



Washington State Department of
Labor & Industries
Workers' Compensation Services

Miscellaneous Services Billing Manual

Miscellaneous Services Billing Manual

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About Billing Instructions

Where can you find help with L&I billing procedures?

Labor & Industries (L&I) provides resources to help you understand and comply with the Industrial Insurance laws in the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC).

L&I publishes the Medical Aid Rules and Fee Schedule (MARFS) which has the payment policies and fees schedule. You can find MARFS online at www.Lni.wa.gov/FeeSchedules.

In addition, L&I publishes a general billing manual and one billing manual for each bill form. Below is a list of the billing manuals L&I provides:

- General Provider Billing Manual.
- CMS 1500 Billing Manual.
- Home and Residential Care Billing Manual.
- Hospital Billing Instructions.
- Miscellaneous Services Billing Instructions.
- Pharmacy Billing Instructions.
- Retraining and Job Modification Billing Instructions.

Each manual includes the following information:

- Information about Industrial Insurance and Crime Victims.
- Electronic and paper billing information.
- How to complete the bill forms.
- Where to send bill forms.
- Billing examples.
- Links to billing forms.

About Labor & Industries (L&I) Industrial Insurance

As administrator of Washington State's workers' compensation system, L&I is similar to a large insurance company that provides claim-related coverage to workers who suffer job-related injuries and illnesses.

Two programs cover Washington's industrially injured/ill workers: the Washington State Fund and the Self Insured Employer Program (SIE). Both programs are governed by the Revised Code of Washington (RCWs) and the Washington Administrative Code (WACs).

State Fund Industrial Insurance

The Washington State Fund is financed by premiums from employers, workers, and income from investments. L&I claim managers oversee State Fund benefits to workers who are injured or become ill on the job. The State Fund covers all employers in the state who are not self-insured or covered by the U.S. Department of Labor.

State Fund claim numbers begin with one letter (B, C, F, G, H, J, K, L, M, N, P, X, Y, or Z) followed by 6 numbers or two letters (AA, AB) followed by 5 numbers. Example state fund claim numbers include: B123456 or AM95370.

Additional information about billing State Fund can be found in this manual or online at www.Lni.wa.gov/ClaimsIns/Providers/Billing or you can call the Provider Hotline at 800-848-0811.

Self-Insured Employer Program

L&I regulates about 400 large, self-insured employers (SIE) who have qualified to provide their own workers' compensation insurance. Every SIE must authorize medical treatment and pay bills in accordance with Title 51 RCW and the Medical Aid Rules and Fee Schedules of the State of Washington per WAC 296-15-330(1).

Self-Insured claim numbers all start with S, T, or W followed by 6 numbers or 2 letters followed by 5 numbers. Example self-insured claim numbers include T123456 or SG12345.

For a list of self-insured employers, please go to www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp.

Additional information about billing for self-insured claims can be directed to the employer or their third party administrator (TPA).

Getting Paid for Services Provided to Washington Workers

Every provider who treats injured workers must have an active provider payment account with L&I to be eligible for payment (WAC 296-20-015). Please visit L&I's website for detailed information about becoming an L&I provider at www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp.

State Fund Electronic Billing

There are 3 ways to bill electronically for state fund claims:

1. Direct Entry using a free online form.
2. Upload billing files using your own software.
3. Submit bills through a Clearinghouse.

L&I offers free electronic billing through Provider Electronic Billing (PEB). PEB saves time and money and allows for greater control over the payment process, eliminates entry time, and allowing to process payments faster than paper billing. PEB reduces keying errors and decreases bill processing costs.

You can find detailed PEB information on our website at www.Lni.wa.gov/ElectronicBilling.

You can also find a Cost Comparison Estimator for electronic billing at www.Lni.wa.gov/ClaimsIns/Files/Providers/EstimatorFinal042009.xls.

Self-Insurance Electronic Billing

Please contact the employer or their TPA for billing information.

State Fund Paper Billing

The type of service you provide determines which billing form you need to use. See a list of a bill requirements for each provider type in the General Provider Billing Manual – page 7.

You must submit your bills on L&I approved bill forms. Please **don't fax** your bills. Mail your bills to the address below:

**Department of Labor & Industries
PO Box 44269
Olympia WA 98504-4269**

Self-Insurance Paper Billing

You must submit your bills on L&I or self-insured approved forms (WAC 296-20-125(1)).

Mail your bills directly to the SIE or TPA. For a list of SIE/TPAs and their contact information, please visit: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

Crime Victims Compensation Program

The Crime Victims Compensation Program is a secondary insurance program that provides financial, medical, and mental health benefits to victims of crimes.

Crime Victims claim number begin the letter V followed by 6 digits or a 2 letters, such as VA, followed by 5 digits.

Additional information about the Crime Victims Compensation Program can be found online at www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources or by calling the Crime Victims Compensation Program at 360-902-5377 or 800-762-3716.

Getting Paid for Services Provided to Crime Victims

You can find Crime Victims billing forms online at:
www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources.

Please ***don't fax*** your bills to Crime Victims Compensation Program. Mail your bills to:

**Department of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520**

Provider Specific Instructions

Dental Services

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

Authorization and treatment plan requirements:

You may use the Quick Fee Lookup tool on our website www.Lni.wa.gov/FeeSchedules.

If the Fee Schedule, procedures requiring prior authorization are noted with a “Y” in the “Prior Auth” column.

Contact the following for procedures requiring prior authorization:

- L&I claim manager for State Fund and Crime Victims claims.
- Self-insurance employer (SIE) or their third party administrator (TPA):
www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList

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.

State Fund treatment plans:

Fax to: 360-902-4567

Mail to: Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

MAIL Crime Victims treatment plans to:

Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

Mail self-insured treatment plans to the SIE/TPA.

www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList

Copies of the HCPCS Level I and II codes may be downloaded from www.cms.hhs.gov/HCPCSReleaseCodeSets or purchased from:

The Superintendent of Documents
United States Government Printing Office
Washington DC 20402

DME Services

Error! Bookmark not defined. 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 are **not 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.

For covered prosthetics that pay by report, providers must bill their usual and customary fees. The provider will be paid at 80% of the bill charge.

A modifier is always required with HCPCS codes to indicate purchase or rental.

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

The HCPCS Section of the www.Lni.wa.gov/FeeSchedules lists the HCPCS E codes and the HCPCS K codes that require either the –NU or –RR modifier. Look in the HCPCS/CPT® code column of the fee schedule for the appropriate modifier. There is also a column in the fee schedule that designates the HCPCS code as requiring prior authorization. There is no need to get prior authorization if the code does not 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).

Exception: HCPCS Codes

- 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 non-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.

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.

Exception: HCPCS Codes

- 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. Contact the claims manager for rental beyond 14 days.

E1800-E1818, E1825-E1840, extension/flexion devices are rented for 1 month. If needed beyond 1 month, a claims manager's authorization is required.

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 and relative to the injury or type of treatment being received.

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 is not 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.

Some DME requires a prior authorization. Prior authorization for L&I claims can be obtained by calling the claim manager, or the Provider Hotline at 1-800-848-0811 (or from Olympia 902-6500).

Oxygen

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.

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.

DME Repair and Maintenance

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

Exception: 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.

Bill code K0739 and K0740 as one unit per each 15 minutes. Each 15 minutes should be represented by one unit of service on the “Units” field.

For example, 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would bill 3 units of service.

A copy of the original warranty is required on repair service completed.

For State Fund claims, send a copy to:

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

Write the claim number in the upper right hand corner of the warranty document. Payment will be denied if:

- No original warranty document is received.
- The item is still under warranty.

For Provider Hotline Durable Medical Equipment authorization requests, see L&I form [F245-418-000](https://www.lni.wa.gov/Forms/F245-418-000).

For further information regarding DME services, refer to the DME chapter in the current billing and payment policies section of the Medical Aid Rules and Fee Schedule www.Lni.wa.gov/FeeSchedules.

Drug & Alcohol Treatment

H0001	Assessment	H0011	Acute Detoxification
H0002	Screening	H0012	Sub-Acute Detoxification
H0003	Screening; Lab Analysis	H0013	Acute Detoxification
H0004	Individual Counseling	H0014	Ambulatory Detoxification
H0005	Group Counseling	H0015	Intensive Outpatient
H0006	Case Management	H0017	Residential
H0007	Crisis Intervention	H0018	Short-Term Residential
H0008	Sub-Acute Detoxification	H0019	Long-Term Residential
H0009	Acute Detoxification	H0020	Methadone Administration
H0010	Sub-Acute Detoxification		

Hearing Aid Services

The following policies and requirements apply to all hearing aid services and devices except for CPT® codes.

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 (L&I form [F262-013-000](#)).
- Occupational Hearing Loss Questionnaire (L&I form [F262-016-000](#)).
- Valid audiogram.
- Medical report.
- Hearing Services Worker Information (L&I form [F245-049-000](#)).
- Authorization to Release Information (L&I form [F101-010-000](#)).
- Hearing Aid Repair/Durable Medical Equipment Authorization Request (L&I form [F245-418-000](#)).

The insurer **does not pay** any provider or worker to fill out the Employment History Hearing Loss or Occupational Hearing Loss Questionnaire.

Physician or ARNPs may be paid for a narrative assessment of work-relatedness to the hearing loss condition. Refer to the [Attending Doctor's Handbook](#) table on Other Miscellaneous Codes and Descriptions.

Note: Sending workers batteries that they have not requested and for which they do not have an immediate need for 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.

Don't bill your usual and customary fee. (See specific billing instructions for these items in the following table.)

If you are billing for. . .	Then these can be:
Supply items for hearing aids, including: <ul style="list-style-type: none"> • Tubing • Wax guards, <i>and</i> • Ear hooks. 	Billed within the warranty period.
Parts for hearing aids, including: <ul style="list-style-type: none"> • Switches, • Controls, • Filters, • Battery doors, <i>and</i> • Volume control covers 	Billed as replacement parts only, but not within the warrant period.
Shells (“ear molds” in HCPCS codes)	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).	Only billed when the manufacturer doesn’t include these in the base invoice for the hearing aid.

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.

Who may bill for hearing aid services and devices?

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).

What billing forms should providers use?

Fitters/dispensers and DME providers should use the department’s [Statement for Miscellaneous Services Bill form \(F245-072-000\)](#).

Physicians, ARNPs, and licensed audiologists are to bill the department using the [CMS-1500 form \(F245-127-000\)](#). For further information regarding hearing aid services, please refer to the “Professional Services” section of the current www.Lni.wa.gov/FeeSchedules.

Interpreter Services

Code/Description	Units of Service
9988M – Group Interpretation Direct services time between more than one client(s) and health care or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute.	Bill 1 unit for each minute
9989M – Individual Interpretation Direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute.	Bill 1 unit for each minute
9996M – IME No show Interpreter	Bill 1 unit only per occurrence
9986M – Mileage	Bill 1 unit for each mile
9997M – Document Translation	Bill 1 unit for each page translated

Interpretive Services providers must provide proof of their credentials using the “Submission of Credentials for Interpretive Providers” form F245-055-000. This form is available online as well as from Provider Accounts.

Interpretive Services Appointment Record form and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.

Document translation services are only paid when performed at the request of L&I or the self-insurer. Services will be authorized before the request packet is sent to the translator.

Individual Interpretation Services: You must bill services for the same client, for the same date of service on one bill or your bill may be not be paid.

Group Interpretation Services: Time and mileage is divided between all clients participating in group. Send a separate bill for each client with prorated amounts. Send an Interpretive Services Appointment Record (ISAR) form and mileage to each workers’ compensation client’s file.

Adjustments vs. Submitting a New Bill for State Fund Claims

- When the whole bill is denied, then you need to submit a new bill.
- When part of the bill is part, then you need to do an adjustment. Additional information on adjustments is available at <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp>.

If the time or mileage need to be corrected, you should adjust the **last paid** bill.

Refer to the “Professional Services” section of the current Medical Aid Rules and Fee Schedule, www.Lni.wa.gov/FeeSchedules, for further information regarding interpreter services including:

- L&I authorization and limit information
- Interpreters/Translators not eligible for payment
- Credential required for L&I provider account number
- Covered and non-covered services.
- Individual interpretation services billing information
- Group interpretation services billing information
- Mileage and travel billing information
- Billing examples
- Standard and responsibilities for interpretive services

Do not staple the Interpretative Services Appointment Record form and mileage verification to bill forms. Send or fax documentation separately from bills for State Fund or Crime Victims Compensation Program claims.

State Fund:

Fax to: 360-902-4567

Mail to: Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

MAIL Crime Victims treatment plans to:

Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

Mail self-insured **bills and reports** to the SIE/TPA.

For a list of SIE/TPAs and their contact information, go to:

www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList

Licensed Massage Therapy

Note: DO NOT bill services spanning multiple dates of service. Bill one date per line.

Massage is a **covered** physical medicine service when performed by a licensed massage therapist ([WAC 296-23-250](http://www.wa.gov/WAC296-23-250)) or other provider whose scope of practice includes massage techniques.

Massage therapist must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **will not pay** message 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.

The daily maximum allowable amount is \$93.33.

The following are bundled into the massage therapy service and are not separately payable:

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

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

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

Units Reported on the Claim	Number of 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 does not 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.

Report the duration of treatment for each timed code billed in the daily treatment note. You must submit all documents that support your billing (e.g. flow sheets and charts notes).

More information about L&I Massage Therapy policies is also available on L&I web site at www.Lni.wa.gov/FeeSchedules.

Refer to [WAC 296-20-030](#) and [WAC 296-23](#) chapter for additional information.

Authorization Required

“Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker’s attending doctor.”

“Massage therapy treatment beyond the initial six treatments will be authorized only upon substantiation of improvement in the worker’s condition in terms of functional modalities, i.e. range of motion; sitting and standing tolerance; reduction in medication, etc.”

Provider Hotline Service Authorization Request for Massage Therapy ([F245-417-000](tel:1-800-417-000)).

“Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the department or self-insurer.”

“Massage therapy treatments exceeding once per day must be justified by attending doctor.”

Please refer to [WAC 296-23-250](#) for additional information and reporting requirements.

License Nursing

Advanced Registered Nurse Practitioner (ARNP)

Refer to [WAC 296-23-240](#) for licensed nursing rules and [WAC 296-23-245](#) for licensed nursing billing instructions. ARNP services will be paid at a maximum of 90% of the allowed fee that would be paid to a physician.

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. The only modifiers that are valid for CRNAs are —QX and —QZ.

Refer to [WAC 296-23-240](#) for licensed nursing rules and [WAC 296-23-245](#) for licensed nursing billing instructions. For more detailed billing instructions, visit our website <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/default.asp>.

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

Please refer to the “Professional Services” section of the current Medical Aid Rules and Fee Schedules www.lni.wa.gov/FeeSchedules.

Registered Nurse as Surgical Assistants

Licensed registered nurses may be paid to perform surgical assistants services if you submit a completed provider application along with the following documents:

- A photocopy of your valid and current registered nurse license, *and*
- 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.

For further information, please refer to [WAC 296-23-240](#) and [WAC 296-23-245](#).

Lodging/Meal Services

For rates and more information, visit: <http://www.ofm.wa.gov/resources/travel/colormap1214.pdf>.

Code	Description
0406A	Lodging
0407A	Breakfast
0408A	Lunch
0409A	Dinner
1061M	Per Diem (Lodging/Meals)

Nurse Case Management

All nurse case management (NCM) services require prior authorization. Contact the insurer to make a referral for NCM services.

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.

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 local billing 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.

Copies of reports, correspondence, and expenses shall be maintained in the case record.

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	\$10.17
1221M	Visits, per 6 minute unit	\$10.17
1222M	Case planning, per 6 minute unit	\$10.17
1223M	Travel/Wait, per 6 minute unit (16 hour limit)	*\$5.00
1224M	Mileage, per claim – 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 (meal and lodging). Requires prior authorization from the claim manager (\$725 limit).	By report

Billing Units Information

- Units are whole number and not tenths units
- Each traveled mile is 1 unit of service.
- Each 6 minutes of care coordination 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
16	=	3	48	=	8
24	=	4	54	=	9
30	=	5	30	=	10

Case note codes shall be converted to billing codes as bills are processed by the nurse case manager or firm.

For example, all time associated with telephone calls during a 30-day period is added, converted to units of service, and then total charges. Likewise, all time associated with visits during a 30-day period is added, converted to units of service, and then total charges.

Examples below describe how to convert time to units and calculate total charges. Examples are also shown for mileage and expenses.

Phone Calls, Visits, or Case Planning

Step 1 – Time to Units

Total minutes ÷ 6 = Total Number of Units 102 minutes ÷ 6 = 17 units

Step 2 – Units of Total Charges

Total units x per unit charge = Total Charges 17 units x \$10.17 = \$172.89

Travel/Wait

Step 1 – Time to Units

Total minutes ÷ 6 = Total Number of Units 150 minutes ÷ 6 = 25 units

Step 2 – Units of Total Charges

Total units x per unit charge = Total Charges 25 units x \$5.00 = \$125.00

Mileage

Mileage is reimbursed at the Washington State rate for mileage reimbursement.

The rate effective January 1, 2015 is \$0.58 per mile. Mileage during a 30-day period is added then multiplied by 0.58 to obtain the total mileage expenses for the month.

For example:

112 miles x 0.58 = \$64.96

Expenses

Expenses will be reimbursed at cost. Receipts for expenses shall be maintained in the case record. Receipts for parking are not required, but preferred. All expenses with a 30-day period shall be added, and then coded as 1225M on the Statement for Miscellaneous Services bill form www.Lni.wa.gov/Forms/pdf/F245-072-000.pdf.

Attachment B describes covered and non-covered medical case management expenses.

For example:

\$5.00 (parking) + \$7.50 (records) = \$12.50

For further information regarding nurse case management services, please refer to the “Professional Services” section of the current Medical Aid Rules and Fee Schedule.

Case Note Codes

Phone Calls:

PCW:	Injured worker, family members, injured workers' attorney or legal representative.
PCD:	Department of Labor and Industries staff.
PCE:	Employer or employer representatives.
PCV:	Vocational rehabilitation counselors.
PCP:	Attending physician, physician consultants, and other allied healthcare personnel.
PCO:	Governmental agencies, social services, community and/or volunteer resources, etc.

Visits:

VW:	Injured worker, family members, injured workers' attorney or legal representative.
VD:	Department of Labor and Industries staff.
VE:	Employer or employer representative
VP:	Attending physician, physician consultants, and other allied healthcare personnel.
VO:	Governmental agencies, social services, community and/or volunteer resources, etc.

Case Planning:

CR:	Case Review: review and analyze current or new data between monthly reporting periods.
FRV:	File Record Review: review and analyze historical file documentation.
COR:	Correspondence: prepare correspondence, i.e., letters memo, fax.
RE:	Research: research medical literature, condition specific.
RW:	Report Writing: prepare monthly reports, i.e., initial, progress and closure reports and special reports.
RR:	Record Retrieval: obtain medical records, reports or evaluations.
TC:	Team Conference: participate in or conduct team conferences.

Travel/Wait:

TR:	Travel: travel to person being visited
WA:	Wait to meet with person(s) being visited.

Mileage:

Not applicable

Expenses:

Not applicable

Case Note Codes, Descriptions, and Instructions

Phone Calls:

Definition: Made by or to a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used by clarify or alter previous instructions, to integrate new information from other health care professionals into medical treatment plan; or to assess the need to modify or change the current treatment plan to facilitate the worker's recovery; to assess the success of current therapies or treatment, overall.

Billing Instructions: Bill 1 unit of service to each 6 minutes of time. Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the call, to whom the phone calls was made, their title if applicable (MD, RN, DO, PT, etc), the reason for the call, details of the discussion, and the length of the phone call.

Billing Codes and Descriptions:

PCW:	Injured worker, family members, injured workers' attorney or legal representative.
PCD:	Department of Labor and Industries staff.
PCE:	Employer or employer representatives.
PCV:	Vocational rehabilitation counselors.
PCP:	Attending physician, physician consultants, and other allied healthcare personnel.
PCO:	Governmental agencies, social services, community and/or volunteer resources, etc.

Visits:

Definition: Onsite meetings or scheduled face-to-face meetings by a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instruction; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to further recovery; to assess the success of current therapies or treatment overall when telephonic services are not adequate to obtain the necessary information.

Billing Instructions: Bill 1 unit of service to each 6 minutes of time. Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the visit, who was visited, their title if applicable (MD, RN, DO, PT, etc.), the reason for the visit, details discussed and the length of visit.

Billing Codes and Descriptions:

VW:	Injured worker, family members, injured workers' attorney or legal representative.
VD:	Department of Labor and Industries staff.
VE:	Employer or employer representative
VP:	Attending physician, physician consultants, and other allied healthcare personnel.
VO:	Governmental agencies, social services, community and/or volunteer resources, etc.

Case Planning:

Case Review (CR) Definition:

The time taken to review and analyze current or new data between monthly reporting periods; includes documentation of impact of new data on overall case plan.

Case Review (CR) Billing Instructions:

Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include the date, case note with the data and description of the data, analysis, and plan. Case planning is not to be billed for writing case notes to document onsite visits or phone calls. Phone calls and visits already include payment for associated documentation.

File Record Review (FRV) Definition:

The time taken to review and analyze historical file documentation at the onset of referral to medical case management.

File Record Review (FRV) Billing Instructions:

Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include a case note describing the date of review, material reviewed, and time spent reviewing the records. If a separate file review is completed, a copy of the document will be kept in the working file and attached to the monthly report. Copies of historical file documents shall be kept with the nurse case manager's case record.

Correspondence (COR) Definition:

The time taken to prepare correspondence, i.e., letters, memo, fax to the department, injured worker, provider, vocational counselor and other governmental agencies, social services, community and/or volunteer resources for the purpose of updating, clarifying or confirming the medical treatment plan.

Correspondence (COR) Billing Instructions:

Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include the date when the correspondence was produced, a case note describing the correspondence and time to prepare the correspondence. A copy of the document will be kept in the case record and attached to the monthly report.

Research (RE) Definition:	The time taken to research medical literature, condition specific.
Research (RE) Billing Instructions:	Bill 1 unit of service for each 6 minutes of time. Documentation of this service is to include the date research was conducted, a summary of the findings of the literature review, the impact of the information on the injured worker's case plan, and time to complete research. If document produced, a copy will be kept in the case record and attach to the monthly report.
Report Writing (RW) Definition:	The time taken to prepare monthly reports, i.e., initial, progress and closure reports, as well as special reports requested by department representatives.
Report Writing (RW) Billing Instructions:	Bill 1 unit of service for each 6 minutes of time. The initial report shall not exceed 2 billable hours per case. Progress and closure reports shall not exceed 1 hour per case. Documentation of this service is to include the date of the report, a notation in the case notes, a report, (for special reports, note requesting part in case note documentation using appropriate billing code, e.g., PCD or VD) and the time to complete the report. A copy of the report will be kept in the case record and sent to the claims representative on a monthly basis.
Record Retrieval (RR) Definition:	The time taken to obtain records, reports or evaluations not currently contained in the department's records for case planning. This method of obtaining records should be limited. The most cost-effective method of obtaining records should be used first, prior to use of professional time, e.g., faxing, mailing, etc.
Record Retrieval (RR) Billing Instructions:	Bill 1 unit of service for each 6 minutes of time. Documentation of this service is to include the date of record retrieval, a case note identifying the record source, summary of records obtained, and the total time (including travel, wait, and photocopying cost) to obtain the report.

Team Conference (TC) Definition:

The time taken to participate in or conduct a team conference with 3 or more health care professionals, vocational rehabilitation counselors, employer, injured worker and/or representative, or other governmental agencies, social services, community and/or volunteer resources to coordinate activities of patient care, provide for the injured worker's health care needs and/or return to work efforts for the injured worker. Includes documentation of impact of conference data on the overall case plan.

Team Conference (TC) Billing Instructions:

Bill 1 unit of service for each 6 minutes of time. Visit codes are not to be billed for team conferences. Documentation of this service is to include the date of the conference, a case note, summary of conference findings, analysis, plan of action, and time.

Travel (TR) Definition:

The time to travel from the nurse case manager's home office or home, whichever is closest, to the person being visited.

Travel (TR) Billing Instructions:

Bill 1 unit of service for each 6 minutes of time. Transportation costs including parking, ferry, toll fees, cab, and airfare are reimbursable at cost. Travel expenses resulting from single or multiple visits which involve visits or conferences on more than one injured worker must be prorated between the multiple injured workers visited. For example, if the case manager travels to a hospital in Seattle, and visits with 3 injured workers, the costs should be billed by dividing the mileage and travel time between the three cases.

Documentation of the service is to include date of travel, a case note with starting and ending location, whether visit was prorated, mileage, odometer reading start and finish, and other associated transportation expenses, and time.

Mileage costs may be reimbursed at the current Washington state rate for mileage reimbursement. Mileage costs should be billed using the 1224M mileage billing code. Parking, toll, ferry, cab or airfare expenses will be billed with the new 1225M expense billing code. Meals and lodging required outside normal business hours will be paid with prior approval by the claims manager and at the state per diem rate in effect at the time for the area. Meals and lodging and a copy of any original invoice shall be kept in the case record for a minimum of five years.

Wait (WA) Definition:	The time to wait to meet with person(s) being visited during scheduled visits.
Wait (WA) Billing Instructions:	<p>Bill 1 unit of service for each 6 minutes of time to a maximum of 16 hours. Case managers are encouraged to use wait time to conduct other business e.g., phone calls, visits, case planning, file record review, and record retrieval during wait time.</p> <p>Documentation of the service is to include the date of wait time, a case note with location of visit, time of arrival at appointment, and end time (when appointment visit began).</p>

Attachment B

Covered and Non-Covered Expenses

Covered expenses:

The following expenses will be covered —

- Transportation other than mileage, including parking, ferry, toll fees, and cab. Mileage is reimbursed at the current Washington state rate for mileage reimbursement.
- Meals and lodging required outside normal business hours with prior claims manager approval and at the Washington state per diem rate in effective at the time for the area.
- Airfare with prior approval from the claim manager.
- Mileage greater than 600 miles round trip requires prior approval from the claim manager.
- Fees for obtaining medical records, reports or evaluations per request of department and at no more than the maximum allowable rate per page. For further information regarding fees for obtaining medical records, reports, or evaluation, please refer to the “Professional Services” section of the current *Medical Aid Rules and Fee Schedules*.

Non-covered expenses:

The following expenses will be covered —

- Activities associated with nurse case manager training, e.g. training on office policies and procedures, including report writing and billing.
- Supervisory activity such as supervisor – nurse case manager visits, case reviews, or conferences between supervisor and nurse case manager.
- Postage, printing, or photocopying costs (with the exception of medical records per request of department). See above explanation.
- Telephone expenses including unanswered phone calls, long-distance phone calls, and facsimile.

- Time spent on any clerical activity, including processing a referral, file “set up”, typing, copying, mailing, distribution, filing, invoice preparation, record keeping, delivering or picking up mail.
- Travel time to a post office or a fax machine.
- Wait time exceeding 16 hours.
- Fees related to legal work, e.g. deposition, testimony, etc. Legal fees may be charged to the requesting party, but not the claim. Contact the requesting party regarding how legal services are billed.
- Any other administrative cost not specifically mentioned above.

Obesity Treatment

Obesity does not 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.

Prior authorization is required for all obesity treatment services.

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 worker pays the joining fee and weekly membership fees up front for programs and can be reimbursed. The worker is eligible for dietician services with a doctor’s order and prior auth of the CM. Only certified dieticians (CDs) can be paid for counseling services.

The procedure codes for dietician counseling are as follows:

- 97802 Initial visit, maximum of 4 units, maximum fee per unit is \$59.98
- 97803 Maximum 2 units per visit with maximum of 3 visits, maximum fee per unit is \$51.58

For further information regarding obesity treatment services, please refer to the “Obesity Treatment” chapter 20 of the current Medical Aid Rules and Fees Schedules www.Lni.wa.gov/FeeSchedules.

Occupational Therapy

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

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 Non-covered 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. 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 for additional information.

Use CPT Code	For Description
97001 – 97004	Physical and occupational therapy evaluations and reevaluations.
97001 and 97003	To report the evaluation by the physician or therapist to establish a plan of care.
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

Occupational Therapy (Vocational Services)

Code	Description	Maximum Fee
0378R	Stand Alone Job Analysis – (non-VRC) 1 unit = 6 minutes	\$9.06
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	\$11.02
0390R	Vocational Evaluation, 1 unit = 6 minutes	\$9.06
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	\$4.99
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.

See [WAC 296-23-230](#) for additional information regarding Occupational Therapy Rules.

For further information regarding occupational therapy services, please refer to the “Professional Services” section of the current *Medical Aid Rules and Fee Schedules*.

www.Lni.wa.gov/FeeSchedules

Optometry/Optician Services

Please refer to [WAC 296-20-100](#) Eyeglasses and refractions for more information.

Functional Capacity Evaluation (FCE) – Previously Physical Capacity Evaluation (PCE)

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

1045M Performance-based FCE with report and summary of capacities...\$743.90.
(Limit of 1 per 30 days per worker.)

Vocational Services

Code	Description	Maximum Fee
0378R	Stand Alone Job Analysis – (non-VRC) 1 unit = 6 minutes	\$9.06
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	\$11.02
0390R	Vocational Evaluation, 1 unit = 6 minutes	\$9.06
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	\$4.99
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.

Vocational Rehabilitation Services

This section details the requirements and information Vocational Rehabilitation providers should know and follow in submitting bills.

How to Submit a Bill:

Each provider who works on a referral must bill separately and must list the precise number of units of service worked for each date span on a referral. Each date span billed must have both a state and end date. The provider must also bill for each referral separately. Even if a third party does the billing, the provider receiving the referral is responsible for ensuring that all billing is correct.

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 referral 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.
- 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.

Example:

Acme Rehabilitation employs counselor X, as well as interns Y and Z. Acme may not submit aggregate bills: Acme Rehabilitation must submit a separate bill for Counselor X, Intern Y, and Intern Z—for each referral worked by X, Y, and Z.

For more detailed information about completing billing forms, consult the samples of completed forms, which are located in an attached section.

Reimbursement Rates

Each referral is a separate authorization for services. L&I will pay interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate and forensic evaluators at 120% of the VRC professional rate.

The table below lists the professional, travel/wait; and mileage rate for vocational services.

1 unit = 6 minutes

Provider Type	Rate	Rate per Unit
VRC Professional Rate	\$90.60 hour	\$9.06
Intern Professional Rate	85% of VRC Professional Rate	
Forensic Rate	120% of VRC Professional Rate	
Travel/Wait Rate	\$45.40	\$4.54
Mileage Rate	Current State Rate/Mile	

Fee Caps and Thresholds

As part of the changes to the reimbursement structure, the department has adopted fee caps. Provider must be aware that fee caps are **hard** caps with **no** exceptions.

When cumulative payments for a referral have reached the cap, the Remittance Advice sent with the State Fund bill payment will contain an Explanation of Benefits indicating that the referral has reached its fee cap. The department will adjust the amount of the bill to pay no more than the fee cap allows and will authorize no payment beyond the cap. It is very important that vocational providers work closely with their billing staffs to monitor costs on their referrals.

At 100% of the fee cap the claim manager is notified and instructed to close the referral. When the claim manager has closed the referral, the vocational provider must submit a closing report.

Please consult the following fee cap table.

Description	Available Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	\$1861.00
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	\$1814.00
Assessment Referral Cap, per referral	0810V, 0811V	\$3103.00
Assessment Services Exception (vrc), (Intern) additional fee cap	0812V,0813V	\$906.00
Plan Development Referral Cap, per referral	0830V, 0831V	\$6515.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	\$7046.00
Plan Implementation Services Exception (VRC),(Intern) additional fee cap	0842V,0843V	\$2094.00

The fee cap for vocational evaluation services applies to multiple referral types.

Description	Available Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	\$1861.00

Codes

The following table lists the codes, and their corresponding definitions for use in billing for vocational services. Reimbursement will occur according to the level of providers described below. Separate codes and provider specialties exist for vocational interns, counselors, and forensic specialists.

Example:

Intern Y at Acme Rehabilitation bills code 0881V. Result: The department does not pay, because it only authorizes qualified providers to do forensic work.

Code	Description	Counselor Level
Early Intervention		
0800V	Early Intervention Services	VRC
0801V	Early Intervention Services—Intern	Intern
0802V	Graduated RTW and Work Hardening	
0803V	Graduated RTW and Work Hardening	Intern

Stand Alone Job Analysis		
0808V	Stand Alone or Provisional Job Analysis	VRC
0809V	Stand Alone or Provisional Job Analysis – Intern	Intern

Assessment		
0810V	Assessment Services	VRC
0811V	Assessment Services—Intern	Intern

Vocational Evaluation		
0821V	Work Evaluation	VRC
0823V	Pre-job or Job Modification Consultation	VRC
0824V	Pre-job or Job Modification Consultation—Intern	Intern
0821V	Work Evaluation	VRC

Plan Development		
0830V	Plan Development Services	VRC
0831V	Plan Development Services—Intern	Intern

Plan Implementation		
0840V	Plan Implementation Services	VRC
0841V	Plan Implementation Services—Intern	Intern

Forensic and Testimony		
0881V	Forensic Services	VRC—Forensic
0882V	Testimony on VRC’s Own Work	VRC
0883V	Testimony on Intern’s Own Work	Intern
0884V	AGO Witness Testimony	VRC

Other		
0891V	Travel/Wait Time	VRC
0892V	Travel/Wait Time—Intern	Intern
0893V	Professional Mileage	VRC
0894V	Professional Mileage—Intern	Intern
0895V	Air Travel	Intern/VRC/ Forensic

Code & Description	Early Int.	Assess	Plan Dev	Plan Imp	Forensic	Provider Type(s)
0896V – Ferry Charges	M	M	M	M	M	68
0897V – Hotel Charges *	O	O	O	O	O	68
0391R – Travel/wait (non-voc)	O	O	O	O	O	34, 52, 55, 97
0392R – Mileage (non-voc)	O	O	O	O	O	34, 52, 55, 97
0393R – Ferry Charges (non-voc)	O	O	O	O	O	34, 52, 55, 97

* This code is only allowable for approved out-of-state cases.
M – code loads automatically when referral is made.
O – claim manager must load code after specific authorization.

Ancillary Services

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 number than you), you cannot bill as a vocational provider (a provider type 68). You must use another provider number that is authorized to bill the ancillary services codes (type 34, 52, 55) or obtain a miscellaneous service provider number (type 97) and bill the appropriate codes for those services.

Codes 0896V, 0897V, and 0393R are payable By Report, and a receipt must be placed in the case file for documentation. Code 0391R pays at \$4.99 per unit. Recall that the department requires billing for services in units, in increments of 6 minutes per unit, or 10 units per hour. Code 0392R pays at the standard federal rate per mile, similar to codes 0893V and 0894V.

Stand Alone or Provisional Job Analysis

This type of request authorizes a vocational provider to conduct a job analysis when no other services are needed. The claim may be allowed or in provisional status. The assigned vocational provider is responsible for all work performed by all providers in the completion of that referral. A physical or occupational therapist may perform work and should follow the instructions under their section of these instructions. The combined fees of all the providers will accrue to a single fee cap.

Date Span Information

When providers are completing billing forms, it is very important to include both start and end dates for the date span of services. Providers must include all services provided during this date span on the bill. They may not submit a new bill for additional services during the same date span. If this circumstance occurs on a State Fund bill, a "[Provider's Request for Adjustment](#)" form must be completed to adjust the original charges.

Units of Service

One unit of service equals 6 minutes of time. The stated hourly rate is equal to 10 units of service. The unit of service for mileage reimbursement is per one mile. This applies to all 'V' (Voc) procedure code and 'R' procedure codes as applicable.

Example: the professional VRC rate is \$90.60 per hour; 1 unit of service (6 minutes) pays \$9.06 (\$90.60/10); 2 units of service (12 minutes) pays 2 x \$9.06 = \$18.12

Referral Identification Number on Bills

When completing billing forms, a provider must include the referral identification numbers for each submitted bill. The department will deny payment for any bill submitted without a referral identification number. Each department referral has a unique referral identification number.

Documentation

Documentation that supports billing includes the provider's case notes. Providers should ensure that their case notes include evidence of the time spent on various activities. **Example:** A provider who spends a half-hour on a progress report for a case might specify that half-hour in his or her case notes as ".5 hours preparing progress report." Specific requirements for case note documentation can be found in the rules governing vocational rehabilitation services, [WAC 296-19 Chapter A](#).

Travel/Wait and Mileage

The department developed separate codes for vocational providers' travel/wait time. The department pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The department does NOT pay for travel time between two different service locations or branch offices where a provider is working cases.

Providers should bill from the branch office where the referral has been received by the VRC to necessary destinations, such as the following: 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 his or her home. For out of state cases, VRC may only bill from the branch office nearest the worker.

Vocational provider case notes must specify point of origin for travel. Travel is normally billed from assigned service location, but when travel is actually less, it should be billed as less. For example, if referral is made to Olympia service location and the vocational provider travels from Tacoma branch to Seattle training site; it should be billed for the lesser distance.

Example: A vocational counselor indicates to the department that he or she is willing to work referrals in Seattle, Yakima, and Longview.

Result: The department will reimburse the provider for travel/wait time on cases in each of these three areas, but will not pay for the provider to drive from Seattle to Yakima, or from Longview to work a Seattle or Yakima referral.

Travel/wait is reimbursed at 50% of the standard vocational counselor rate, regardless of referral type or provider specialty. Travel/wait must be pro-rated if more than one referral is included in a particular trip.

Mileage, as determined by the federal rate, is reimbursed at the same rate as that of travel on state business. The department reimburses mileage at the same rate, regardless of referral type or provider specialty.

Obtaining a Copy of the Vocational Rehabilitation Rules

Providers can obtain a copy of the rules governing vocational services ([WAC 296-19A](#)) through the internet at the following address: www.Leq.wa.gov/LawsAndAgencyRules/.

Place of Service Codes

- | | | |
|---|--|--|
| 03. School | 22. Outpatient hospital | 53. Community mental health ctr |
| 04. Homeless shelter | 23. Emergency room - hospital | 54. Intermediate care facility/mentally retarded |
| 05. Indian Health Service free-standing facility | 24. Ambulatory surgical center | 55. Residential substance abuse trmt center |
| 06. Indian Health Service provider-based facility | 25. Birthing center | 56. Psychiatric residential trmt ctr |
| 07. Tribal 638 free-standing facility | 26. Military treatment facility | 57. Non-residential substance abuse treatment center |
| 08. Tribal 638 provider-based facility | 31. Skilled nursing facility | 60. Mass immunization center |
| 09. Correctional facility | 32. Nursing facility | 61. Comprehensive inpatient rehabilitation facility |
| 11. Office | 33. Custodial care facility | 62. Comprehensive outpatient |
| 12. Patient's home | 34. Hospice | 65. End stage renal disease treatment facility |
| 14. Group home | 41. Ambulance - land | 71. State or local public health clinic |
| 15. Mobile unit | 42. Ambulance - air or water | 72. Rural health clinic |
| 16. Temporary lodging | 49. Independent clinic rehabilitation facility | 81. Independent laboratory |
| 17. <i>Walk-in retail health center</i> | 50. Federally qualified hlth ctr | 99. Other unlisted facility |
| 20. Urgent care facility | 51. Inpatient psychiatric facility | |
| 21. Inpatient hospital | 52. Psychiatric facility partial hospitalization | |

Instructions for Completing the Statement of Miscellaneous Services

Type of Service:

Check the appropriate box for the type of service for which you are billing. If your type of service is not listed, check the "Other" box and list the type of service you provided.

Worker Information:

Claim number	Give the worker's claim number.
Name	Write the worker's legal name in the last, first, middle initial format.
Date of injury	Date of injury.
Home address	Give the most current physical address of the worker.
Social Security Number	Write the worker's Social Security Number. Used to verify claim number only.
Phone number	Write the worker's phone number.

Provider Information:

L&I provider number/NPI	Give the provider's L&I provider number or provider's NPI.
Provider name	Write the provider's name as registered with L&I.
Provider address	Write the provider's physical address.
Your Patient Account Number	Write the number you use to identify your patient's account. This field is optional and not used by L&I.
Federal Tax ID	Write the Federal Tax ID (EIN) for the billing provider. This must match the EIN on file with the agency.
Phone number	Give the phone number where the agency can call if there any questions about your bill.
Name of referring physician or other source	Write the name of the referring physician or other source for the services provided.
Referring provider number/NPI	Write the L&I provider number or NPI of the referring provider
Referral ID	Write the referral ID number.

Bill Information:

Is this bill to reimburse the injured worker?	Check the appropriate box. If this bill is to reimburse a worker, receipts are required. Send copies of your receipts. Receipts must be itemized and legible. No credit card slips.
For glasses, is the old prescription available?	Check the appropriate box.
For inpatient services	Write date of admission and the date of discharge in the mm/dd/yy format.

Use one line for each service provided. Complete each applicable field.

From date of service	Starting date of service.
To date of service	Ending date of service.
POS	Place of service. See the list below for the appropriate two-digit code.
Proc Code	Procedure code.
Mod	Modifier code if applicable.
Diagnosis	Diagnosis code. Enter the primary diagnosis code for each service.
Description	Give a brief description of services provided.
Dental tooth number	Tooth number dental services were provided for.
Home nursing	Give the number of hours you are billing for. Give your hourly or daily rate for your services.
Charges	Enter the charge for each service provided.
Units	Enter the number of units for service.

Sample Bills

Sample ARNP Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, ARNP			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 0000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	XXXXXX			XXX.XX	Description of service				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample CRNA Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, CRNA			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 0000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	XXXXXX			XXX.XX	Description of service				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) _____ Date _____

Jane Smith _____ *00/00/00*
 Signature Date

Sample Dental Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, DDS			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 0000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	D0330			XXX.XX	Panoramc Image				\$XX.XX	X
2	XX	XX	XX	D7111			XXX.XX	Tooth Extraction	9			\$XX.XX	X
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) _____ Date _____

Jane Smith _____ *00/00/00*
 Signature Date

Sample DME Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name ABC Medical Equipment			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 0000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	K0001			XXX.XX	Std Wheelchair rental				\$XX.XX	X
2	XX	XX	XX	K0002			XXX.XX	Wheelchair purchase				\$XX.XX	X
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample Group Interpretation Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, Interpreter			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	9988M				Group Interpretation Bill 1 unit per minute				\$XX.XX	X
2	XX	XX	XX	9986M				Group Interpretation Bill 1 unit per minute				\$XX.XX	X
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample Interpreter Mileage and Translating Bill

Billing 1 Client for Two Appointments on the Same Day

Mail completed forms to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, Interpreter			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	9989M				Individual Interpretation				\$XX.XX	X
2	XX	XX	XX	9986M				Mileage				\$XX.XX	X
3	XX	XX	XX	9989M				Individual Interpretation				\$XX.XX	X
4	XX	XX	XX	9986M				Mileage				\$XX.XX	X
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) _____ Date _____

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*
Signature Date

Sample Interpreter Translation Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, Interpreter			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	9997M				Document Translation Bill 1 unit per page				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) Date

Jane Smith *00/00/00*

Signature Date

Sample No Show for IME Interpreter Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
City Any City			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, Interpreter			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	9996M				IME No Show - Bill 1 unit only				\$XX.XX	X
2	XX	XX	XX	9986M				Mileage - Bill 1 unit only				\$XX.XX	X
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample Massage Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, LMT			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	97124				Massage				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample Nurse Case Management Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith, NCM			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 00000000000
Name of referring physician or other source Dr. Jones MD			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	1220M				Phone Calls				\$XX.XX	X
2	XX	XX	XX	1221M				Visits				\$XX.XX	X
3	XX	XX	XX	1222M				Case Planning				\$XX.XX	X
4	XX	XX	XX	1223M				Travel/Wait Mileage				\$XX.XX	X
5	XX	XX	XX	1224M				(Enter as in units)				\$XX.XX	X
6	XX	XX	XX	1225M				Expenses				\$XX.XX	X
7													
8													
9													
10													

Total Charge
\$ XX.XX

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) _____ Date _____

Jane Smith _____ *00/00/00*
 Signature Date

Sample Obesity Treatment Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	97802				Medical Nutrition Thpy Initial Assessment				\$XX.XX	X
2	XX	XX	XX	97803				Medical Nutrition Thpy Reassessment				\$XX.XX	X
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) _____ Date _____

Jane Smith _____ *00/00/00*
 Signature Date

Sample Occupational Therapy Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith Occupational Therapist			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	97003			XXX.XX	Occupational Therapy Evaluation				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) _____ Date _____

Jane Smith _____ *00/00/00*
 Signature Date

Sample Optician Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith Optician			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample RNFA Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith RNFA			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 000000000000
Name of referring physician or other source If available		Referring provider number/NPI If available	Phone no. 000-000-0000
			Referral ID

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
	For inpatient services: Date admitted: _____ Date discharged: _____

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
2													
3													
4													
5													
6													
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Signature (Required for worker reimbursement) Date

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Jane Smith *00/00/00*

Signature Date

Sample Vocational Rehab Services Bill

Mail completed forms to:
 Department of Labor and Industries
 PO Box 44269
 Olympia WA 98504-4269



STATEMENT FOR MISCELLANEOUS SERVICES

Instructions on next page

Type of Service:

- Dental Service
 Glasses
 Home Health / Nursing Home
 Medical Equipment/ Prosthetics-Orthotics
 Transportation
 Vocational/Retraining
 Other: _____

Worker Information (Please print)

Name (Last, First, Middle Initial) Doe, John A.			Claim No. AA12345
Home address (not PO Box) 123 E. 4th Ave			Date of injury 00/00/00
City Any City	State WA	ZIP 98501	Social Security No. (for ID only) 123-45-6789
Apt #			Phone no. 000-000-0000

Provider Information (Please print)

Provider name Jane Smith VRC (or intern)			L&I provider number/NPI 0123456
Address Location Address			Your Patient Account Number Your reference number
City Any City	State WA	ZIP 98501	Federal Tax ID/Employer ID Number 00000000000
Name of referring physician or other source If available			Phone no. 000-000-0000
Referring provider number/NPI If available		Referral ID	

Billing Information

For glasses, is the old prescription available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this bill to reimburse the injured worker? <input type="checkbox"/> Yes (Receipt and signature required) <input type="checkbox"/> No
For inpatient services: Date admitted: _____ Date discharged: _____	

	From Date of Service	To Date of Service	POS	Proc Code	Mod	Mod	Diagnosis	Describe procedures, medical services or supplies furnished.	Dental tooth #	Home Nursing		Charges	Units
										No. of hrs/day	Hourly/Day rate		
1	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
2	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
3	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
4	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
5	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
6	XX	XX	XX	XXXX			XXX.XX	Description of Service				\$XX.XX	X
7													
8													
9													
10													

Total Charge
\$ **XX.XX**

Worker Signature:

These expenses are related to my workers' compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false.

Provider Signature:

I certify that the information in the bill is true and correct. I have not been reimbursed for any part of this bill.

Signature (Required for worker reimbursement) _____ Date _____

Jane Smith _____ *00/00/00*
 Signature Date