



Washington State Department of
Labor & Industries
Workers' Compensation Services

Home Care

Billing Instructions

STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES

BILLING INSTRUCTIONS

HOME AND RESIDENTIAL CARE

The Washington State Department of Labor and Industries’ State Fund, or the self-insured employer is responsible for the costs of medically necessary services associated with an accepted industrial injury. No co-payments or deductibles are required or allowed from workers or other payers. Home care/home health services require prior authorization, which can be obtained through the injured workers claim manager or the L&I occupational nurse consultants who review the medical necessity. Rules for reimbursement and billing of home nursing and attendant services are explained in the department’s Medical Aid Rules and Fee Schedules. The Washington Administrative Codes ([WACs](#)) relating specifically to home care are:

WAC 296-20-091, WAC 296-23-246, & WAC 296-20-01002

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Where can I find billing forms?

Find bill forms on the L&I Website: www.Lni.wa.gov/ or call Provider Hotline at 800-848-0811.
[Statement for Home Nursing Services \(F248-160-000\)](#)
[Statement for Miscellaneous Services \(F245-072-000\)](#)

HOW TO COMPLETE THE “STATEMENT FOR MISCELLANEOUS SERVICES” and the “STATEMENT FOR HOME NURSING SERVICES” FORMS

FIELD DESCRIPTION / INSTRUCTIONS

- 1 If using the Statement for Miscellaneous Services bill form, check the “Home Health/Nursing Home Services” box located in the upper right corner of the form.
- 2 **WORKER’S NAME in full:** Enter the worker’s last name, first name and middle initial.
- 3 **SOCIAL SECURITY NUMBER:** Enter the worker’s social security number. This information helps identify the proper claim when the claim number has been entered incorrectly or the worker’s name is common.
- 4 **CLAIM NUMBER:** Enter the worker’s claim number. Claim numbers are alpha-numeric, consisting of seven characters. The first letter identifies the funding source:

STATE FUND INDUSTRIAL INSURANCE

- Interactive Voice Response System- 1-800-831-5227
- Provider Hotline- 1-800-848-0811

State Fund claim numbers contain six digits and are preceded by one of the following letters: B, C, F, G, H, J, K, L, M, N, P, X, or Y or double alpha (example AA) followed by 5 digits. Do not fax State Fund bills. Mail State Fund bills to:

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

CRIME VICTIMS COMPENSATION PROGRAM

- Contact - 1-800-762-3716

Crime victim claim numbers are either six digits preceded by a V, or five digits preceded by a VA-VZ. Send all bills for Crime Victims claims to:

Crime Victim Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

SELF-INSURANCE

- Contact self insured employer directly for bill payment/denial questions according to the instructions on your Explanation of Benefits.
- Contact L&I's Self Insurance Section at 360-902-6938 for help with bill processing disputes.

Self-Insurance (SI) claim numbers consist of six digits preceded by an S, T, W, or double alpha (SA-SZ, TA-TZ, WA-WZ) followed by 5 digits. You may use department bill forms, SI forms, or other forms acceptable to SI. Send SI documents directly to the employer's designated address for the mailing of all claims-related correspondence.

Find contact information for self-insured employers and their third party administrators online at www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp.

5 **ADDRESS:** Enter injured worker's current address.

6 **EMPLOYER'S NAME:** Enter the employer at the time of injury. This information helps identify the proper claim if the claim number has been entered incorrectly.

7 **DATE OF INJURY:** Enter the date of injury. A worker may have several claims, so the injury date helps the insurer apply charges to the proper claim.

8 **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter the name of the provider who referred the worker to you.

9 **REFERRING PHYSICIAN PROVIDER NUMBER/NPI:** Enter the referring provider's L&I provider account number and NPI (national provider identifier).

10 **DIAGNOSIS:**
ICD9-CM codes are required. Designate left or right side of body when applicable.
ICD9-CM codes are not required when billing for vocational services, personal transportation, public transportation, ambulance, placement agency, interpreter, miscellaneous non-physician, lodging, vehicle modification and home modification providers.

11 **FOR GLASSES:** Not applicable.

12 **GIVE HOSPITALIZATION DATES:** Not applicable

13 **ITEMIZATION OF SERVICES AND CHARGES:**

A. **DATE(s) OF SERVICE:** Enter in month, day and year format (MM/DD/YY) the date(s) the service was provided or item(s) were furnished.

- **Intermittent dates of service:** Enter one date of service per line.
- **Consecutive dates of service:** Enter the beginning date of service in the "from-date-of-service" box and the ending date in the "to-date-of-service" box.

DO NOT OVERLAP DATES OF SERVICE BETWEEN LINES OR BILLS

- B. **POS -PLACE OF SERVICE:** Enter the 2-digit place of service code. See list of codes on the reverse side of the billing form..
- C. **PROC CODE - PROCEDURE CODE:** Enter the procedure code for the service you have provided. Enter only one code per line. Some home and residential care codes are listed in this manual under Home Health, Residential Care, and Home Infusion headings.
- D. **MOD CODE:** Not applicable.
- E. **DESCRIPTION OF SERVICES:** Briefly describe the item or service (e.g., RN visits)
- F. **DENTAL:** Not applicable.
- G. **HOME NURSING:** Enter your time period and billing rate.

Number of hours/days:

Enter the number of 15-minute units, hours per day, or days per month as appropriate for your provider type.

Hours/visits/daily rate:

Record the rate per 15-minute unit, per hour, or per day for services provided.

- H. **GLASSES:** Not applicable.
- I. **CHARGES:** Enter the total charges for the service on this line.
- J. **UNIT:** Enter total number of hours, days, or 15-minute units as appropriate for your provider type.

14 **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** Enter your name and current address.

If your name, address or business status changes, submit a [Provider Account Change Form](#) (F245-365-000) found online at www.becomeprovider.Lni.wa.gov, or call Provider Accounts at 360-902-5140.

Fax completed Provider Accounts forms to 360-902-4484, or mail to:

Provider Accounts
 Department of Labor and Industries
 PO Box 44261
 Olympia WA 98504-4261

15 **PROVIDER NUMBER:** Enter the L&I provider account number issued to you by the Department of Labor and Industries.

If you do not have an L&I provider account number, complete a [Provider Account Application Form](#) (F245-011-000) found at www.becomeprovider.Lni.wa.gov or call Provider Accounts at 360-902-5140.

- 16 **NPI:** Enter your NPI. You must have an active L&I account number, and you must register your NPI number with the dept.
- 17 **TOTAL CHARGE:** Enter total of all charges listed in the Charges column. The department does not accept “balance forward” or “balance due” billings.
- 18 **YOUR PATIENT’S ACCOUNT NUMBER:** Enter the number you use to identify the injured worker’s account. The State Fund will include the account number on your remittance advice. We can accept up to 12 characters.
- 19 **SIGNATURE/DATE:** Signature may be that of the provider or the person completing the bill form. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. If the bill is prepared by computer, the signature field may be left blank. Enter the date the bill is prepared.
- 20 **REMARKS:** Enter any further information necessary to explain your charges. When using an unlisted code, please describe the item or service in this field, or payment may be denied.
- 21 **FEDERAL TAX I.D. NUMBER:** Enter either your employee identification number (EIN) or your Social Security number (SSN) (use the same number you used to apply for a provider account with the department).

Tips for sending attachments:

- See the department’s [Medical Aid Rules and Fee Schedules](#) for documentation requirements.
- **Write the injured worker’s name and claim number on the upper right corner of every page of attachments.**
- Attach a copy of the doctor’s signed prescription, and for supplies or equipment, include the manufacturer’s itemized cost invoice.

HOME CARE

Home Health Services include attendant care, home health, home care, infusion therapy, and hospice. All of these services require prior authorization.

Attendant care services provide assistance in the home for personal care and activities of daily living. Attendant care services must be provided by an agency that is licensed, certified, or registered to provide home health or home care services. In-home aide, RN, physical therapy, occupational therapy, and speech therapy services provided by a licensed home health agency may be covered when services become proper and necessary to treat a worker's accepted condition.

Please note the correct billing units for your provider type (15 minutes, hours, or days).

Home Care Billing Codes (See L&I's [Medical Aid Rules and Fee Schedules](#) for additional codes)

S9122	Attendant care in the home provided by a home health aide or certified nurse assistant per hour	
S9123	Attendant care in the home provided by a registered nurse per hour	
S9124	Attendant in the home provided by licensed practical nurse per hour	
G0151	Services of physical therapist in the home, 15 min units. Maximum of 4 units per day.	
G0152	Services of occupational therapist in the home, 15 min units. Maximum 4 units per day.	
G0153	Services of speech and language pathologist in the home, 15 min units. Maximum 4 units per day.	
G0154	Services of skilled nurse RN/LPN in the home 15 min unit.	
G0156	Services of home health aide in the home. 15 min unit. Maximum of 96 units per day	
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units.	
Q5001	Hospice care in the home, per day	
8901H	Department approved spouse attendant in the home per hour.	

HOME INFUSION SERVICES

Prior authorization is required for home infusion nurse services, drugs, and any supplies, regardless of who is providing services. Home infusion services can be authorized independently or in conjunction with home health services.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with National Drug Code (NDC) codes or Universal Product Code (UPC) codes if no NDC codes are available. Compound drugs must be billed on the [Statement for Compound Prescription](#) form (F245-010-000).

Only pharmacies and durable medical equipment suppliers, including IV infusion companies, may be paid for infusion therapy supplies. Supplies (including infusion pumps) require authorization, and must be billed with HCPCS codes. See [WAC 296-20-1102](#) for information on the rental or purchase of infusion pumps.

Home Infusion Codes (See L&I's [Medical Aid Rules and Fee Schedules](#) for additional codes)

99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit.
99602	Skilled RN visit for each additional hour per visit.
G0154	Services of skilled nurse RN/LPN in the home, 15 min unit.

RESIDENTIAL CARE FACILITIES

(ADULT FAMILY HOMES, BOARDING HOMES, NURSING HOMES, SKILLED NURSING FACILITIES, TRANSITIONAL CARE UNITS)

Providers treating injured workers under negotiated arrangements made prior to January 1, 2005 may continue their negotiated arrangements until the injured worker's need for those services ends or until the worker is admitted to a new facility. Continue using code 8902H for the remainder of the time the worker is treated.

Providers beginning treatment on or after January 1, 2005 must use the fee schedule or new daily rates appropriate for the type of facility providing treatment, and must meet other requirements outlined in L&I's [Medical Aid Rules and Fee Schedules](#).

For State Fund claims, you must fax RUG assessments to the department's occupational nurse consultant (ONC) to get codes authorized.

For self-insured claims, contact the self-insured employer (SIE), or their third party administrator (TPA) directly. Find contact information for SIE/TPAs online at:
www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

What bill form do I submit for residential care services?

Bill State Fund residential care services on the [Statement for Miscellaneous Services](#) form (F245-072-000).

Residential Care Codes (See L&I's [Medical Aid Rules and Fee Schedules](#) for additional codes)

8880H	Nursing facility rehab - Ultra High (per day)	
8881H	Nursing facility rehab - Very High (per day)	
8882H	Nursing facility rehab - High (per day)	
8883H	Nursing facility rehab - Medium (per day)	
8884H	Nursing facility rehab - Low (per day)	
8885H	Extensive services (per day)	
8886H	Special care - High (per day)	
8887H	Special care - Low (per day)	
8888H	Clinically complex (per day)	
8889H	Behavioral symptoms and cognitive performance (per day)	
8890H	Reduced physical function (per day)	
8893H	L&I RF Low	
8894H	L&I RF Medium	
8895H	L&I RF High	
8902H	Nursing Home or Residential Care (group or boarding home)	



STATEMENT FOR HOME NURSING SERVICES

Dept of Labor and Industries
 Claims Section
 PO Box 44269
 Olympia WA 98504-4269

SAMPLE BILL ONLY

DO NOT WRITE IN SPACE ➤

Worker's full name Last XXXXXXX	First XXXX	Middle X	Social Security Number (for ID only) XXX-XX-XXXX	Claim Number AB00000
Address XXXX XXXXXXXXXXXX XXX			Employer's Name ABC EMPLOYER	
City XXXXXXXXXX	State XX	ZIP XXXXXX	Reimburse Claimant <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Date of Injury XX-XX-XX	Name of referring physician or other source		Referring physician provider number / NPI	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable. 1. XXX.XX 2. 3. 4. 5.	For glasses, advise if old Rx was Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	REFUND CERTIFICATION I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof. CLAIMANT'S SIGNATURE:
	Give hospitalization dates for inpatient Services Admitted ____/____/____ Discharged ____/____/____	

FROM DATE OF SERVICE	*POS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges \$ ¢	Unit	TO DATE OF SERVICE
						No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
07/01/11	XX	S9122		Attendant care by CNA		5	26.01			2731.05	110	07/31/11
<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Example</p> <p>Worked 5 hrs a day Monday – Friday Rate: \$26.01 per hour</p> <p>21 days x 5 hrs = 105 hrs 105 hrs x \$26.01 = \$2731.05</p> </div>												

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid. Signature: VVVVVVVVVVVVVV MM / DD / YY Bill date:	Provider or Supplier name XXXXX XXXXXXXXXXXXX	Provider Number 0000000	NPI 0000000000	Taxonomy XXXXXXXXXXXX
	Address XXXX XXXXXXXXXXXX XX			Total Charge 2731.05
	City XXXXXXXXXXXX	State XX	ZIP + 4 00000-0000	Phone Number XXX-XXX-XXXX
Remarks:	Federal tax ID number XXX-XX-XXXX <input checked="" type="checkbox"/> EIN <input type="checkbox"/> SSN	Your Patient's Account Number		

