) for more information.

False advertising includes mailers and advertisements that:

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

BILLING REQUIREMENTS

Billing for Binaural Hearing Aids

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

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left).
- Bill the appropriate HCPCS code for binaural aids.
- Only 1 unit of service should be billed even though 2 hearing aids (binaural aids) are dispensed.

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing format.

Billing for a Monaural Hearing Aid

When billing the insurer for 1 hearing aid, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected.
- Bill the appropriate HCPCS code for monaural aid.
- Only 1 unit of service should be billed.

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing formats.

Billing for Hearing Aids, Devices, Supplies, Parts and Services

All hearing aids, parts, and supplies must be billed using HCPCS codes. Hearing aids and devices are considered to be durable medical equipment and must be billed at their acquisition cost. Refer to the [Acquisition Cost Policy](#), page 136, for more detail.

The table below indicates which services and devices are **covered** by provider type.

Provider Type	Service/Device
Fitter/Dispenser	HCPCS codes for all hearing related services and devices
Durable Medical Equipment Providers	Supply and battery codes
Physician, ARNP, Licensed Audiologist	HCPCS codes for hearing related services and devices; and CPT® codes for hearing-related testing and office calls

AUTHORIZED FEES

Dispensing Fees

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

- Up to 4 follow up visits (ongoing checks of the aid as the wearer adjusts to it), and
- 1 hearing aid cleaning kit, and
- Routine cleaning during the first year, and
- All handling and delivery fees.

Restocking Fees

The Washington State Department of Health statute ([RCW 18.35.185](#)) and rule ([WAC 246-828-290](#)) allow hearing instrument fitter/dispensers and licensed audiologists to retain \$150.00 or 15% of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee is sometimes called a restocking fee. Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds the purchase agreement.

The insurer must receive Termination of Agreement (Rescission) form (F245-050-000) or a statement signed and dated by the provider and the worker. The form must be faxed to L&I at (360) 902-6252 or forwarded to the SIE/TPA within 2 business days of receipt of the signatures. The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer for the restocking fee of \$150.00 or 15% of the total purchase price, whichever is less. Use code 5091V. Restocking fees can't be paid until the insurer has received the refund.

Fee Schedule

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

HCPCS Code	Description	Maximum Fee
V5008	Hearing screening	\$ 76.55
V5010	Assessment for hearing aid	Bundled
V5011	Fitting/orientation/checking of hearing aid	Bundled
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V)	\$ 51.04
V5020	Conformity evaluation (1 visit allowed after the 30-day trial period)	Bundled
V5030	Hearing aid, monaural, body worn, air conduction	Acquisition cost
V5040	Body-worn hearing aid, bone	Acquisition cost
V5050	Hearing aid, monaural, in the ear	Acquisition cost
V5060	Hearing aid, monaural, behind the ear	Acquisition cost
V5070	Glasses air conduction	Acquisition cost
V5080	Glasses bone conduction	Acquisition cost
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	Acquisition cost
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	Acquisition cost
V5130	Binaural, in the ear	Acquisition cost
V5140	Binaural, behind the ear	Acquisition cost
V5150	Binaural, glasses	Acquisition cost
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$ 1449.38
V5170	Hearing aid, cros, in the ear	Acquisition cost
V5180	Hearing aid, cros, behind the ear	Acquisition cost
V5190	Hearing aid, cros, glasses	Acquisition cost
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$ 868.72
V5210	Hearing aid, bicros, in the ear	Acquisition cost
V5220	Hearing aid, bicros, behind the ear	Acquisition cost
V5230	Hearing aid, bicros, glasses	Acquisition cost
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$ 868.72
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	\$ 724.69
V5242	Hearing aid, analog, monaural, cic (completely in the ear canal)	Acquisition cost
V5243	Hearing aid, monaural, itc (in the canal)	Acquisition cost
V5244	Hearing aid, digitally programmable analog, monaural, cic	Acquisition cost
V5245	Hearing aid, digitally programmable, analog, monaural, itc	Acquisition cost
V5246	Hearing aid, digitally programmable analog, monaural, ite (in the ear)	Acquisition cost
V5247	Hearing aid, digitally programmable analog, monaural, bte (behind the ear)	Acquisition cost
V5248	Hearing aid, analog, binaural, cic	Acquisition cost
V5249	Hearing aid, analog, binaural, itc	Acquisition cost
V5250	Hearing aid, digitally programmable analog, binaural, cic	Acquisition cost
V5251	Hearing aid, digitally programmable analog, binaural, itc	Acquisition cost
V5252	Hearing aid, digitally programmable, binaural, ite	Acquisition cost
V5253	Hearing aid, digitally programmable, binaural, bte	Acquisition cost
V5254	Hearing aid, digital, monaural, cic	Acquisition cost
V5255	Hearing aid, digital, monaural, itc	Acquisition cost
V5256	Hearing aid, digital, monaural, ite	Acquisition cost

HCPCS Code	Description	Maximum Fee
V5257	Hearing aid, digital, monaural, bte	Acquisition cost
V5258	Hearing aid, digital, binaural, cic	Acquisition cost
V5259	Hearing aid, digital, binaural, itc	Acquisition cost
V5260	Hearing aid, digital, binaural, ite	Acquisition cost
V5261	Hearing aid, digital, binaural, bte	Acquisition cost
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	Acquisition cost
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	\$ 0.88
V5267	Hearing aid supply/accessory	Acquisition cost
5091V	Hearing aid restocking fee (the lesser of 15% of the hearing aid total purchase price or \$150 per hearing aid)	By report
5092V	Hearing aid cleaning visit per ear (1 every 90 day, after the first year)	\$ 23.81
5093V	Hearing aid repair fee. Manufacturer's invoice required	By report

INTERPRETIVE SERVICES

INFORMATION FOR HEALTH CARE AND VOCATIONAL PROVIDERS

Workers or crime victims who have limited English proficiency or sensory impairments may need interpretive services to effectively communicate with providers. Interpretive services don't require **prior authorization**.

Under the Civil Rights Act of 1964, the health care or vocational provider will determine whether effective communication is occurring.

If assistance is needed, the health care or vocational provider:

- Selects an interpreter to facilitate communication.
- Determines if an interpreter (whether paid or unpaid) accompanying the worker meets the communication needs.

If health care or vocational provider determines a different interpreter is needed:

- The worker may be consulted in the selection process.
- Sensitivity to the worker's cultural background and gender is encouraged when selecting an interpreter.
- Ultimate decision rests with health care or vocational provider

Either paid or unpaid interpreters may assist with communications. In all cases:

- A paid interpreter must meet the credentialing standards contained in this policy.
- Persons identified as ineligible to provide services in this policy may not be used even if they are unpaid.
- Persons under age 18 may not interpret for workers or crime victims.

Please review the sections related to eligible and ineligible interpretive services providers.

For paid interpreters, healthcare or vocational providers or their staff must verify services on the Interpretive Services Appointment Record (F245-056-000) or a similar interpreter provider's verification form which will be presented by the interpreter at the end of the appointment. Providers should also note in their records that an interpreter was used at the appointment.

When a procedure requires informed consent, a credentialed interpreter should help you explain the information.

POLICY APPLICATION

This policy applies to interpretive services provided for health care and vocational services in all geographic locations to workers and crime victims having limited English proficiency or sensory impairment; and receiving benefits from the following insurers:

- The State Fund or
- SIEs or
- The Crime Victims Compensation Program.

This policy doesn't apply to interpretive services for workers or crime victims for legal purposes, including but not limited to:

- Attorney appointments
- Legal conferences
- Testimony at the Board of Industrial Insurance Appeals or any court
- Depositions at any level

Payment in these circumstances is the responsibility of the attorney or other requesting party(s).

CREDENTIALS REQUIRED FOR L&I PROVIDER ACCOUNT NUMBER

An interpreter or translator must have an L&I provider account.

To obtain an L&I interpretive services provider account number, an interpreter or translator must:

- Submit credentials using the “Submission of Provider Credentials for Interpretive Services” form (F245-055-000).
- Credentials accepted include those listed below under “Certified Interpreter” and “Certified Translator” or “Qualified Interpreter” or “Qualified Translator”.
- Provisional certification isn’t accepted.

Interpreters and translators can only be paid for services in the languages for which they have provided credentials.

Credentialed Employees of Health Care and Vocational Providers

Credentialed employees of health care and vocational providers are eligible to receive payment for interpretive services under the following circumstances:

- The individual’s sole responsibility is to assist patients or clients with language or sensory limitations and
- The individual is a credentialed interpreter or translator and
- The individual has an L&I provider account number for interpretive services.

Interpreters/Translators Not Eligible for Payment

Other persons may, on occasion, assist the worker or crime victim with language or communication limitations. These persons don’t require provider account numbers, but also **won’t be paid** for interpretive services. These persons may include but aren’t limited to:

- Family members
- Friends or acquaintances
- The healthcare or vocational provider
- Employee(s) of the health care or vocational provider whose primary job isn’t interpretation
- Employee(s) of the health care or vocational provider whose primary job is interpretation but who isn’t a credentialed interpreter or translator
- Interpreters/translators who don’t comply with all applicable state and/or federal licensing or certification requirements, including but not limited to, business licenses as they apply to the specific provider’s practice or business

Persons Ineligible to Provide Interpretation/Translation Services

Some persons may not provide interpretation or translation services for workers or crime victims during health care or vocational services delivered for their claims. These persons are:

- The worker’s or crime victim’s legal or lay representative or any employee of the legal or lay representative
- The employer’s legal or lay representative or any employee of the legal or lay representative
- Persons under age 18

NOTE: Workers or crime victims using children for interpretation purposes should be advised they need to have an adult provide these services.

Persons Ineligible to Provide Interpretation/Translation Services at IMEs

Under [WAC 296-23-362\(3\)](#), “The worker may not bring an interpreter to the examination. If interpretive services are needed, the insurer will provide an interpreter.” Therefore, at Independent Medical Examinations (IMEs), persons (including interpreter/translator providers with account numbers) who may not provide interpretation or translation services for workers or crime victims are:

- Those related to the worker or crime victim
- Those with an existing personal relationship with the worker or crime victim
- The worker’s or crime victim’s legal or lay representative or employees of the legal or lay representative
- The employer’s legal or lay representative or employees of the legal or lay representative
- Any person who couldn’t be an impartial and independent witness
- Persons under age 18

Interpreters and translators located outside of Washington State must submit credentials from their state Medicaid programs, state or national court systems or other nationally recognized programs.

For interpretive services providers in any geographic location, credentials submitted from agencies or organizations other than those listed below may be accepted if the testing criteria can be verified as meeting the minimum standards listed below:

Interpreter test(s) consists of, at minimum:	Document translation test(s) consists of, at minimum:
A verbal test of sight translation in both English and other tested language(s); and	A written test in English and in the other language(s) tested; or
A written test in English; and	A written test and work samples demonstrating the ability to accurately translate from one specific source language to another specific target language
A verbal test of consecutive interpretation in both languages; and	
For those providing services in a legal setting, a verbal test of simultaneous interpretation in both languages	

Certified Interpreter

Interpreter who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate
Washington State Administrative Office for the Courts (AOC)	Certificate
RID-NAD National Interpreter Certification (NIC)	Certified Advanced (Level 2), or Certified Expert (Level 3)
Registry of Interpreters for the Deaf (RID)	Comprehensive Skills Certificate (CSC), or Master Comprehensive Skills Certificate (MSC), or Certified Deaf Interpreter (CID), or Specialist Certificate: Legal (SC:L), or Certificate of Interpretation and Certificate of Transliteration (CI/CT)
National Association for the Deaf (NAD)	Level 4, or Level 5
Federal Court Interpreter Certification Test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate

Qualified Interpreter

Interpreter who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Translators and Interpreters Guild	Certificate
Washington State Department of Social and Health Services (DSHS)	Letter of authorization as a qualified social and/or medical services interpreter
Federal Court Interpreter Certification Examination (FCICE)	Letter of designation or authorization

Certified Translator

Translator who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
DSHS	Translator Certificate
Translators and Interpreters Guild	Certificate
American Translators Association	Certificate

Qualified Translator

Translator who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
A state or federal agency; A state or federal court system; Other organization including language agencies; and/or An accredited academic institution of higher education.	Certificate or other verification showing: Successful completion of an examination or test of written language fluency in both English and in the other tested language(s); and A minimum of 2 years experience in document translation.

Maintaining Credentials

Interpretive services providers are responsible for maintaining their credentials as required by the credentialing agency or organization. Should the interpretive services provider's credentials expire or be removed for cause or any other reason, the provider must immediately notify the insurer.

Hospitals and other facilities may have additional requirements

Hospitals, free standing surgery and emergency centers, nursing homes and other facilities may have additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider isn't a contractor or employee of the facility. The facility is responsible for notifying the interpretive services provider of their additional requirements and managing compliance with the facilities' requirements.

PRIOR AUTHORIZATION

Services not requiring prior authorization

Direct interpretive services (either group or individual) and mileage don't require **prior authorization** on open claims. Providers should check claim status with the insurer prior to service delivery.

Services requested by the insurer or requiring prior authorization

IME Interpretation services

When an IME is scheduled, the insurer or IME provider will arrange for the interpretive services. **Prior authorization** isn't required. The worker may ask the insurer to use a specific interpreter. However, only the interpreter scheduled by the insurer or the IME provider will be paid for IME interpretive services. Interpreters who accompany the worker, without insurer approval, won't be paid or allowed to interpret at the IME.

IME No Shows

Authorization must be obtained prior to payment for an IME no show. For State Fund claims, contact the Central Scheduling Unit supervisor at 206-515-2799, or the SIE/TPA for self-insured claims, after occurrence of IME no show. 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."

Document translation

Document translation services are only paid when performed at the request of the insurer. Services will be authorized before the request packet is sent to the translators.

COVERED AND NONCOVERED SERVICES

Services that may be payable.

Services prior to claim allowance aren't payable except for the initial visit. If the claim is later allowed, the insurer will determine which services rendered prior to claim allowance are payable.

Only services to assist in completing the reopening application, and for insurer requested IMEs, are payable unless or until a decision is made. If a claim is reopened, the insurer will determine which other services are payable.

Covered and may be billed to the insurer.

Payment is dependent upon service limits and L&I policy:

- Interpretive services which facilitate language communication between the worker and a health care or vocational provider
- Time spent waiting for an appointment that doesn't begin at time scheduled (when no other billable services are being delivered during the wait time)
- Assisting the worker to complete forms required by the insurer and/or health care or vocational provider
- A flat fee for an insurer requested IME appointment plus mileage when the worker doesn't attend
- Translating document(s) at the insurer's request
- Miles driven from a point of origin to a destination point and return

Not covered and may not be billed to nor will they be paid by the insurer:

- Services exceeding 480 minutes per day
- Services provided for a denied or closed claim (except services associated with the initial visit or the visit for the worker's application to reopen a claim)
- No show for any service other than an insurer requested IME (for example, physical therapy visits)
- Mileage for no shows for any service other than an insurer requested IME (for example, physical therapy visits)
- Personal assistance on behalf of the worker such as scheduling appointments,

translating correspondence or making phone calls

- Document translation requested by anyone other than the insurer, including the worker
- Services provided for communication between the worker and an attorney or lay worker representative
- Services provided for communication not related to the worker's communications with health care or vocational providers
- Travel time and travel related expenses such as meals, parking, lodging
- Overhead costs, such as phone calls, photocopying and preparation of bills

FEES, SERVICE DESCRIPTIONS AND LIMITS

The coverage and payment policy for interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization and Limit Information
9988M	Group interpretation Direct services time between more than one client and health care or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute	1 minute equals 1 unit of service	\$0.79 per minute	Limited to 480 minutes per day Doesn't require prior authorization
9989M	Individual Interpretation Direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute	1 minute equals 1 unit of service	\$0.79 per minute	Limited to 480 minutes per day Doesn't require prior authorization
9986M	Mileage, per mile	1 mile equals 1 unit of service	State rate	Mileage billed over 200 miles per claim per day will be reviewed Doesn't require prior authorization
9996M	Interpreter "IME no show" Wait time when insured doesn't attend the insurer requested IME, flat fee	Bill 1 unit per worker no show at IME	Flat fee \$52.74 Mileage to and from appointment will also be paid	Payment requires prior authorization Contact Central Scheduling Unit at 260-515-2799 Or the SIE/TPA after no show occurs. Only 1 no show per worker per day
9997M	Document translation, at insurer request	1 page equals 1 unit of service	By report	Authorization will be documented on translation request packet. Over \$500 per claim will be reviewed

BILLING FOR INTERPRETIVE SERVICES

Interpretive services providers use the miscellaneous bill form and billing instructions.

Individual Interpretation Services

Services delivered for a single client may include:

- Interpretation performed with the worker and a health care or vocational provider
- Form completion and
- Wait time is time spent waiting for an appointment that doesn't begin at time scheduled (when no other billable services are being delivered during the wait time)

When billing for Individual Interpretation Services:

- Only the time spent actually delivering those services may be billed.
- You must bill all services for the same client, for the same date of service, on one bill to avoid bill denial.
- Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services ended.
- If there are breaks in service due to travel between places of service delivery, this time must be deducted from the total time billed.

Interpretive Services Appointment Record form

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625> and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.

See the Billing Examples, “General Provider Billing Manual” and “Miscellaneous Services Billing Instructions” for further information.

Billing Tip

All services provided to a client on the same date must be billed on one bill form or your bills may be denied.

Group Interpretation Services

When interpretive services are delivered for more than 1 person (regardless of whether all are workers and/or crime victims), the time spent must be prorated between the participants.

- Send a separate bill for each client with prorated amounts.

Interpretive Services Appointment Record form

<http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625> and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.

For example, if 3 persons are receiving a 1 hour group physical therapy session at different stations and the interpretive services provider is assisting the physical therapist with all 3 persons:

- The interpretive services provider must bill only 20 minutes per person.
- The time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end.

See the Billing Examples, “General Provider Billing Manual” and “Miscellaneous Services Billing Instructions” for further information.

The combined total of both individual and group services is limited to 480 minutes (8 hours) per day.

Billing Tip

You must send a completed Interpretive Services Appointment Record form <http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625> including the health care or vocational provider’s signature, and the mileage verification by the time your bill is processed or your bill may be denied.

IME No Show

Per [WAC 296.20.010\(5\)](#) only services related to No Shows for insurer requested IMEs will be paid. The insurer will pay a flat fee for IME no show. Mileage to and from the IME appointment will also be paid.

Mileage and Travel

Insurers won’t pay interpretive service providers’ travel time or for travel expenses such as hotel, meals, parking, etc.

Interpretive service providers may bill for actual miles driven to perform interpretation services for an individual client or group of clients. The interpreter must split the mileage between the worker and the next client if this isn’t the last appointment of the day.

When mileage is for services to more than 1 person (regardless of whether all are workers and/or crime victims):

- The mileage must be prorated between all the persons served.
- When you interpret for a group, mileage between appointments on the same day should be split between the clients.

Mileage is payable for no show appointments for IME's only.

Send mileage verification to each client's claim file at the same time you bill the insurer or **your bill may not be paid.**

See the Billing Examples, "General Provider Billing Manual" and "Miscellaneous Services Billing Instructions" for further information.

Mileage over 200 miles per day will be reviewed for necessity before being paid.

Document Translation Services

Document translation is an insurer requested service only. Payment for document translation will be made only if the service was requested by the insurer. If anyone other than the insurer requests assistance with document translation, the insurer must be contacted before services can be delivered.

Billing Examples

Example 1 – Individual Interpretive Services

Example Scenario	Time Frames	Type of Service	Code and Units to Bill
Interpreter drives 8 miles from their place of business to the location of an appointment for an worker	Not applicable	Mileage	8 units 9986M
Worker has an 8:45 a.m. appointment. The interpreter and insured enter the exam room at 9:00 a.m. The exam takes 20 minutes. The health care provider leaves the room for 5 minutes and returns with a prescription and an order for X-rays for the insured. The appointment ends at 9:30 a.m.	8:45 a.m. to 9:30 a.m.	Individual Interpretive Services	45 units 9989M
Interpreter drives 4 miles to X-ray service provider and meets insured.	Not applicable	Mileage	4 units 9986M
Interpreter and insured arrive at the radiology facility at 9:45 a.m. and wait 15 minutes for X-rays which takes 15 minutes. They wait 10 minutes to verify X-rays don't need to be repeated.	9:45 a.m. to 10:25 a.m.	Individual Interpretive Services	40 units 9989M
Interpreter drives 2 miles to pharmacy and meets insured.	Not applicable	Mileage	2 units 9986M
The worker and the interpreter arrive at the pharmacy at 10:35 a.m. and wait 15 minutes at the pharmacy for prescription. The interpreter explains the directions to the worker which takes 10 minutes.	10:35 a.m. to 11 a.m.	Individual Interpretive Services	25 units 9989M
After completing the services, the interpreter drives 10 miles to the next interpretive services appointment. The interpreter splits the mileage between the worker and the next client if this isn't the last appointment of the day	Not applicable	Mileage	5 units 9986M

Example 2 – Group Interpretive Services

Example Scenario	Time Frames	Type of Service	Code and units to Bill
Interpreter drives 9 miles from his place of business to the location of an appointment for 3 clients. 2 are insured by the State Fund.	Not applicable	Mileage	3 units of 9986M to each state fund claim
The 3 clients begin a physical therapy appointment at 9:00 a.m. The interpreter circulates between the 3 clients during the appointment which ends at 10 a.m.	9 a.m. to 10 a.m.	Group Interpretive Services	20 units of 9988M to each state fund claim
After completing the appointment the interpreter drives 12 miles to next appointment location. The interpreter splits the mileage between the 3 clients and the next client if this isn't the last appointment of the day (12 divided by 2=6; 6 divided by 3=2).	Not applicable	Mileage	2 units 9986M to each state fund claim

Adjustment vs. Submitting a New Bill for State Fund Claims

- When the whole bill is denied, then you must submit a new bill to be paid.
- When part of the bill is paid, then you must submit an adjustment for the services that were not paid. Additional information on adjustments is available at <http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp>

Billing Tip

If the time or mileage needs to be corrected, you should adjust the **last paid** bill.

DOCUMENTATION REQUIREMENTS

Interpretive service appointment and mileage documentation must be submitted to L&I when the services are billed.

Billing Tip

Don't staple documentation to bill forms. Send documentation separately from bills for State Fund or Crime Victims Compensation Program claims to:

State Fund

Department of Labor and Industries
PO Box 44291
Olympia, WA 98504-4291
360-902-6500
1-800-848-0811
Fax number:
(360) 902-4567

Crime Victims Compensation Program

Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
360-902-5377
1-800-762-3716

Self-insurer

To determine insurer see the SIE/TPA list at

<http://www.Lni.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp>, or call 360-902-6901.

Send State Fund bills to:

Department of Labor and Industries
PO Box 44269
Olympia, WA 98504-4269

Interpretive Services Appointment Documentation

- Direct interpretive services must be recorded on the Interpretive Services Appointment Record form [F245-056-000](#). Copies can be obtained on L&I's website or a supply of forms can be ordered from the warehouse. Interpretive services providers may also use their own encounter forms to document services, meeting the criteria listed below.
- Provider or agency encounter forms used in lieu of L&I's Interpretive Services Appointment Record **must** have the following information:
 - Claim number, worker's full name, and date of injury in upper right hand corner of form
 - Interpreter name and agency name (if applicable)
 - Encounter (appointment) information including:
 - Health care or vocational provider name
 - Appointment address
 - Appointment date
 - Appointment start time
 - Interpreter arrival time
 - Appointment completion time
 - If a group appointment, total number of clients (not health care or vocational providers) participating in the group appointment
 - Actual mileage information including:
 - Actual miles from starting location (including street address) to appointment
 - Actual miles (not prorated) from appointment to next appointment or return to starting location (include street address)
 - Actual total miles
 - Verification of appointment by health care or vocational provider (Printed name and signature of person verifying services).
 - Date signed

NOTE: All agency encounter and Interpretive Services Appointment Record forms must be signed by the health care or vocational provider or the provider's staff to verify services including mileage for IME no shows.

NOTE: All agency encounter and Interpretive Services Appointment Record forms and mileage verification must be in the claim file before payment is made.

Mileage Documentation

Include mileage documentation that supports the number of miles between appointments. Documentation must be a printout from a software mileage program and name of software program used.

Translation Services Documentation

Documentation for translation services must include:

- Date of service and
- Description of document translated (letter, order and notice, medical records) and
- Total number of pages translated and
- Total words translated and
- Target and source languages.

TELEPHONE INTERPRETIVE SERVICES

Telephone interpretive services are covered when requested by health care providers and vocational counselors through the State of Washington's Western States Contracting Alliance (WSCA) Telephone Based Interpreter Services Contract. Only department preapproved vendors listed in the WSCA contract may provide and be paid for telephone interpretive services. See the below list for preapproved WSCA contracted vendors.

Telephone interpretive services are payable only when the health care or vocational provider has direct (face-to-face) contact with the worker or crime victim.

Credentials required for telephonic interpretive services

Vendor's telephonic interpreter tests will consist of, at minimum:

- Oral fluency in English and other language
- Verbal test of consecutive interpretation in both languages

FEES, SERVICE DESCRIPTIONS AND LIMITS

The coverage and payment policy for telephone interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization and Limit Information
9999M	Telephone Interpretation Direct service time between client(s) and health care or vocational provider, per minute	1 minute equals 1 unit of service	Per WSCA contract only*	Payable to L&I preapproved WSCA contracted vendors only Doesn't require prior authorization

*CTS Language Link fee is **\$0.82/minute** for all languages
Pacific Interpreters, Inc. fee is **\$0.86/minute** for all languages

WSCA Telephone Based Interpreter Services contract is available at:

<https://fortress.wa.gov/ga/apps/ContractSearch/ContractSummary.aspx?c=03508>

Prior Authorization

Services not requiring prior authorization

Telephone interpretive services **don't** require **prior authorization** on open claims. Providers should check claim status with the insurer prior to service delivery.

Contracted WSCA vendors

Each vendor must have an active department assigned provider account number.

Providers, both in and out-of-state, who use telephone interpretive services, must use one of the preapproved WSCA contracted vendors.

The approved vendors are:

CTS Language Link	Pacific Interpreters, Inc.
911 Main St., Suite 10 Vancouver, WA 98660 Toll-Free Number: 877-626-0678 Website: http://www.ctslanguagelink.com	707 SW Washington, Suite 200 Portland, OR 97205 Toll-Free Numbers: State Fund Claim: 877-810-4721 Self-Insurance Claim: 877-810-4723 Crime Victims Claim: 877-840-2083 Website: http://pacificinterpreters.com

Telephone Interpretive Services Documentation

- Documentation for telephone interpretive services **must** include:
 1. Claim number
 2. Worker's/victim's full name
 3. Date of injury
 4. Interpreter Name and ID Number
 5. Language
 6. Vendor Name
 7. Health care or vocational provider name
 8. Appointment address
 9. Appointment date
 10. Appointment start time
 11. Appointment completion time

Billing for Interpretive Services

Bills for telephone interpretive services must be submitted to the appropriate insurer.

For State Fund

Bill State Fund claims electronically.

For Self-insurer

Bill the SIE/TPA using the Statement for Miscellaneous Services bill form, or other form approved by the SIE/TPA.

For Crime Victims

To bill for services, use the Statement for Crime Victim Miscellaneous Services form [F245-072-000](#) available at <http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1976> or form CMS 1500.

STANDARDS AND RESPONSIBILITIES FOR INTERPRETIVE SERVICES PROVIDER CONDUCT

L&I is responsible for assuring workers and crime victims receive proper and necessary services. The following requirements set forth the insurer's expectations for quality interpretive services.

RESPONSIBILITIES

Responsibilities toward the Worker and the Health Care or Vocational Provider

The interpreter must ensure that all parties understand the interpreter's role and obligations. The interpreter must:

- Inform all parties that everything said during the appointment will be interpreted and they should not say anything they don't want interpreted.
- Inform all parties the interpreter will respect the confidentiality of the worker.
- Inform all parties the interpreter is required to remain neutral.
- Disclose any relationship to any party that may influence or someone could perceive to influence the interpreter's impartiality.
- Accurately and completely represent their credentials, training and experiences to all parties.

STANDARDS

Accuracy and Completeness

- Interpreters always communicate the source language message in a thorough and accurate manner.
- Interpreters don't change, omit or add information during the interpretation assignment, even if asked by the worker or another party.
- Interpreters don't filter communications, advocate, mediate, speak on behalf of any party or in any way interfere with the right of individuals to make their own decisions.
- Interpreters give consideration to linguistic differences in the source and target languages and preserve the tone and spirit of the source language.

Confidentiality

The interpreter must not discuss any information about an interpretation job without specific permission from all parties or unless required by law. This includes content of the assignment such as:

- Time or place
- Identity of persons involved
- Content of discussions
- Purpose of appointment

Impartiality

- The interpreter must not discuss, counsel, refer, advise or give personal opinions or reactions to any of the parties.
- The interpreter must turn down the assignment if he or she has a vested interest in the outcome, or when any situation, factor, or belief exists that represents a real or potential conflict of interest.

Competency

Interpreters must meet L&I's credentialing standards and be:

- Fluent in English.
- Fluent in the worker's language.
- Fluent in medical terminology in both languages.
- Willing to decline assignments requiring knowledge or skills beyond their competence.

Maintenance of Role Boundaries

- Interpreters must not engage in any other activities that may be thought of as a service other than interpreting, such as:
 - Driving the worker to and from appointments
 - Suggesting that the worker receive care at certain providers
 - Advocating for the worker

Prohibited Conduct

In addition, interpreters can't:

- Market their services to workers or crime victims.
- Arrange appointments in order to:
 - Create business of any kind.
 - Fit into the interpreter's schedule including canceling and rescheduling a worker's medical appointment.
- Contact the worker other than at the request of the insurer or health care or vocational provider.
- Provide transportation for the worker to and from health care or vocational appointments.
- Require the worker to use the interpreter provider's services exclusive of other approved L&I interpreters.
- Accept any compensation from workers or crime victims or anyone else other than the insurer.
- Bill for someone else's services with your individual (not language agency group) provider account number

Tips for Interpretive Services Providers

Some things to keep in mind when working as an interpreter on workers' compensation or crime victims' claims:

- Arrive on time.
- Always provide identification to the worker and providers.
- Introduce yourself to the worker and provider.
- Don't sit with the worker in the waiting room unless assisting him or her with form completion.
- Acknowledge language limitations when they arise and always ask for clarification.
- Don't give your home (nonbusiness) telephone number to the worker or providers.
- Sign up to get L&I provider news and updates at <http://www.Lni.wa.gov/Main/Listservs/Provider.asp>
- Mail to L&I:
 - Completed Interpreter Services Appointment Record or other qualifying encounter form signed by health care or vocational provider
 - Printout of mileage documentation that supports the number of miles between appointments from a software mileage program and name of software program used

OTHER SERVICES

AFTER HOURS SERVICES

After hours services CPT® codes 99050 - 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.
- When services are provided on an emergency basis, out of the office, that disrupt other scheduled office visits.

After hours service codes aren't payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

Only 1 code for after hours services will be paid per worker per day, and a 2nd day may not be billed for a single episode of care that carries over from 1 calendar day to the next.

LOCUM TENENS

- Modifier –Q6 denotes services furnished by a locum tenens physician.
- Modifier –Q6 **isn't covered** and L&I **won't pay** for services billed under another provider's account number.

L&I requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered. Refer to [WAC 296-20-015](#) for more information about the requirements.

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the SIE makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or the SIE. Although L&I doesn't use codes for medical testimony, SIEs must allow providers to use CPT® code 99075 to bill for these services. State Fund utilizes a separate voucher A19 form which will be provided to you by the Office of the Attorney General, thus providers shouldn't use the CPT® code and L&I can't provide prepayment for any of these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), but don't include side trips.

The time calculation for testimony, deposition or related work performed in the provider's office or by phone is based upon the actual time used for the testimony or deposition.

The medical witness fee schedule is set by law, which requires any provider having examined or treated a worker must abide by the fee schedule and testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General or the self-insurer. The Office of the Attorney General or the self-insurer and the provider must cooperate to schedule a reasonable time for the provider's testimony during business hours. Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeals.

The Office of the Attorney General provides a medical provider testimony fee schedule when testimony is scheduled. No service will be paid in advance of the date it is provided. Requests for a nonrefundable amount will be denied. Any exceptions to the fee schedule will be on a case by case basis.

The party requesting interpretive services for depositions or testimony is responsible for payment.

Testimony and Related Fees (applied to doctors as defined in [WAC 296-20-01002](#))

Description	Maximum Fee
Medical testimony (live or by deposition)	\$ 100.00/unit* (Maximum of 17 units)
Record review	\$ 100.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	\$ 100.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 100.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to all other health care providers)

Description	Maximum Fee
Medical testimony (live or by deposition)	\$ 22.50/unit* (Maximum of 17 units)
Record review	\$ 22.50/unit* (Maximum of 25 units)
Conferences (live or by telephone)	\$ 22.50/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 22.50/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to vocational providers)

Description	Maximum Fee
Medical testimony (live or by deposition), regular vocational services Medical testimony (live or by deposition), forensic vocational services	\$ 22.50/unit* \$26.25/unit* (Maximum of 17 units)
Record review, regular vocational services Record review, regular vocational services, forensic vocational services	\$ 22.50/unit* \$26.25/unit* (Maximum of 25 units)
Conferences (live or by telephone), regular vocational services Conferences (live or by telephone), forensic vocational services	\$ 22.50/unit* \$26.25/unit* (Maximum of 9 units)
Travel , regular vocational services Travel, forensic vocational services (Paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 22.50/unit* \$26.25/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to all out-of-state doctors as defined in [WAC 296-20-01002](#))

Description	Maximum Fee
Medical testimony (live or by deposition)	\$ 125.00/unit* (Maximum of 17 units)
Record review	\$ 125.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	\$ 125.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	\$ 125.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Attorney General/SIE will pay a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Attorney General/SIE won't pay a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management (NCM) services require **prior authorization** by the claim manager or ONC. Contact the insurer to make a referral for NCM services.

Workers with catastrophic work related injuries, and/or workers who have moved out-of-state and need assistance locating a provider, and/or workers with medically complex conditions may be selected to receive NCM services.

NCM is:

- A collaborative process used to meet worker's health care and rehabilitation needs.
- Provided by registered nurses:
- With case management certification.
- Aware of resources in the worker's location.

The nurse case manager works with the attending provider, worker, allied health personnel, and insurers' staff to assist in locating a provider and/or with coordination of the prescribed treatment plan. Nurse case managers organize and facilitate timely receipt of medical and health care resources and identify potential barriers to medical and/or functional recovery of the worker. They communicate this information to the attending doctor, claim manager, or ONC to develop a plan for resolving or addressing the barriers.

Nurse case managers must use the following local codes to bill for NCM services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	\$ 9.64
1221M	Visits, per 6 minute unit	\$ 9.64
1222M	Case planning, per 6 minute unit	\$ 9.64
1223M	Travel/Wait, per 6 minute unit (16 hour limit)	\$ 4.74
1224M	Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager	State rate
1225M	Expenses (parking, ferry, toll fees, cab, lodging and airfare) at cost or state per diem rate (meals and lodging). Requires prior authorization from the claim manager (\$725 limit)	By report

NCM services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

Billing Units Information

- Units are whole numbers and not tenths units.
- Each traveled mile is 1 unit service.
- Each 6 minutes of phone calls, visits, case planning, or travel/wait time is 1 unit of service.
- Each related travel expense is 1 unit of service.

Minutes = # of Units	Minutes = # of Units
6 = 1	36 = 6
12 = 2	42 = 7
14 = 3	48 = 8
24 = 4	54 = 9
30 = 5	60 = 10

Non-covered expenses include:

- Nurse case manager training
- Supervisory visits
- Postage, printing and photocopying (except medical records requested by L&I)
- Telephone/fax
- Clerical activity (e.g. faxing documents, preparing documents to be mailed, organizing documents, etc.)
- Travel time to post office or fax machine
- Wait time exceeding 16 hours
- Fees related to legal work, for example, deposition, testimony. Legal fees may be charged to the requesting party, but not the claim
- Any other administrative costs not specifically mentioned above

Case Management Records and Reports

Case management records must be created and maintained on each claim. The record shall present a chronological history of the worker’s progress in NCM services.

Case notes shall be written when a service is given and shall specify:

- When the service was provided, and
- What type of service was provided using case note codes, and
- Description of the service provided including subjective and objective data, and
- How much time was spent providing each service.

NCM reports shall be completed monthly. Payment will be restricted to up to 2 hours for initial reports and up to 1 hour for progress and closure reports. For additional information about billing, refer to the “Miscellaneous Services Billing Instructions”. Contact the Provider Hotline at 1-800-848-0811 to request a copy.

Report Format

Initial assessment, monthly, progress, and closure reports must include **all** of the following information:

- Type of report (initial or progress)
- Worker name and claim number
- Report date and reporting period
- Worker date of birth and date of injury
- Contact information
- Diagnoses
- Reason for referral
- Present status/current medical
- Recommendations
- Actions and dates
- Ability to positively impact a claim
- Health care provider(s) name(s) and contact information
- Psychosocial/economic issues
- Vocational profile
- Amount of time spent completing the report
- Hours incurred to date on the referral

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the insurer. The fees listed below include postage for sending documents to the insurer:

Code	Report/Form	Max Fee	Special notes
CPT® 99080	60-Day Report	\$ 43.51	60-day reports are required per WAC 296-20-06101 and don't need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of 1 per 60 days per claim.
CPT® 99080	Special Report (Requested by insurer or VRC)	\$ 43.51	Must be requested by insurer or vocational counselor. Not payable for records or reports required to support billing or for review of records included in other services. Don't use this code for forms or reports with assigned codes. Limit of 1 per day.
1027M	Loss of Earning Power (LEP)	\$ 18.93	Must be requested by insurer. Payable only to attending provider. Limit of 1 per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	\$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.
1040M	Provider's Initial Report – for Self Insured claims	\$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.

Code	Report/Form	Max Fee	Special notes
1041M	Application to Reopen Claim	\$ 49.18	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.
1055M	Occupational Disease History Form	\$ 183.56	Must be requested by insurer. Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s).
1057M	Opioid Progress Report Supplement or any standardized objective tool to evaluate pain and function	\$ 30.27	Payable only to attending provider. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days. See WACs 296-20-03021 , -03022 and the Labor and Industries Medical Treatment Guidelines. Limit of 1 per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	\$ 37.84	Must be requested by insurer. Payable only to attending provider. Limit of 1 per request.
1064M	Initial report documenting need for opioid treatment	\$ 56.77	Payable only to the attending provider. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and the Labor and Industries Medical Treatment Guidelines for what to include in the report.
1065M	Attending Doctor IME Written Report	\$ 28.37	Must be requested by insurer. Payable only to attending provider when submitting a separate report of IME review. Limit of 1 per request.
1066M	Provider Review of Video Materials with report	By report	Must be requested by insurer. Payable once per provider per day. Report must include actual time spent reviewing the video materials. Not payable in addition to CPT® code 99080 or local codes 1104M or 1198M.
1073M	Insurer Activity Prescription Form (APF)	\$49.18	Must be requested by insurer or vocational rehabilitation counselor (VRC). Payable once per provider per worker per day. Exception: APF may accompany the ROA/PIR
1074M	AP response to VRC/Employer request about RTW	\$30.27	For written communication with VRCs and employers. Team conference, office visit, telephone call, or online communication with a VRC or employer can't be billed separately.

More information on some of the reports and forms listed above is provided in [WAC 296-20-06101](#). Many L&I forms are available and can be downloaded from <http://www.Lni.wa.gov/FormPublications/> and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the insurer using HCPCS code S9982. Payment for S9982 includes all costs, including taxes and postage. S9982 isn't payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

S9982 \$0.48

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles. This code requires **prior authorization** and usage is limited to extremely rare circumstances.

Code	Description	Max Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	\$4.86

REVIEW OF JOB OFFERS AND JOB ANALYSES

Attending providers must review the physical requirements of any job offer submitted by the employer of record and determine whether the worker can perform that job. Whenever the employer asks, the attending provider should send the employer an estimate of physical capacities or physical restrictions and review each job offer submitted by the employer to determine whether or not the worker can perform that job.

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see [RCW 51.32.09\(4\)](#).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, nonwork related skills and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending providers, independent medical examiners and consultants will be paid for review of job descriptions or JAs. A job description/JA review may be performed at the request of the employer, the insurer, vocational rehabilitation counselor (VRC), or TPA. Reviews requested by other persons (for example, attorneys or workers) won't be paid. This service doesn't require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires **prior authorization** and won't be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in [WAC 296-19A-170](#). The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Max Fee	Special notes
1038M	Review of Job Descriptions or JA	\$ 49.18	Must be requested by insurer, employer or vocational counselor. Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Not payable to IME examiner on the same day as the IME is performed. .
1028M	Review of Job Descriptions or JA, each additional review	\$ 36.89	Must be requested by insurer, employer or vocational counselor. Payable to attending provider, IME examiner or consultant. Bill to L&I. For IME examiners on day of exam: may be billed for each additional JA after the first 2. For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using 1038M).

VEHICLE AND HOME MODIFICATIONS

Refer to [WAC 296-14-6200](#) through [WAC 296-14-6238](#) for home modification information. A home modification consultant must be a licensed registered nurse, occupational therapist or physical therapist and trained or experienced in both rehabilitation of catastrophic injuries and in modifying residences. Additional information is available at:

<http://www.ini.wa.gov/ClaimsIns/Voc/BackToWork/JobMod/Default.asp>

A vehicle modification consultant must be a licensed occupational or physical therapist, or licensed medical professional with training or experience in rehabilitation and vehicle modification.

Code	Description	Maximum Fee
8914H	Home modification, construction and design. Requires prior authorization based on approval by the assistant director of Insurance Services	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification. Requires prior authorization based on approval by the assistant director of Insurance Services	Maximum payable for all work is ½ the current Washington state average wage. The amount paid may be increased by no more than \$4,000 by written order of the Supervisor of Industrial Insurance RCW 51.36.020(8b) .
8916H	Home modification evaluation and consultation. Requires prior authorization	By report
8917H	Home/vehicle modification mileage, lodging, airfare, car rental. Requires prior authorization	State rate
8918H	Vehicle modification, evaluation and consultation. Requires prior authorization	By report
0391R	Travel/wait time per 6 minutes. Requires prior authorization	\$4.83

JOB MODIFICATIONS AND PRE-JOB ACCOMMODATIONS

This benefit provides funding to modify a job or retraining site to accommodate a restriction related to the industrial injury.

- In some cases, the department may reimburse for consultation services.
- The need for a job modification or pre-job accommodation must be identified and documented by L&I, the attending healthcare provider, treating occupational or physical therapist, employer, worker, or vocational rehabilitation counselor.
- Job modification and pre-job accommodations must be preauthorized. Consultations pertaining to a specific job modification or pre-job accommodation must be pre-authorized after the need has been identified. (See b above).

The provider of a job modification or pre-job accommodation consultation must be a licensed occupational therapist or physical therapist, vocational rehabilitation provider, or ergonomic specialist.

Pre-job accommodation benefits are only available for state fund claims. However, self-insured employers may cover these costs for self-insured claims.

The following codes are payable to:

- Physical therapists
- Occupational therapists
- Ergonomic specialists
- Vocational rehabilitation counselors not associated with the group assigned to the vocational referral
-
-

Code	Description	Activities	Maximum Fee
0389R	Pre-job or job modification consultation, analysis of physical demands (non-VRC), per 6 minutes. Requires prior authorization	Consultation time with worker Composing the report Communication Instruction in work practices When indicated: <ul style="list-style-type: none"> Obtains bids Completes and submits assistance application packet Analysis of job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only)	\$ 10.66
0391R	Travel/wait time (non-VRC), per 6 minutes. Requires prior authorization	Traveling to work/training site as part of direct consultation services	\$ 4.83
0392R	Mileage (non-VRC), per mile. Requires prior authorization	Mileage to work/training site as part of direct consultation services	State rate
0393R	Ferry Charges (non-VRC). Requires prior authorization	If required to travel to work/training site as part of direct consultation services	State rate

Vocational rehabilitation counselors and interns in the group assigned to the vocational referral must bill these services using procedure codes 0823V and 0824V. See [Vocational Evaluation](#) on page 177.

If services are provided to a worker with an open vocational referral, see Vocational Evaluation and Related Codes for additional information for non-vocational providers on page 179.

Services Not Billable

- Performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals.
- Activities associated with reports other than composing or dictating complete draft of the report (for example, editing, filing, distribution, revising, typing, and mailing).
- Time spent on any administrative and clerical activity, including typing, copying, faxing, mailing, distributing, filing, payroll, recordkeeping, delivering mail, picking up mail.

The following codes are payable to authorized equipment vendors:

Code	Description	Activities	Maximum Fee
0380R	Job modification Requires prior authorization	Equipment/Tools <ul style="list-style-type: none"> • Installation • Set up • Basic training in use • Delivery (includes mileage) • Tax • Custom Modification/Fabrication Work area modification/reconfiguration	Maximum allowable for 0380R is \$5,000 per job or job site.
0385R	Pre-job accommodation Requires prior authorization	Equipment/Tools <ul style="list-style-type: none"> • Installation • Set up • Basic training in use • Delivery (includes mileage) • Tax • Custom Modification/Fabrication Work/Training area modification/reconfiguration	Maximum allowable for 0385R is \$5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal can't exceed \$5,000.

Consultants may supply the equipment/tools only if:

- Custom design and fabrication of unique equipment or tool modification is required, and,
- Prior authorization is obtained, and
- Proper justification and cost estimates are provided.

Additional information is available at

<http://www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/default.asp>

VOCATIONAL SERVICES

Vocational services providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions (F248-095-000). Maximum fees apply equally to both State Fund and self-insured vocational services.

BILLING CODES BY REFERRAL TYPE

All vocational services require **prior authorization**. Vocational services are authorized by referral type. The State Fund uses 6 referral types.

- Early intervention
- Assessment
- Plan development
- Plan implementation
- Forensic
- Stand alone job analysis

Each referral is a separate authorization for services. Insurers will pay interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate and forensic evaluators at 120% of the VRC professional rate. All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. See [fee caps](#), page **180** for more information.

Early Intervention

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0800V	Early Intervention Services (VRC)	\$ 8.77
0801V	Early Intervention Services (Intern)	\$ 7.47
0802V	Early Intervention Services Extension (VRC)	\$ 8.77
0803V	Early Intervention Services Extension (Intern)	\$ 7.47

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0810V	Assessment Services (VRC)	\$ 8.77
0811V	Assessment Services (Intern)	\$ 7.47

Vocational Evaluation, Job and Pre-job Modification Consultation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0821V	Vocational Evaluation (VRC)	\$ 8.77
0823V	Pre-job or Job Modification Consultation (VRC)	\$ 8.77
0824V	Pre-job or Job Modification Consultation (Intern)	\$ 7.47

Plan Development

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0830V	Plan Development Services (VRC)	\$ 8.77
0831V	Plan Development Services (Intern)	\$ 7.47

Plan Implementation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0840V	Plan Implementation Services (VRC)	\$ 8.77
0841V	Plan Implementation Services (Intern)	\$ 7.47

Forensic Services

The VRC assigned to a forensic referral must directly perform ALL the services needed to resolve the vocational issues and make a supportable recommendation.

Exception: Vocational evaluation services may be billed by a third party, if authorized by the insurer.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0881V	Forensic Services (Forensic VRC)	\$ 10.50

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses. For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager. Bills for dates of service beyond the 15th day will not be paid.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0808V	Stand Alone Job Analysis (VRC)	\$ 8.77
0809V	Stand Alone Job Analysis (Intern)	\$ 7.47
0378R	Stand Alone Job Analysis (non-VRC)	\$ 8.77

Other billing codes

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC) 1 unit = 6 minutes	\$ 4.38
0892V	Travel/Wait Time (Intern) 1 unit = 6 minutes	\$ 4.38
0893V	Professional Mileage (VRC) 1 unit = 1 mile	State rate
0894V	Professional Mileage (Intern) 1 unit = 1 mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	By report
0896V	Ferry Charges (VRC, Intern or Forensic VRC)	By report
0897V	Hotel Charges (VRC, Intern or Forensic VRC) out-of-state only	By report

Travel/Mileage Billing

The insurer pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The insurer **doesn't pay** for travel time or mileage between two different service locations or branch offices where a provider is working cases. Providers may bill from the branch office where the referral was assigned by the VRC to necessary destinations. Examples include: going to the location of the employer of record, visiting an attending physician's office and the meeting of a VRC with an injured worker at the worker's home. For out of state cases, VRC may only bill from the branch office nearest the worker.

Special Services, Nonvocational Providers

L&I established a procedure code to be used for special services provided during Assessment Plan Development, and Plan Implementation, for example: commercial driver's license (CDL), physicals, background checks, driving abstracts and fingerprinting.

The code must be billed by a medical or a miscellaneous nonphysician provider on a miscellaneous services billing form. The referral ID and referring vocational provider account number must be included on the bill. Limit 1 unit per day, per claim.

The code requires **prior authorization**. For State Fund claims, VRCs must contact the vocational services specialist (VSS) to arrange for prior authorization from the claim manager. For self-insured claims, contact the SIE/TPA for prior authorization.

The code can't be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

Code	Description	Maximum Fee
0388R	Plan , providers	By report

Vocational Evaluation and Related Codes for Nonvocational Providers

Certain nonvocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	\$ 10.66
0390R	Vocational Evaluation, 1 unit = 6 minutes	\$ 8.77
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	\$ 4.83
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry Charges (non-VRC) ⁽¹⁾	State rate

(1) Requires documentation with a receipt in the case file.

A provider can use the **R** codes if he or she is a:

- Nonvocational provider such as an occupational or physical therapist, or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you), you can't bill as a vocational provider (provider type 68). You must either use another provider account number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider account number (type 97) and bill the appropriate codes for those services.

NOTE: These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, and
- The service provider ID for the assigned vocational provider in the "Name of physician or other referring source" box at the top of the form, and
- Nonvocational provider's own provider account numbers at the bottom of the form.

FEE CAPS

Vocational services are subject to fee caps. The following fee caps are by referral. All services provided for the referral are included in the cap. Travel, wait time and mileage charges aren't included in the fee cap for any referral type.

Description	Applicable Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	\$1,801.00
Assessment Referral Cap, per referral	0810V, 0811V	\$3,003.00
Plan Development Referral Cap, per referral	0830V, 0831V	\$6,014.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	\$6,818.00
Stand Alone Job Analysis Referral Cap, per referral	0808V, 0809V, 0378R	\$ 459.00

The fee cap for vocational evaluation services applies to multiple referral types.

Description	Applicable Codes	Maximum Fee
Work Evaluation Services Cap	0821V, 0390R	\$1,316.00

For example, if \$698.00 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment under another referral type.

Referrals that Reach the Fee Cap

Fee cap requirements:

- The vocational provider must track costs associated with their referrals to assure the fee cap isn't exceeded
- When a fee cap is reached, vocational providers aren't required to continue to provide services over and above the fee cap without payment. However, providers must notify the VSS or SIE/TPA of the situation. Providers must continue to deliver services as required by [WAC 296-19A](#) until the cap is reached.
- Providers must comply with all requirements in [WAC 296-19A](#) with regard to closing referrals, including submitting a closing report, even if the claim manager has closed the referral.
- Providers shouldn't enter any closure outcome with their closing report. Only the CM can enter the ADM7 closure code for fee cap reached.
- Vocational providers must not recommend the claim manager close a referral with an alternative closure code to avoid reaching the fee cap. After closing a referral due to reaching a fee cap, any subsequent referral of the same type may not be assigned to the same vocational counselor.
- Early Intervention Fee Cap Extension
- For early intervention referrals, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **1 time only per claim** and doesn't create a new referral. The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills. The claim manager must authorize the extension. No other early intervention professional services (for example, services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.
-

Description	Applicable Codes	Maximum Fee
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	\$ 1,756.00

Fee Cap Exceptions for AWAs and Plan Implementation Referrals

- Exception codes must be used to authorize an extra number of billable hours. Any use of these exception codes requires prior authorization by the VSS for State Fund claims, or by the SIE/TPA for self-insured claims.
- For AWA referrals, 2 new exception codes are available with an additional fee cap of \$877.00.

Code	Description	Maximum Fee
0812V	Assessment Services Exception (VRC)	\$ 8.77 per 6 minutes
0813V	Assessment Services Exception (Intern)	\$ 7.47 per 6 minutes

- For Plan Implementation referrals, 2 new exception codes are available with an additional fee cap of \$2,026.00.

Code	Description	Maximum Fee
0842V	Plan Implementation Services Exception (VRC)	\$ 8.77 per 6 minutes
0843V	Plan Implementation Services Exception (Intern)	\$ 7.47 per 6 minutes

Fee-Cap Exception Request

The vocational provider assigned to the referral may request additional time:

- Within 2 hours (\$175.00) of reaching the fee cap; and

NOTE: Extra time isn't available if the original cap has been reached.

- Plan must demonstrate that the extra time will allow for resolution of the referral; and
- Referrals must have started on or after January 1, 2008

Denial of Request

The vocational provider must follow department policy on referrals that reach the fee cap.

Approval of Request

- The vocational provider may bill the exception code up to the additional cap.
- Once the added cap has been reached, the provider exhausts the original fee cap.

NOTE: Extra time isn't available if the original cap has been reached.

Not Complete After Fee-Cap Exception

The provider must follow department policy on referrals that reach the fee cap.

ADDITIONAL REQUIREMENTS

ADMA Billing

Vocational providers may use ADMA outcome-- VRC declines referral--for up to 14 days after the referral assignment. This outcome is to be used when VRC determines that the referral isn't appropriate. Examples include:

- Conflict of interest
- Not ready for a referral due to medical issues, etc

Prior to entering an ADMA outcome, VRC needs to contact the claims manager to discuss the reasons for declining the referral.

A maximum of three professional hours may be billed for reviewing the file and preparing a brief rationale, using the standard VCLOS routing sheet.

Preferred Worker Certification for workers who choose Option 2

Vocational providers must consider assisting a worker in obtaining Preferred Worker Certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining Preferred Worker Certification for up to 14 days after an Option 2 selection has been made.

Insurer Activity Prescription Form (APF), 1073M

Only the insurer or VRC can request that a health care provider complete an Insurer APF. For State Fund claims, healthcare providers will not be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

- Employers can obtain physical capacity information by:
- Using completed APFs available on the department's Claim and Account Center at <http://www.Lni.wa.gov/ORLI/LoGon.asp>, or
- Requesting an APF through the claim manager when updated physical capacity information is needed.

Other Requests for Return-to-Work Information

Health care providers may bill 1074M for written responses to employer requests regarding return-to-work issues. Examples include:

- Concurrence with performance based physical capacities evaluation (PBPCE)
- Authorization for worker to participate in PBPCE
- Job modification or pre-job modification reviews
- Proposed work hardening program
- Plan for graduated, transitional, return to work

Vocational Evaluation

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing
- Interest testing
- Work samples
- Academic achievement testing
- Situational assessment
- Specific and general aptitude and skill testing

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational providers, provider type 68, must use procedure code 0821V to bill for vocational evaluation services.

Use code 0821V for the formal testing itself, or for a meeting that is *directly* related to explaining the purposes or findings of testing.

Non-vocational providers must use procedure code 0390R. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, and
- Service provider ID for the assigned vocational provider in the "Name of the physician or other referring source" box at the top, and
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form and
- Obtain the vocational referral ID number from the VRC and place on the billing form and
- Obtain the VRC's service provider number and place in the "Name of the physician or other referring source" box at the top, and
- Place the school's provider account number at the bottom of the form.

Retraining Plans that Exceed Statutory Benefit Limit

- The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit.
- The VSS won't approve a plan with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers may not develop or submit such a plan.

How Multiple Providers Who Work on a Single Referral Bill for Services

Multiple providers may deliver services on a single referral if they have the **same** payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where 1 provider covers the caseload of an ill provider. When more than 1 provider works on a referral, each provider must bill separately for services delivered on the referral; and each provider must use:

- His/her individual provider account number,
- The payee provider account number and
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the **assigned** provider's performance rating.

Split Billing across Multiple Referrals

When a worker has 2 or more open time-loss claims, State Fund may make a separate referral for each claim. In cases where State Fund makes 2 (or more) concurrent referrals for vocational services, State Fund will specify if the vocational provider is to split the billing.

When billing for vocational services on multiple referrals and/or claims, follow these instructions:

1. Split billable hours over a larger interval of work (up to the entire billing date span), rather than per each single activity.

Example: Provider XYZ has 2 open referrals for the same worker. If the provider bills once a week, one approach would be to total all the work done with that worker on both referrals in a day, or in the entire week, then divide by 2.

2. Bills must be split equally, in whole units, charging the same dollar amount on each claim/referral.

3. If, after totaling all work done during the billing period, the total is still not an even number of units, round to the nearest even whole number of units, then divide by 2 as directed above.
4. If split bills don't contain the same number of units, they will be denied and must be rebilled in the correct format. If there are 3 (or more) claims requiring time-loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received.

Vocational providers must document multiple referrals and split billing for audit purposes.

Referral Resolution

A vocational referral initially made to a firm, and then assigned to a VRC must close if the same VRC is no longer available to provide services. Referrals made directly to the VRC may be transferred by the claim manager to the VRC's new firm, only if the VRC has already *established a relationship with a new firm within the same service location*, via the Vocational Provider Account Application process.

Vocational providers **must** notify the insurer if the VRC assigned to a referral is no longer available to provide services on that referral. Following are guidelines for notifying the insurer:

Example 1:

For referrals made to the firm and assigned to a VRC:

- It is the responsibility of the assigned VRC to close the referral on Voc Link Connect with the outcome, "VRC no longer available". This outcome must be entered immediately on the VRC's change in status.
- It is the responsibility of the vocational manager of the firm to notify the claim manager(s) of the change in status for that referral. State Fund must be notified by telephone and/or fax within 3 working days of the change in status. Notification by the vocational manager isn't necessary if the VRC assigned to the referrals successfully closes the referral as noted above.

The VRC assigned to the referral(s) **may not** contact the claim manager(s) for the purpose of informing them of a change in employment. This would be considered marketing, which is prohibited by department policy. The resolution (for example, re-referral) of the referral is at the sole discretion of the claim manager.

Example 2:

For referrals made directly to the VRC:

- The VRC is responsible for notifying the claim manager of his/her new status, and should be prepared to inform the claim manager of the payee provider account number of the new firm, as well as the VRC's new service provider account number associated with that firm
- The claim manager, at his/her sole discretion, may transfer the referral(s) to the VRC at the new firm, provided that the VRC is available to work in the same service location in which the original referral was made

Appropriate Timing of VocLink Connect Outcome Recommendations for State Fund Claims

State Fund has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral. The VRC must complete the report before a *VocLink* outcome recommendation is made to State Fund. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which isn't complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include "VRC no longer available" and "VRC declines referral".

In all other cases, the paper report must be submitted to State Fund at the same time the recommendation is made.

Submitting a Vocational Assessment or Retraining Plan for Self-Insured Claims

- What is the Self-Insurance Vocational Reporting Form? (See: [WAC 296-15-4302](#))
- What must the self-insurer do when an assessment report is received? ([WAC 296-15-4304](#))
- When must a self-insurer submit a vocational rehabilitation plan to the department? ([WAC 296-15-4306](#))
- What must the vocational rehabilitation plan include? ([WAC 296-15-4308](#))
- What must the self-insurer do when the department denies the vocational rehabilitation plan? ([WAC 296-15-4310](#))
- What must the self-insurer do when the vocational rehabilitation plan is successfully completed? ([WAC 296-15-4312](#))
- What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? ([WAC 296-15-4314\(5\)](#))

Responsibilities of Service Providers and Firms in Regard to Changes in Status

NOTE: Change in status responsibilities apply to both State Fund and self-insurance vocational providers.

The insurer must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status include:

- VRC or intern ends their association with a firm.
- VRC assigned to a referral is no longer available to provide services on the referral(s).
- Firm closes.

Notification to L&I requires:

1. Resolution of the open referral(s) and
2. Submission of the Vocational Provider Change Form(s) to Private Sector Rehabilitation Services (L&I, PO Box 44326, Olympia WA 98504-4326).

These forms may be found at L&I's vocational services web site

<http://www.lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/Default.asp>.

A firm or service provider that fails to notify L&I of changes in status may be in violation of WAC and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in [WAC 296-19A-260](#) and [WAC 296-19A-270](#).

Approved Plan Services that Occur Prior to the Plan Start Date

The following are services/fees that the insurer may cover prior to a plan start date and outlines the procedure for adjudicating bills for dates of service prior to a plan start date.

- Registration fees billed as retraining tuition, R0310.
- Rent, food, utilities and furniture rental. (Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.)

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, R0330, **isn't payable** prior to a plan start date. Travel that occurs prior to a plan start date is generally to a jobsite to evaluate whether a particular job goal is reasonable, or to a school to pay for registration, books or look over the campus. These types of trips aren't part of a retraining plan and should be billed by the worker under V0028. Travel to appointments with the VRC should also be billed under V0028.

Selected Plan Procedure Code Definitions

L&I has defined the following retraining codes:

- R0312 Retraining supplies are consumable goods such as:
 - Paper
 - Pens
 - CDs
 - Disposable gloves
- R0315 Retraining equipment, tools such as:
 - Calculator
 - Software
 - Survey equipment
 - Welding gloves & hood
 - Bicycle repair kits
 - Mechanics tools
- R0350 Other, includes professional uniforms, including uniform shoes, required for training, and other items that don't fit the more defined categories. Items purchased using R0350 must be for vocational rehabilitation retraining.

The insurer doesn't have the authority to purchase glasses, hearing aids, dental work, clothes for interviews, or other items as a way to remove barriers during retraining.

Reimbursement for Food

The insurer reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan.

The vocational provider must review charges for these expenses for inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.) and to ensure each date of purchase is itemized on the bill. Charges for food, combined in weekly or monthly date spans, **aren't allowed**. Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable. The provider and/or the worker should also retain a copy of receipts.

The worker won't be reimbursed over the monthly-allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker doesn't exceed their monthly allotment for food.

The vocational provider will review the receipts, deduct personal and other noncovered items and sign the Statement for Retraining and Job Modification Services form.

Once the vocational provider signs the Statement for Retraining and Job Modification Services form the insurer will assume the provider has reviewed the bill and receipts, removed inappropriate charges and has verified the charges are within the worker's per diem allotment for that month.

Mileage on Transportation Cost Encumbrance

The insurer reimburses mileage only in whole miles. Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Transportation Cost Encumbrance form should be referred to the VSS.