

Procedure Description	Procedure Codes	Limits*	Non-Facility Fee
Activity Prescription (APF) Form — ** If restricted work or not released to work, file with the Report of Accident (ROA)	1073M	AP only, self generate (see limits*), per insurer request	\$51.84
Chiropractic care (Level 1 – 3)	2050A – 2052A	One per day	\$43.42 – \$67.76
Consultation including report	99241 – 99245	MD, DO, ARNP. Approved Chiropractic Consultants (may only bill the first four levels of the CPT® office consultation codes.)	\$82.77 – \$382.07
	99241 – 99244		\$82.77 – \$313.10
Electronic communication (Physician)	99444	Physician only	\$45.58
Electronic communication (Non-physician)	98969	Non-physician	\$45.58
Final Report by AP	1026M	AP only	\$26.35
Impairment Rating by AP	1191M – 1192M	AP only, per insurer request	\$520.22 – \$650.25
Independent Medical Exam (IME), Review of written report	1063M	AP only, per insurer request	\$39.88
Independent Medical Exam — written report by AP, after reviewing an IME	1065M	AP only, per insurer request	\$29.91
Job offer or analysis: first one reviewed	1038M	AP / psych service provider, on request	\$51.84
Job offer or analysis: each additional review	1028M	AP / psych service provider, per review	\$38.89
Loss of Earning Power	1027M	AP only, per insurer request	\$19.95
Occupational Disease History Report, Review of	1055M	AP / Prescriber only, per insurer request	\$193.47
Opioids: Chronic opioid request form	1078M	AP only	\$31.90
Opioids: Subacute opioid request form with documentation	1077M	AP / Prescriber only	\$59.83
Opioids: Subacute opioid request form without documentation	1076M	AP / Prescriber only	\$31.90
Physical medicine procedures by non-physical medicine AP	1044M	6 units per claim	\$45.38
Reopening Application	1041M	AP only	\$51.84
Report of Accident (ROA) or the Provider's Initial Report (PIR) (payment scale based on date received following the date of first treatment)	1040M	AP only: When submitted within 5 business days	\$39.88
		Within 6–8 business days	\$29.88
		If received 9 or more business days	\$19.88
Return to Work request by VRC/Employer, AP's response to	1074M	AP / psych service provider — one per day	\$31.90
60 day report (must be in SOAPER format)	99080	AP / psych service provider — 1 per 60 days	\$45.86
Special Report	99080	AP only, per insurer/VRC request — 1 per day	\$45.86
Team conference, patient present	Approp. Level E&M	Physician only	Varies by code
Team conference, patient not present	99367	Physician only	\$154.75
Team conference, patient present	99366	Non-physician	\$72.58
Team conference, patient not present	99368	Non-physician	\$62.38
Telephone calls with employer, claim manager, other providers, or VRC	99441 – 99443	Physician only	\$23.99 – \$67.78
Telephone calls with employer, claim manager, other providers, or VRC	98966 – 98968	Non-physician	\$23.99 – \$67.78

* Limits

AP only: Attending provider — a person licensed to practice as one or more of the following provider types: MD, DO, ND, DC, DM, PA-C and ARNP's. (PA-C and ARNP providers are paid at a maximum of 90% of the allowed fee.)

Non-physician: ARNP, PA-C, PhD, PT, and OT must bill using non-physician codes.

Note: Beyond the initial visit to file the Report of Accident, only network providers can treat injured workers. Learn more at www.Lni.wa.gov/ProviderNetwork.

APF Limits: A provider may submit up to 6 APFs per worker within the first 60 days of the initial visit date and then up to 4 times per 60 days thereafter.

This handout is based on Washington State Dept. of Labor & Industries' Medical Aid Rules and Fee Schedules. For complete billing rules and policies, see www.Lni.wa.gov/apps/FeeSchedules.



Working with L&I

www.Lni.wa.gov/Providers

Resources for Treating Patients and Getting Paid

- Become a Provider/Update your account
- Treating Patients
- Billing and Payment
- Workshops and Training (free CMEs offered)

Provider Tools

- Claim and Account Center (CAC)
- Drug Lookup
- Explanation of Benefits Lookup (EOB)
- Fee Schedule Lookup
- Find a Doctor (if you need to refer patients)
- Transfer of Care (online)
- Authorizations

Tip 1

Start with our **Fee Lookup** to determine if the procedure requires prior authorization and who to contact.

Tip 2

If you need authorization by a claim manager, use the **Preauthorization Request for Services form**: it creates a high-priority work item for the claim manager. (For L&I/State fund claims only.)

Helping Workers Get Back to Work *(under Treating Patients)*

- Activity Prescription Form (APF)
- Attending Doctor's Return-to-Work Desk Reference (How to complete the APF Form)
- Stay at Work Program

Billing Self-Insured Employers *(under Billing and Payment)*

- Have a billing dispute with a self-insured employer? Learn how to take action.
- Need proof of your network status? Check the Provider Network Status Report (PNSR).
- Need to know where to mail your self-insured bill? Our list of Self-Insured Employers includes contact information for their administrators.
- Want to know more about how self-insured employers authorize care? Review the laws and rules.

Tip 3

By rule, self-insurers must follow the same rules and fee schedules as L&I (WAC 296-15-330).

Questions about self-insured employers' coverage? Call 360-902-6901 or fax 360-902-6900.

Upon request, foreign language support and formats for persons with disabilities are available. Call 1-800-547-8367. TDD users, call 360-902-5797. L&I is an equal opportunity employer.