



Washington State Department of
Labor & Industries
Workers' Compensation Services

General Provider Billing Manual

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Introduction

Thank you for treating Washington's injured workers. We hope this general billing guide will be helpful to all providers and their billing staff.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Find out what's happening at L&I

Join the L&I listserv for up-to-date information about changes to payment policies and fee schedules. Join at: www.Lni.wa.gov/Main/Listservs/Provider.asp.

Know who you are billing

Two programs cover Washington's industrially injured/ill workers: the Washington State Fund and the Self-Insured Employer Program.

L&I also has a Crime Victims Compensation Program which is a secondary insurance program that provides financial, medical, and mental health benefits to victims of crime.

Medical record copy fees

Photocopy service fees may not be billed for documentation submitted to support billing for services provided.

The insurer will pay according to the fee schedule for copies of medical records requested by the department or self-insurer for information relevant to the adjudication of a specific claim.

The cost of copying medical records must be billed by the provider who performed the service(s). Bills submitted by the service companies will be denied.

Timely billing

Bills must be received within 1 year of the date of service OR 1 year from the date of claim allowance.

State Fund

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 1 letter (A, B, C, E, F, G, H, J, K, L, M, N, P, X, Y, or Z) followed by 6 numbers or 2 letters followed by 5 numbers (for example B123456 or AM95370).

State Fund contact information

Provider Hotline

800-848-0811

Report of Industrial Injury or Occupational Disease

Fax: 800-941-2976

Fax: 360-902-6690

Mail to:

Department of Labor & Industries

PO Box 44299

Olympia WA 98504-4299

Correspondence and reports to:

Fax: 360-902-4567

Bill forms to:

Do not fax bills.

Mail to:

Department Labor & Industries

PO Box 44291

Olympia WA 98504-4291

Mail to:

Department of Labor & Industries

PO Box 44269

Olympia WA 98504-4269

Payment cycle for State Fund bills

Adjudicated bills are processed every other Friday, and payments are mailed the following week.

For billing cutoff dates and warrant payment dates, go to:

www.Lni.wa.gov/ClaimsIns/Providers/Billing/PayStatus/default.asp.

Self-Insured Employer

Self-insured employers (SIE) must authorize medical treatment and pay bills in accordance with Title 51 RCW and the Medical Aid Rules & Fee Schedules of the state of Washington.

Self-insured claim numbers start with either an S, T, or W followed by 6 numbers, or two letters followed by 5 numbers (for example T123456 or SG12345).

Direct self-insurance billing questions to the employer or its third party administrator (TPA). For a list of SIE/TPAs and their contact information, go to:

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

Crime Victims Compensation Program

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

Providers can use the same L&I provider number to bill for State Fund and Crime Victims. New providers can sign up for both programs at the same time using one provider application.

Crime Victims claim numbers begin with V followed by six digits, or double alpha letters (i.e. VA) followed by 5 digits (for example V123456 or VA12345).

Because Crime Victims compensation is a secondary insurance, your billings must include any explanation of benefits (EOBs) from another insurance resource prior to billing.

For dates of service on or after July 1, 2011 for Crime Victims Compensation Program will be 37% of L&I's fees. Prior to July 1, 2011 CVC used the DSHS/MAA payment schedule. The Crime Victims Program is administered under RCW 7.68 and follows the agency Medical Aid Rules and Fee Schedule, in addition there are some specific CVC rules.

The Crime Victims Program laws and rules can be found at

<http://apps.leg.wa.gov/RCW/default.aspx?cite=7.68>

<http://apps.leg.wa.gov/WAC/default.aspx?cite=296-30>

<http://apps.leg.wa.gov/WAC/default.aspx?cite=296-31>

For the Crime Victims Compensation reimbursement rates, go to:

www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources.

Find Crime Victims forms and information online at:

www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/.

or

Contact the Crime Victims Compensation Program at 360-902-5355 or 800-762-3716.

Send bills for Crime Victims claims to:

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

L&I Provider Account Number

To bill, you need an active individual L&I provider number. If you don't have a provider number, complete the appropriate forms from the list below.

<p>Out of state providers: Complete and submit the Non-network Provider Application (F248-011-000)</p>	<p>In state providers:</p> <ul style="list-style-type: none">• Physicians (Some hospital-based physicians don't need to enroll)• Chiropractors• Naturopathic Physicians• Podiatric Physicians & Surgeons• Advanced Registered Nurse Practitioners• Physician Assistants• Dentists• Optometrists <p>Complete and submit the following:</p> <ul style="list-style-type: none">• Washington Provider Application (WPA)• Provider Network Agreement• Statewide Payee Registration and W-9
<p>Interpreters: Complete and submit the Non-network Provider Application (F248-011-000) and the Submission of Provider Credentials for Interpretive Services (F245-055-000)</p>	<p>In state providers: If your provider type is not listed above, complete and submit the Non-network Provider Application (F248-011-000)</p>

If you have questions about becoming a provider or about your account, contact Provider Credentialing at 360-902-5140.

If your address, phone number and/or business status changes, notify us in writing using the [Provider Credentialing Change Form](#) (F245-365-000).

Provider Network

Beginning January 1, 2013, all current and new providers in Washington State of the following types must be in our network to provide care for injured workers beyond the initial office or emergency-room visit:

- Physicians (Some hospital-based physicians don't need to enroll)
- Chiropractors
- Naturopathic Physicians
- Podiatric Physicians & Surgeons
- Advanced Registered Nurse Practitioners
- Physician Assistants
- Dentists
- Optometrists

For more information, visit: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/Network

Electronic billing

State Fund

There are three ways to bill electronically. They are: Direct Entry, uploading billing files using your own software, or using a clearinghouse.

Use the remarks field only to indicate multiple claims, to list multiple modifiers, or to describe unlisted codes or drugs. Any other data will delay the processing of your bill.

Chart notes and reports are submitted separately from bills.

Find additional information about electronic billing online at www.electronicbilling.Lni.wa.gov.

Self-Insured

Check with the individual SIE/TPA.

Crime Victims Compensation Program

You can bill Crime Victims electronically using Direct Entry. For additional information about Direct Entry go to: www.electronicbilling.Lni.wa.gov.

Paper billing

The type of service you provide determines which billing form to use. Fill out of the appropriate form completely. Be sure to include the claim number on all bill forms and correspondence. The following pages list provider types and the associated billing form.

Billing forms

Most billing forms are available for download from the L&I website.

(Click here for [Crime Victims forms](#))

Click on the form name for instructions and sample bill form. Click on the form number to go a fillable form online.

[CMS 1500 \(F245-127-000\)](#)

[Provider's Request for Adjustment \(F245-183-000\)](#)

[Statement for Compound Prescription \(F245-010-000\)](#)

[Statement for Home Nursing Services \(F248-160-000\)](#)

[Statement for Miscellaneous Services \(F245-072-000\)](#)

[Statement for Pharmacy Services \(F245-100-000\)](#)

[Statement for Retraining and Job Modification Services \(F245-030-000\)](#)

[UB04 HCFA 1450 \(F245-367-000\)](#)

CMS 1500

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Click here for the [CMS 1500](#) form.

Used by:

- Ambulatory surgery centers
- Chiropractors
- Hospital ER/professional services
- Laboratories
- Naturopaths
- Osteopathic Physicians
- Panel Examiners
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Radiologists

Hospitals:

Hospitals are responsible for establishing criteria to define inpatient and outpatient services.

However, bills for patients admitted and discharged on the same day may be submitted as outpatient bills and may be paid via POAC rate.

Hospitals are reimbursed only for the technical component for outpatient radiology, pathology, and laboratory service.

Specific individual hospital rates are announced via letter sent to hospital administrators.

For outpatient bills only, the following documents are required:

- Emergency room reports.
- Operative reports.
- Other documents as requested by the insurer.

For State Fund claims, Critical Access Hospitals are paid for swing bed services utilizing a hospital-specific POAC rate.

The following field on the CMS 1500 must be completed for your bill to be processed:

Field number on CMS 1500:	Field title on CMS 1500:	Information L&I needs:
1A	Insured ID Number	Worker's social security number.
2	Patient's Name	Worker's legal name in the last, first, middle initial format.
3	Patient's Birth Date	Worker's date of birth.
5	Patient's Address	Worker's current address.
11	Insured's ID Number	L&I claim(s) number.
14	Date of Injury/Illness	Date of injury.
17	Name of Referring Physician	Referring provider, if applicable.
17A	ID Number of Referring Physician or Other Source	L&I provider number of referring provider if applicable.
17B	National Provider Identifier (NPI)	NPI of referring provider.
21	Diagnosis or Nature of Injury or Illness	Diagnosis code (ICD-9 or ICD-10 code).
23	Prior Authorization Number	L&I prior authorization number
24 A	Date(s) of Service	Date(s) of service.
24B	Place of Service	Enter an L&I place of service. See the L&I place of service list below.
24D	Procedure, Service, or Supply	Procedure performed (ICD code, HCPCS, or Local Code).
24E	Diagnosis Pointer	Diagnosis code (ICD-9 or ICD-10 code).
24F	Charges	Your usual & customary fee.
24G	Days or Units	Total number of units, minutes, or days.
24J	Rendering Provider ID #	L&I provider number or L&I registered NPI.
25	Federal Tax ID Number	Federal Tax ID Number.
26	Patient Account Number	The number you use to identify the patient account.
31	Signature of Physician or Supplier	Signature of rendering provider.
32	Service Facility	Facility where treatment was provided.
33A	NPI	Rendering provider NPI.
33B	Group Provider Number	Rendering provider L&I provider number.

FICA										FICA									
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (RSN or ID) <input type="checkbox"/> FECA BLK (LNU) (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										15. INSURED'S I.D. NUMBER (For Program in Item 1) 123-45-6789									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John J.										3. PATIENT'S BIRTH DATE MM DD YY 07 04 76					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>				
7. INSURED'S ADDRESS (No., Street) 123 Main Street SW										7. INSURED'S ADDRESS (No., Street)									
CITY Anytown					STATE WA					CITY					STATE				
ZIP CODE 12345					TELEPHONE (Include Area Code) (555) 555-5555					ZIP CODE					TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER AB12345									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____ DATE _____										SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 01 01 12										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Smith										16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 354 0										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE									
C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER									
E. DIAGNOSIS POINTER										F. \$ CHARGES									
G. DAYS ON UNITS										H. EPST Family Plan									
I. ID QUAL										J. RENDERING PROVIDER ID. #									
1 01 01 12 11 64721 500 00 1 NPI 99999999999																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER 9-99999999999										26. PATIENT'S ACCOUNT NO. DoeJ010112					27. ACCEPT ASSIGNMENT? For gov. claims, see back. <input type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ 500 00										29. AMOUNT PAID \$					30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION Dr. Smith's Office 456 Main Street SW Anytown WA 12345									
33. BILLING PROVIDER INFO & PH # (555) 555-5555																			
SIGNED _____ DATE _____										SIGNED _____ DATE _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Provider's Request for Adjustment

Click here for the [Provider's Request for Adjustment](#) form.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- All provider types for State Fund claims.

This form should be used for a total overpayment, a partial overpayment, and an underpayment. Don't use this form if your bill denied in full. Please rebill with the corrected information.

For more information about adjustments, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp.

Department bill forms are furnished at no charge to the vendor, and may be obtained at: <http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider+billing&Submit=Search> or by calling the local department office

ADJUSTMENT REQUEST FORM

IF YOUR ORIGINAL BILL WAS DENIED IN FULL, DO NOT USE THIS FORM. PLEASE SUBMIT A NEW BILL. THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ----- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover the money from your future payment(s); OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the Internal Control Number (ICN) overpaid. Submit refunds to:

Cashiers Office
Department of Labor and Industries (L&I)
PO Box 44835
Olympia WA 98504-4835

PARTIAL OVERPAYMENT ----- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information for the procedures/items paid incorrectly.

UNDERPAYMENT ----- A portion of the bill was underpaid. Complete adjustment request form with correct information for the procedures/items paid incorrectly. Corrections or justification and/or reports must be included.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

1. **WORKER'S NAME:** Clearly print injured worker's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **PROVIDER NAME:** Enter the name of the provider who performed these services.
4. **ICN NUMBER:** Enter the 17-digit number found in the ICN column on the remittance advice, to identify the ICN needing correction.
5. **L&I PROVIDER NUMBER / NPI:** Enter the L&I provider account number or NPI.
6. **SERVICE ITEMIZATION:** Enter the line item number(s) that corresponds to the line item number on your original bill. Enter ONLY the information you want to correct, as it should have appeared on your original bill.

Example: 2 units of service billed on line 3 and should have billed 6 units. Enter line item number 3 in column 6 and 6 in column i.

- a. **From/to Date of Service or Covered Dates:** Date of service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
- b. **Place of Service: (POS)** Two digit code identifying the place service was performed.
- c. **Type of Service: (TOS)** One digit code identifying the type of service performed.
- d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
- e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
- f. **ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
- g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
- h. **Charge:** Total of charges for services provided this line.
- i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
- j. **Days Supply:** Total number of days a prescription is intended to cover.
- k. **Description:** Describe procedure or service.

If you have questions completing this form, please call Provider Hotline at 1-800-848-0811.

F245-183-000 backer 4-2010

Statement for Compound Prescriptions

Click here for the [Statement for Compound Prescriptions](#) form.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- Pharmacies.
- Workers.

All compound drug products require prior authorization. Compounded drug products include, but aren't limited to, antibiotics for home intravenous therapy, pain cocktails for opioid weaning, topical preparations containing multiple active ingredients or any non-commercially available preparations.

Pharmacies must submit paper bills for compound drugs after authorization has been obtained. Third party pharmacy billers can't bill for compound drugs.

NO STAPLES IN
BAR CODE AREA

Dept. of Labor and Industries
PO Box 44289
Olympia WA 98504-4289



STATEMENT FOR COMPOUND PRESCRIPTION

Instructions for completing form on the reverse side

DO NOT
WRITE IN
SPACE

Soc. Sec. No. (For ID only) 123-45-6789
Claim No. AB12345

Worker's name (last, first, middle)
Doe, John J.

Pharmacy name & address Anytown Pharmacy 9876 Main Street Anytown WA 12345	L&I provider No. / NPI 0123456 NCPDP NO. 01-98765	Address 1234 Main Street City Anytown State WA ZIP 12345 Bill date 02/01/12 Employer Jones' Business
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Is this a request to reimburse the injured worker? YES NO

Is this a private insurance co-payment? YES NO

We do not reimburse for a private insurance co-payment. Call L&I at 1-800-848-0811 for instructions.

PRESCRIPTION DETAIL

DX Code (ICD-9)	S/B	Date of injury	Date RX written	Prescribing provider's name	Prescribing prov. no. (L&I #, license #, DEA # or NPI)	Drug cost	\$ 1000.00
		01/01/12	01/15/12	Dr. Smith	0123456		
Prescription Number RX101010	Date Rx filled	Refill Number (0-99)	Quantity	Doses: 30	Grams:	Milliliters:	Dispensing fee \$ 15.00
Compound drug code 00990000000	Total No. of ingredients 3	Dispense as written product selection code (DAW) (0, 1 or 6)	Compounding time 60 minutes	Professional fee \$ 15.00			
Prescription filled for:	<input checked="" type="checkbox"/> Antibiotic IV therapy	<input type="checkbox"/> Total parental nutrition	<input type="checkbox"/> Pain cocktail	<input type="checkbox"/> Topical preparation	Prescription total \$ 1030.00		

COMPOUND ITEMIZATION

ATTACH ADDITIONAL ITEMIZATION OF OTHER
INGREDIENTS IF MORE THAN 10 WERE USED

NDC/UPC	Name	Strength	Quantity	(X)	Drug cost/unit	(=)	Drug cost
1. 123456789	Sterile water		1000 ml		250.00	1	\$ 250.00
2. 987654321	Cipro	250	1		750.00	1	\$ 750.00
3.							\$
4.							\$
5.							\$
6.							\$
7.							\$
8.							\$
9.							\$
10.							\$

The injured worker has paid for the above services and prescription(s).

Pharmacist's Signature

Print Name

X

X

When you submit this bill, you are certifying that the prescription information is correct.
L&I must receive this statement within 12 months of the date of service or claim allowance.

F245-010-000 statement for compound prescription 04-2010

Department bill forms are furnished at no charge to the vendor, and may be obtained at: <http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider+billing&Submit=Search> or by calling the local department service location.

Instructions for completing "Statement for Compound Prescription" form

Do not complete this form for reimbursement of a private insurance co-payment. Call L&I at 1-800-848-0811 for instructions

Types of Insurance

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits." Send bills for Industrial Insurance claims to:

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

CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK, VL or VS." Send bills for Crime Victims claims to:

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

SELF-INSURANCE

Claim numbers are six digits beginning with an "S, T, W", or double alpha (SA-SZ, TA-TZ, WA-WZ). Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9." Send bills to the employer or their service company.

Pharmacy address changes

PHARMACY NAME AND ADDRESS:

If any of this information changes, call 1-800-848-0811 immediately.

(Simply indicating a new address on the bill will not change L&I's record of address for the provider.)

For further information, find us at:

www.lni.wa.gov/claimsinsurance/providerpay/billing/provider

Prescription Information

<p>L&I PROVIDER NUMBER / NPI: The specific Provider number or NPI issued to the pharmacy.</p> <p>NCPDP NO: The 7-digit number assigned by National Council for Prescription Drug Programs.</p> <p>REIMBURSE INJURED WORKER: Place "X" in applicable box.</p> <p>S/B (SIDE OF BODY): Designate "L" (left), "R" (right) side of body or "B" (bilateral), to indicate location of injury.</p> <p>DATE OF INJURY: This is important and must be included. One worker may have several claims, so it is vital the proper claim be identified and charged for services provided.</p> <p>PRESCRIBING PROVIDER NUMBER (L&I#, LICENSE#, DEA# OR NPI): Provider number issued to the prescribing physician by L&I, a WA state license #, a DEA# or NPI. (not pharmacy's provider#).</p> <p>DRUG COST: Total charge for the filled prescription.</p> <p>REFILL NUMBER: Enter the refill number (0-99), if prescription is a refill otherwise "0" to identify the original prescription.</p> <p>QUANTITY: The total units of medication prescribed. Use the (NCPDP) billing unit standard format, e.g., "each", "ml" or "gm".</p> <p>DISPENSING FEE: The fee for services provided by the pharmacist.</p>	<p>TOTAL NUMBER OF INGREDIENTS: The number of NDC/UPC ingredients used in the prescription.</p> <p>DISPENSED AS WRITTEN PRODUCT SELECTION CODE: Code indicating whether or not the prescriber's instructions regarding generic substitution were followed. Valid values are: 0 = No product selection mandated; 1 = Substitution not allowed by prescriber; 6 = Override for emergency supply - This value is used only by in-state pharmacies when dispensing an emergency supply of a non-preferred drug prescribed by a non-endorsing practitioner.</p> <p>COMPOUNDING TIME: Time required to combine the ingredients in the prescription.</p> <p>PROFESSIONAL FEE: Fee for compounding time.</p> <p>PRESCRIPTION FILLED FOR: Place an "X" in the applicable box</p> <p>TOTAL PRESCRIPTION COSTS: Total charge for the filled prescription. (Drug cost + professional fee + applicable tax).</p> <p>COMPOUND ITEMIZATION: Detail of the ingredients used in the prescription.</p> <p>REIMBURSE THE INJURED WORKER: Signature of pharmacist who supplied the prescription is required.</p>
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F245-010-000 backer 4-2010

Statement for Home Nursing Services

Click here for the [Statement for Home Nursing Services](#) form.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- Attendant care.
- Home health agency services.
- Home nursing 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.

NO STAPLES IN
BAR CODE AREA



STATEMENT FOR HOME NURSING SERVICES

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

DO NOT
WRITE IN
SPACE

Worker's full name Last Doe	First John	Middle J	SSN (ID only) 123-45-6789	Claim Number AB12345
Address 12345 Main Street			Employer's Name Jones' Business	
City Anytown	State WA	ZIP 98512	Reimburse Claimant <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Date of Injury 01/01/12	Name of referring physician or other source Dr. Smith		Referring physician provider number / NPI 0123456	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable 1. 847.1		For glasses, advise if old Rx was available <input type="checkbox"/> Yes <input checked="" 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 date for inpatient services Admitted		
		Discharged		

FROM DATE OF SERVICE	* POS	PROC CODE	MOD CODE	Describe procedure, 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	NEW RX OD OS			
1 03/01/12		8901H		Attendant care			8			10000.00	30	03/30/12
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												

Submission of this bill certifies the material furnished, service provided, expense 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: _____ Bill date: _____	Provider or Supplier name Nancy Nursing	Provider Number 0123456	NPI	Taxonomy
	Address 9876 Main Street			Total Charge 10,000.00
	City Anytown	State WA	ZIP+4 12345	Phone Number 360-555-5555
	Federal tax ID number 0-111111111	<input checked="" type="checkbox"/> EIN	<input type="checkbox"/> SSN	Your Patient's Account Number
Remarks:				

* Place of Service (POS) codes on back

F248-160-000 statement for home nursing services 04-2010

Department bill forms are furnished at no charge to the vendor, and may be obtained at: <http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider+billing&Submit=Search> or by calling the local department service location.

INSTRUCTIONS FOR COMPLETING HOME NURSING SERVICES STATEMENT

1. **INJURED WORKER'S NAME:** Injured worker's full name, last name first.
2. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the worker's name is common.
3. **CLAIM NUMBER:** For the injured worker receiving services.

Types of Insurance

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits."

Send bills for Industrial Insurance claims to:

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

CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK, VL or VS."

Send bills for Crime Victims claims to:

Department of Labor and Industries
PO Box 44320
Olympia WA 98504-4320

SELF-INSURANCE

Claim numbers are six digits beginning with an "S, T, W", or double alpha (SA-SZ, TA-TZ, WA-WZ).

Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9."

Send bills to the employer or their service company.

4. **ADDRESS:** The injured worker's most current address.
 5. **EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
 6. **REIMBURSE CLAIMANT:** Place an "X" in the applicable box. If payment should be made to the claimant, indicate the amount paid.
 7. **DATE OF INJURY:** This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
 8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services.
 9. **REFERRING PHYSICIAN PROVIDER NUMBER / NPI:** The Department of Labor and Industries provider account number or NPI of the referring physician. The number may be obtained from the referring physician.
 10. **DIAGNOSIS:** Not applicable.
 11. **FOR GLASSES:** Not applicable.
 12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
 13. **REFUND CERTIFICATION FOR CLAIMANT REIMBURSEMENT:** Signature of the claimant who received the care.
 14. **ITEMIZATION OF SERVICES AND CHARGES:**
 - A. **DATE(S) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (i.e., home nursing care, attendant care) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
 - B. **PLACE OF SERVICE:** A complete list of Place of Service (POS) codes are printed below. Place the appropriate code in the space provided.
 - C. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the Medical Aid Rules and Maximum Fee Schedule distributed by the Department of Labor and Industries. Enter the appropriate code and describe the procedure. Enter only one code per line.
 - D. **CODE MODIFIER:** Not applicable.
 - E. **DENTAL:** Not applicable.
 - F. **HOME NURSING:** Number of Hours or Days: Enter number of hours per day or number of days per month.
Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home nursing services provided.
 - G. **GLASSES:** Not applicable.
 - H. **CHARGES:** Total line item charge.
 - I. **UNIT:** The total hours if an hourly rate was entered in the home nursing column (item "F") or total of days if a daily rate was entered in the home nursing column (item "F").
 15. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill will not change the department's record of address for the provider.)
 16. **PROVIDER NUMBER:** Enter the L&I provider account.
 17. **NPI:** Enter the national provider identifier.
 18. **TAXONOMY:** Enter the ten-digit taxonomy code.
 19. **TOTAL CHARGE:** Total of all charges for services provided.
 20. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
 21. **BILL DATE:** The date our billing was prepared.
 22. **TAX IDENTIFICATION NUMBER:** The provider taxpayer identification number for IRS (Internal Revenue Service) reports.
 23. **REMARKS:** Any further information necessary to explain your charge.
- ATTACHMENTS:** Must have the corresponding claim number listed in the upper right corner of the attachment.
DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.
The following attachment is not acceptable: Office Visit Slips.
REBILLS: If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "Rebill" on the bill.
Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS)

03. School	14. Group Home	32. Nursing Facility	56. Psychiatric Residential Trmt Ctr
04. Homeless Shelter	15. Mobile Unit	33. Custodial Care Facility	57. Non-residential Substance Abuse Trmt Center
05. Indian Health Service Free-standing Facility	16. Temporary Lodging	34. Hospice	60. Mass Immunization Ctr
06. Indian Health Service Provider-based Facility	17. Walk-in Retail Health Center	41. Ambulance - Land	61. Comprehensive Inpatient Rehabilitation Facility
07. Tribal 638 Free-Standing Facility	20. Urgent Care Facility	42. Ambulance - Air or Water	62. Comprehensive Outpatient Rehabilitation Facility
08. Tribal 638 Provider-based Facility	21. Inpatient Hospital	49. Independent Clinic	65. End Stage Renal Disease Trmt Facility
09. Correctional Facility	22. Outpatient Hospital	50. Federally Qualified Hlth Ctr	71. State or Local Public Health Clinic
11. Office	23. Emergency Rm - Hospital	51. Inpatient Psychiatric Facility	72. Rural Hlth Clinic
12. Patient's Home	24. Ambulatory Surgical Ctr	52. Psychiatric Facility Partial Hospitalization	
13. Assisted Living Facility	25. Birthing Ctr	53. Community Mental Health Ctr	81. Independent Laboratory
	26. Military Trmt Facility	54. Intermediate Care Facility/Mentally Retarded	99. Other Unlisted Facility
	31. Skilled Nursing Facility	55. Residential Substance Abuse Trmt Center	

F248-160-000 backer 4-2010

Statement for Miscellaneous Services

Click here for the [Statement for Miscellaneous Services](#) form.

For provider specific information, go to www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/ and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- Adult family homes
- Ambulance companies
- ARNPs
- Assisted living facilities
- Audiology
- Boarding homes
- CRNAs
- Dental services
- Dietitians
- Durable medical equipment and supplies
- Home health care
- Interpreters
- Massage therapy
- Nurse case management
- Nursing homes
- Occupational therapist
- Opticians
- Optometrists
- Prescribed drugs that do not have National Drug Codes
- Prosthetics/Orthotics
- Replacement glasses
- RNs
- Transportation such as cabulance or taxi
- Vocational rehabilitation services

Interpreters

Interpreters must hold credentials in good standing from our selected list that can be found in the Billing and Payment Policy at www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/.

Interpreters must submit an Interpretative Service Appointment Record (F245-056-000) and mileage verification.

The combined total of both individual and group services is limited 480 minutes (8 hours) per day per interpreter.

For billing purposes, 1 minute = 1 unit.

Document translation services are paid only when requested by the insurer. Services will be authorized before the request packet is sent to the translator.

DME

DME may require prior authorization from the insurer.

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 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.

Drugs for outpatient use, including infusion therapy drugs, must be billed by pharmacy providers either electronically through the point-of-service system, or on appropriate pharmacy forms with national drug codes (NDC or UPC if no NDC is available):

Statement for Pharmacy Services
Statement for compound Prescription or
Statement for Miscellaneous Services

Note: Total parenteral and enteral nutrition products may be billed by home health providers using the appropriate HCPCS codes.



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

STATEMENT FOR MISCELLANEOUS SERVICES

- Dental Services
- Medical Equipment/Prosthetics-Orthotics
- Transportation
- Home Health/Nursing Home Services
- Glasses
- Vocational / Retraining
- Other

DO NOT WRITE IN SPACE >

Worker's full name Last Doe		First John	Middle J	SSN (ID only) 123-45-6789	Claim Number AB12345
Mailing address 123 Main Street SW				Employer's Name ABC Employer	
City Anytown		State WA	ZIP 12345	Reimburse injured worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Date of Injury 01/01/12		Name of referring physician or other source Dr. Smith		Referring physician provider number / NPI 0123456	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Distinguish left or right when applicable 1. 847.1 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 date for inpatient services	
	Admitted _____	
	Discharged _____	

FROM DATE OF SERVICE	* POS	PROC CODE	MOD CODE	Describe procedure, medical services or supplies furnished. Attach lab reports, X-ray findings and any special services	Dental tooth #	Home Nursing		GLASSES		CHARGES \$	Unit	T O DATE OF SERVICE
						No. of holiday	Hourly/Day rate	OLD RX CD	NEW RX OS			
1.	02/01/12	11	9989M	Individual interpretation						56.00	30	02/01/12
2.	02/01/12	11	9986M	Mileage						40.00	80	02/01/12
3.	02/01/12	11	9989M	Individual interpretation - 2nd office visit						56.00	30	02/01/12
4.	02/01/12	11	9986M	Mileage						38.00	16	02/01/12
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
13.												

Submission of this bill certifies the material furnished, service provided, expense 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: _____ Bill date: _____ Remarks: _____	Provider or Supplier name Language Interpretations		Provider number 0123456	NPI 9999999999	Taxonomy	
	Address 456 Main Street NW					
	City Anytown		State WA	ZIP+4 12345+6789	Total Charge 190.00	
	Federal tax ID 9-999999999999		<input checked="" type="checkbox"/> EIN	<input type="checkbox"/> SSN	Phone Number 360-555-5555	
						Your Patient's Account Number

* Place of Service (POS) codes on page 2

F245-072-000 statement for misc services 04-2010

Department bill forms are furnished at no charge to the vendor, and may be obtained at:

<http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider-billing&Submit=Search> or by calling the local department office

INSTRUCTIONS FOR COMPLETING MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
 2. **CLAIM NUMBER:** For the injured worker receiving services.
INDUSTRIAL INSURANCE State Fund Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits". Send bills for Industrial Insurance claims to: Department of Labor and Industries, PO Box 44269, Olympia WA 98504-4269
CRIME VICTIM claim numbers are six digits preceded by a "V" or five digits preceded by a "VA, VB, VC, VH, VJ, VK or VL". Send bills for Crime Victim claims to: Department of Labor and Industries, PO Box 44520 Olympia WA 98504-4520
SELF INSURANCE Claim numbers are six digits preceded by an "S, T or W". Send bills to the employer or their service company.
Department of Energy claims are seven digits beginning with "7, 8 or 9".
 3. **INJURED WORKER'S NAME:** Injured worker's full name, last name first.
 4. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the worker's name is common.
 5. **ADDRESS:** The injured worker's most current address.
 6. **EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
 7. **DATE OF INJURY:** This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
 8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
 9. **REFERRING PHYSICIAN PROVIDER NUMBER / NPI:** The Department of Labor and Industries provider account number or NPI of the referring physician. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
 10. **DIAGNOSIS:** Indicate both the ICD9-CM number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services, personal transportation, etc. See Miscellaneous Billing Instructions F248-095-000 for entire list.)
 11. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
 12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
 13. **ITEMIZATION OF SERVICES AND CHARGES:**
 - A. **DATE(S) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
 - B. **PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
 - C. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the Medical Aid Rules and Maximum Fee Schedule distributed by the Department of Labor and Industries.
 - D. **CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
 - E. **DESCRIPTION OF PROCEDURE:** Enter description of the procedure being performed.
 - F. **DENTAL:** To be used for dental services only. **Tooth Number:** Identify dental services provided by placing the specific tooth number in the appropriate box.
 - G. **HOME NURSING:** To be used for home care only. **Number of Hours or Days:** Identify the number of hours or the number of days that the home care services were provided. **Hourly or Daily Rate:** Record the rate charged (by the hour or day) for the home care services provided.
 - H. **GLASSES:** To be used for glasses repair or replacement only. **Old Rx (OD and OS):** If the old prescription is available, specify for both the left and right eyes. **New Rx (OD and OS):** Specify the new prescription for both the left and right eyes.
 - I. **CHARGES:** Charges for services provided.
 - J. **UNIT:** The sum total services provided for days, units, or miles, etc.
 14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts Immediately. (Indicating a new address on the bill will not change the department's record of address for the provider.)
 15. **PROVIDER NUMBER:** Enter the L&I provider account number.
 16. **NPI:** Enter the national provider identifier.
 17. **TAXONOMY:** Enter the ten-digit taxonomy code.
 18. **TOTAL CHARGE:** Total of all charges for services provided.
 19. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
 20. **REFERRAL ID:** Enter the referral ID.
 21. **REMARKS:** Any information necessary that the provider or supplier feels is necessary for further explanation.
- ATTACHMENTS:** The following attachments must be submitted with billings for appropriate services:
1. X-ray findings
 2. Lab reports
 3. Office Notes
 4. Operative reports
 5. Emergency Room reports
 6. Diagnostic Study reports
 7. Cost invoice of supplies furnished
 8. Consultation reports
- Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.
- DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.** The following attachment is not acceptable: Office Visit Slips
- REBILLS:** If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "Rebill" on the bill. Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS)

03. School	14. Group Home	32. Nursing Facility	56. Psychiatric Residential Trmt Ctr
04. Homeless Shelter	15. Mobile Unit	33. Custodial Care Facility	57. Non-residential Substance Abuse Trmt Center
05. Indian Health Service Free-standing Facility	16. Temporary Lodging	34. Hospice	60. Mass Immunization Ctr
06. Indian Health Service Provider-based Facility	17. Walk-in Retail Health Center	41. Ambulance - Land	61. Comprehensive Inpatient Rehabilitation Facility
07. Tribal 638 Free-Standing Facility	20. Urgent Care Facility	42. Ambulance - Air or Water	62. Comprehensive Outpatient Rehabilitation Facility
08. Tribal 638 Provider-based Facility	21. Inpatient Hospital	49. Independent Clinic	65. End Stage Renal Disease Trmt Facility
09. Correctional Facility	22. Outpatient Hospital	50. Federally Qualified Hlth Ctr	71. State or Local Public Health Clinic
11. Office	23. Emergency Rm - Hospital	51. Inpatient Psychiatric Facility	72. Rural Hlth Clinic
12. Patient's Home	24. Ambulatory Surgical Ctr	52. Psychiatric Facility Partial Hospitalization	
13. Assisted Living Facility	25. Birthing Ctr	53. Community Mental Health Ctr	81. Independent Laboratory
	26. Military Trmt Facility	54. Intermediate Care Facility/Mentally Retarded	99. Other Unlisted Facility
	31. Skilled Nursing Facility	55. Residential Substance Abuse Trmt Center	

F245-072-000 backer 04-2010

Statement for Pharmacy Services

Click here for the [Statement for Pharmacy Services](#) form.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- Pharmacies.
- Workers.

Pharmacies or workers can be reimbursed for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance. Payment is made per L&I's fee schedule.

Pharmacies:

When pharmacies bill L&I and the prescription meets criteria for guaranteed payment, the Point of Sale (POS) system will send reject code 52 or 67 with the following information:

- Maximum allowable amount: \$XX.XX
- Prescription qualifies for first fill; submit prior authorization number 464884254557 after verifying claim number from report of accident of claim ID card.
- Use prior authorization qualifier code 08.

Workers:

For reimbursement workers must submit the following:

- Receipts for their prescriptions.
- A pharmacist signature

Please note: Private insurance copayments aren't eligible for reimbursement because L&I is solely responsible for all related medical costs for an accepted claim. In both scenarios below, the pharmacy must reimburse the worker in full when:

- The worker has already paid a copayment amount,
- The worker has already been reimbursed by L&I.

If workers have questions about the pharmacy reimbursement process, please call the Preferred Drug Line for help at 888-443-6798.

NO STAPLES IN
BAR CODE AREA

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

STATEMENT FOR PHARMACY SERVICES

DO NOT
WRITE IN
SPACE

Instructions for completing form on the reverse side.

Pharmacy name & address Anytown Pharmacy 9876 Main Street Anytown WA 12345		L&I Provider no. / NPI 0123456 NCPDP No 01-98765	Worker's soc. sec. no. (for i.d. only) 123-45-6789	Claim no. AB12345
Worker's name (last, first, middle) print or type Doe, John J.			Worker's mailing address	
City 12345 Main Street		State WA	ZIP 12345	
Pharmacy billing date 02/01/12	Employer Jones' Business			

Is this a request to reimburse the injured worker? YES NO
Is this a private insurance co-payment? YES NO

We do not reimburse for a private insurance co-payment. Call L&I at 1-800-848-0811 for instructions.

Prescription (RX) Information Print Or Type All Information

DX Code (ICD-9)	S/B	Date of injury	Date Rx written	Prescribing Provider's name		Prescribing Provider Number (L&I#, License#, DEA# or NPI)
		01/01/12	01/15/12	Dr. Smith		0123456
Prescription #	Date Rx filled	Refill Number (0 - 99)	Days Supply	Quantity (units)	Dispensed as written product selection code (DAW) (0, 1 or 6)	
RX101010	01/15/12	1	10	5	0	
National Drug Code	Drug name		DUR codes			
00113060462	IBUPROFEN		CNFLT: INTRV: OUTCM:			
Remarks	Prescription clarification code				Total prescription cost	\$ 5.25
	(Refill-too-soon)					

DX Code (ICD-9)	S/B	Date of injury	Date Rx written	Prescribing Provider's name		Prescribing Provider Number (L&I#, License#, DEA# or NPI)
Prescription #	Date Rx filled	Refill Number (0 - 99)	Days Supply	Quantity (units)	Dispensed as written product selection code (DAW) (0, 1 or 6)	
National Drug Code	Drug name		DUR codes			
			CNFLT: INTRV: OUTCM:			
Remarks	Prescription clarification code				Total prescription cost	\$
	(Refill-too-soon)					

DX Code (ICD-9)	S/B	Date of injury	Date Rx written	Prescribing Provider's name		Prescribing Provider Number (L&I#, License#, DEA# or NPI)
Prescription #	Date Rx filled	Refill Number (0 - 99)	Days Supply	Quantity (units)	Dispensed as written product selection code (DAW) (0, 1 or 6)	
National Drug Code	Drug name		DUR codes			
			CNFLT: INTRV: OUTCM:			
Remarks	Prescription clarification code				Total prescription cost	\$
	(Refill-too-soon)					

Reimburse the injured worker: Pharmacist's signature is required.

The injured worker has paid for the above services and prescription(s).

Pharmacist's Signature

Print Name

X

X

When you submit this bill, you are certifying that the prescription information is correct.

L&I must receive this statement within 12 months of the date of service or claim allowance.



Department bill forms are furnished at no charge to the vendor, and may be obtained at: <http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider+billing&Submit=Search> or by calling the local department service location.

Instructions for completing "Statement for Pharmacy Services" form

Do not complete this form for reimbursement of a private insurance co-payment. Call L&I at 1-800-848-0811 for instructions

Types of Insurance

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits." Send bills for Industrial Insurance claims to:

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

CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK, VL or VS." Send bills for Crime Victims claims to:

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

SELF-INSURANCE

Claim numbers are six digits beginning with an "S, T, W", or double alpha (SA-SZ, TA-TZ, WA-WZ). Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9." Send bills to the employer or their service company.

Pharmacy address changes

PHARMACY NAME AND ADDRESS:

If any of this information changes, call 1-800-848-0811 immediately. (Simply indicating a new address on the bill will not change L&I's record of address for the provider.)

For further information, find us at:
www.lni.wa.gov/claims/insurance/providerpay/billing/provider

Prescription Information

<p>L&I PROVIDER NUMBER / NPI: The specific Provider number / NPI issued to the pharmacy.</p>	<p>DISPENSED AS WRITTEN PRODUCT SELECTION CODE: Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.</p>
<p>NCPDP NO: The 7-digit number assigned by National Council for Prescription Drug Programs.</p>	<p>Valid values are: 0 = No product selection mandated; 1 = Substitution not allowed by prescriber; 6 = Override for emergency supply - This value is used only by in-state pharmacies when dispensing an emergency supply of a non-preferred drug prescribed by a non-endorsing practitioner.</p>
<p>REIMBURSE INJURED WORKER: Place "X" in applicable box.</p>	<p>NATIONAL DRUG CODE: National drug identification code. This code must be entered in a 5-4-2 format: e.g., if the NDC format listed in your pricing book is 0005-3250-23, enter 00005 3250 23. If the NDC format is 50419 127 12 enter 50419 0127 12</p>
<p>S/B (SIDE OF BODY): Designate "L" (left), "R" (right) side of body or "B" (bilateral), to indicate location of injury.</p>	<p>DUR CODES: Enter the appropriate conflict, intervention and outcome code.</p>
<p>DATE OF INJURY: This is important and must be included. One worker may have several claims, so it is vital the proper claim be identified and charged for services provided.</p>	<p>PRESCRIPTION CLARIFICATION CODE: Enter the appropriate value for a refill-too-soon.</p>
<p>PRESCRIBING PROVIDER NUMBER (L&I#, LICENSE#, DEA# OR NPI): Provider number issued to the prescribing physician by L&I, a WA state license#, a DEA# or NPI. (not pharmacy's provider#).</p>	<p>TOTAL PRESCRIPTION COSTS: Total charge for the filled prescription. (Drug cost + professional fee + applicable tax).</p>
<p>REFILL NUMBER: Enter the refill number (0-99), if prescription is a refill otherwise "0" to identify the original prescription.</p>	<p>REIMBURSE THE INJURED WORKER: Signature of pharmacist who supplied the prescription is required.</p>
<p>DAYS SUPPLY: Using quantity dispensed and directions for use (sig) on the prescription, calculate the number of days supply. If the directions say as needed or have a dose range, estimate days supply using the maximum dosage per day.</p>	
<p>QUANTITY: The total units of medication prescribed. Use the (NCPDP) billing unit standard format, e.g., "each", "ml" or "gm".</p>	

F245-100-000 backer 4-2010

Statement for Retraining and Job Modification Services

Click here for the [Statement for Retraining and Job Modification Services](#) form.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- Vocational counselors.
- Pre-job accommodations.
- Job modifications.
- Retraining expenses.
- Workers.

Job Modifications and Pre-job Accommodation Assistance

A completed [Job Modification Assistance application](#) and [Pre-job Accommodation Assistance application](#) must accompany billings for job and pre-job modifications. For billing questions or assistance in completing the [Statement for Retraining and Job Modification Services](#) form please call 800-848-0811 or 360-902-6500.



STATEMENT FOR RETRAINING AND JOB MODIFICATION SERVICES

DO NOT
 WRITE IN
 SPACE

Instructions for completing form on
 the reverse side

Worker's Name LAST FIRST MI Doe John J			Claim No. AB12345
Worker's home address (not PO Box) 13245 Main Street			Date of injury 01/01/12
City State ZIP + 4 Anytown WA 12345			Social Security No. (for ID only) 123-45-6789
Please indicate Vocational Rehabilitation Counselors name and telephone number Merry Jobs/555 Main Street/Anytown WA 12345 360-555-5555			Reimburse Injured Worker? If yes, receipt required <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
VRC ID 0123456		REFERRAL ID 9999	REFUND CERTIFICATION These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form.
			INJURED WORKER'S SIGNATURE: X

Itemization of Service and Charges

FROM DATE OF SERVICE	P O S	T O S	PROCEDURE CODE	DESCRIBE SERVICES, OR SUPPLIES FURNISHED	CHARGES \$	UNIT	TO DATE OF SERVICE
1. 04/01/12			R0301	Tuition	1500.00	1	04/30/12
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

Submission of this bill certifies the material furnished, service provided, expense 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.

PROVIDER SIGNATURE:

Bill date:

X

L&I must receive this statement within 12 months of the date of service or claim allowance

Provider name Education R Us	Provider number 0123456	Total Charge 1500.00
Address 999 South Main Street		Phone Number 360-555-5555
City State ZIP+4 Anytown WA 12345	Your Client's Account Number	
Federal tax ID Number 9-99999999	<input checked="" type="checkbox"/> EDN	<input type="checkbox"/> SSN

* Place of Service (POS), Type of Service (TOS) and Procedure codes on back

Department bill forms are furnished at no charge to the vendor, and may be obtained at: <http://www.lni.wa.gov/FormPub/results.asp?Keyword=provider+billing&Submit=Search> or by calling the local department service location.

INSTRUCTIONS FOR COMPLETING RETRAINING AND JOB MODIFICATION SERVICES FORM (Retraining & Job mods only)
IMPORTANT: Retraining mileage must be billed on a Travel Expense Voucher form for injured worker reimbursement. Please call the provider hotline at 1-800-848-0811 for the correct reimbursement form, F245-145-000.

CLAIM NUMBER: For the injured worker receiving services.

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits."
Send bills for Industrial Insurance claims to:

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

CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK, VL or VS."
Send bills for Crime Victims claims to:

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

SELF-INSURANCE

Claim numbers are six digits beginning with an "S, T, W", or double alpha (SA-SZ, TA-TZ, WA-WZ). Department of Energy claims are now Self-Insured. Claim numbers are seven digits beginning with "7, 8 or 9." Send bills to the employer or their service company.

INJURED WORKER'S NAME: Injured worker's full name, last name first.

DATE OF INJURY: This is important and must be included. One worker may have several claims, so it is vital the proper claim be identified and charged for services provided.

HOME ADDRESS: The injured worker's most current address (not PO Box).

SOCIAL SECURITY NUMBER: Record injured worker's social security number. It is helpful when the claim number is wrong and the worker's name is common.

REIMBURSE INJURED WORKER: Place an "X" in applicable box.

VRC ID: L&I provider ID of Vocational Rehabilitation Counselor.

REFERRAL ID: VRC's L&I referral number.

WORKER'S SIGNATURE: Worker's signature is required for claimant reimbursements. Forms not signed will be returned.

VOCATIONAL REHAB COUNSELOR'S NAME AND TELEPHONE NUMBER

ITEMIZATION OF SERVICES AND CHARGES: Receipts required for worker reimbursement.

FROM DATE(S) OF SERVICE: Record the date for each service provided (Note: for food only, a separate line is required for each receipt date).

PLACE OF SERVICE (POS): Put code 99 in this box.

TYPE OF SERVICE (TOS): Put type of service code "V" in this box.

PROCEDURE CODE: Please refer to the list of procedure codes below. Choose a code that best describes your service and enter it in the box.

DESCRIBE SERVICES OR SUPPLIES FURNISHED: Description of service(s) provided.

CHARGES: Charges for service provided. Itemized, dated & business stamped **RECEIPTS REQUIRED FOR WORKER**

REIMBURSEMENT. For food receipts, items purchased must have a description. (Please send receipt copies. Keep your original).

UNIT: Number of days/units for the service billed on each line.

TO DATE(S) OF SERVICE: Record the date for each service provided. (Note: for food only, a separate line is required for each receipt date).

PROVIDER SIGNATURE: Signature required for any provider billings. Forms not signed will be returned.

PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER: If any of this information changes, call 1-800-848-0811 immediately. (Simply indicating a new address on the bill will not change L&I's record of address for the provider.) For further information, find us at: www.lni.wa.gov/claimsinsurance/providerpay/billing/provider

PROVIDER NUMBER: Identification number designated by the Department of Labor and Industries for the provider.

TOTAL CHARGE: Total of all charges for services provided.

YOUR CLIENT'S ACCOUNT NUMBER: The number used for providers to identify their client's account.

FEDERAL TAX ID. NUMBER: The provider taxpayer identification number for IRS (Internal Revenue Service) reports.

CODES

<u>JOB MODIFICATION PROCEDURES CODES:</u>	<u>RETRAINING PROCEDURE CODES:</u>	<u>RETRAINING TRANSPORTATION CODES:</u>
0380R Job Modification	R0310 Tuition, Training Fees	0302R Parking
0385R Pre-Job Accommodation	R0312 Supplies	0303R Bridge and Ferry Tolls
Equipment	R0315 Equipment, Tools	0304R Commercial Transportation
	R0320 Exam, License Fee	
	R0340 Books	
	R0350 Other	
	R0390 Child Care Services	
	<u>LODGING & RELOCATION:</u>	
	R0360 Board (Food) and Utilities	
	R0370 Rent	
	0375R One-Time Relocation Fee (for life-time of claim)	

F245-030-000 backer 8-2010

Hospital Services – Inpatient and Outpatient: UB-04 HCFA 1450 & CMS 1500

Click here for the [UB-04 1450](#) form.

Click here for the [CMS 1500](#) form.

For provider specific information, go to www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched and select the appropriate year, select the Billing & Payment Policies tab, and select your provider type.

Used by:

- Hospitals (in- or outpatient services).

For inpatient bills, the following documents are required:

- Admission history or physical examination.
- Discharge summary for stays over 48 hours.
- Emergency room reports.
- Operative reports.
- Anesthesia records.
- Other documents as required by the department or self-insurer.

For inpatient bills, the following documents are required:

- Admission history or physical examination.
- Discharge summary for stays over 48 hours.
- Emergency room reports.
- Operative reports.
- Anesthesia records.
- Other documents as required by the department or self-insurer.

Professional services for hospitals

Hospitals are responsible for establishing criteria to define inpatient and outpatient services.

However, bills for patients admitted and discharged on the same day may be submitted as outpatient bills and may be paid via POAC rate.

Hospitals are reimbursed only for the technical component for outpatient radiology, pathology, and laboratory service.

Specific individual hospital rates are announced via letter sent to hospital administrators.

For outpatient bills only, the following documents are required:

- Emergency room reports.
- Operative reports.
- Other documents as requested by the department or self-insurer.

For State Fund claims, Critical Access Hospitals are paid for swing bed services utilizing a hospital-specific POAC rate.

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

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. Walk-in retail health center	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	

Reports and documentation

The department or self-insurer requires different kinds of information at various stages of a claim in order to approve treatment, time loss compensation, and treatment bills. The department or self-insurer may request reports at specified points in the claim. The information provided in these reports is needed to adequately manage industrial insurance claims. Failure to provide complete reports can significantly delay bill payment and delivery of benefits to your patient.

Report type	Due
Initial report of injury	Within 5 days of first visit
Office/chart/progress reports	Every 30 - 60 days
Supplemental/special reports	Upon request
Activity Prescription Form	Upon request
Consultation reports	Within 15 days of the consultation
IME reports	Within 14 days of the IME or receipt of special test or study results
Extended service reports	When service is billed

Put the worker's name and claim number on all pages of your reports.

How should providers document services?

Providers must maintain documentation in the worker's medical or healthcare service records to verify the level, type, and extent of services provided. Documentation must include the amount of time spent for each time-type based service performed when:

- Procedures have a time component in their descriptions, and
- Time is a determining factor in choosing the appropriate code.

For charting progress and ongoing care, use the standard **SOAP** (subjective, objective, assessment, plan and progress) format.

In workers' compensation, there is a unique need for work status information. To meet this need, L&I requires that you add **ER** to the SOAP contents.

Chart notes must document:

E Employment issues

- Has the worker been released or returned to work?
- When is release anticipated?
- Is the patient currently working, and if so, at what job?
- Include a record of the patient's physical and medical ability to work.
- Include information regarding any rehabilitation that the worker may need to undergo.

R Restrictions to recovery

- Describe the physical limitations (temporary and permanent) that prevent return-to-work.
- What other limitations, including unrelated conditions, are preventing return-to-work?
- Are any unrelated condition(s) impeding recovery?

- Can the worker perform modified work or different duties while recovering including transitional, part-time, or graduated hours?
- Is there a need for return-to-work assistance?

"SOAP-ER" charting format

Office/chart/progress notes and 60-day narrative reports should include the SOAP contents:

S Worker's Subjective complaints

What the worker states, or what the employer, coworker or significant other (family, friend) reports about the illness or injury.

O Objective findings

What is directly observed and noticeable by the medical provider? This includes factual information. For example: physical exam – skin is red and edematous; lab tests – positive for opiates; X-rays – no fracture.

A Assessment

Conclusions the medical provider makes after evaluating all the subjective and objective information. Conclusions may appear as:

- A definite diagnosis
- A "rule/out" diagnosis, or
- Simply as an impression.

The assessment also can include the etiology (ET), defined as the origin of the diagnosis; and/or prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P Plan and Progress

What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment, and the plan must state how long the treatment will be administered.

Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to claimants.

Add **ER** to the SOAP contents to document work status information.

You may avoid unnecessary requests for claim information from vocational counselors and others by providing the information above in every chart note. If there has been no change in employment or restrictions since your patient's last visit, state this in your chart notes, since this information may be critical for the vocational counselor to proceed with the vocational assessment and plan.

For more information, go to: www.Lni.wa.gov/ClaimsIns/Providers/Claims/DocReport/default.asp

The 60-day report

If you are treating a worker for an extended period, you must mail or fax a report to the insurer every 60 days. Legible, comprehensive chart notes may be submitted in lieu of 60-day narrative reports PROVIDED the chart notes include all the information required. Be sure to identify the report as the "sixty-day report". In addition to the SOAP-ER information above, it should contain the following information:

1. The condition(s) diagnosed with ICD-9-CM codes.
2. The condition's relationship to the industrial injury/illness, if any.
3. The probability, if any, of permanent partial disability (PPD).
4. *If you feel the patient isn't able to return to work, please explain why he or she is still disabled.*

Activity Prescription Form

This form is used by health-care providers to communicate a worker's status, physical capacities, verification of inability to work (time-loss) and treatment plans. Attorneys and State Fund employers may not print or order these forms nor ask doctors to complete them. For more information about the form go to: www.ActivityRX.Lni.wa.gov

Worker's failure to attend scheduled appointment

Workers are expected to attend scheduled appointments.

L&I or self-insurers won't pay for a missed appointment unless the examination was arranged by L&I or the self-insurer.

For appointments not scheduled by L&I or the self-insurer, you may bill the worker for a missed appointment when:

- You have a missed appointment policy that applies to all patients, *and*
- You routinely notify all patients of your missed appointment policy.

The department or self-insurer isn't responsible for implementing or enforcing a provider's missed appointment policy. Providers are to notify the claim manager immediately when a worker fails to show for an appointment.

When a claim has been accepted by the department or self-insurer, no provider may bill the worker for the difference between the allowable fee and the usual and customary charge. Except for missed appointment fees, the worker can't be charged a fee or interest for the completion of forms related to services for the industrial injury or condition.

Split bills

If the worker is treated for two separate conditions at the same visit, the charge for the service must be divided equally between the payers.

If evaluation and treatment of the two injuries increases the complexity of the visit:

- A higher level E/M code might be billed, *and*
- If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed.

Separate chart notes and reports must be submitted when there are two different claims.

Note: The claims may be from injuries sustained while working for two different employers and the employers only have the right to information about injuries they are responsible for.

For non-vocational services providers, list all workers' compensation claims treated when submitting paper bills to L&I or in the remarks field on an electronic bills. Charge your usual and customary fee for each service. L&I will divide charges equally to the claims.

For vocational services providers, submit separate bills for claim number to which services were rendered. The units of service and provider fees must be apportioned between the claim numbers.

For more information about split billing, refer to the Medical Rules and Fee Schedules.

State Fund & Crime Victims Remittance Advices

L&I provides a detailed report of all billing activity in two-week intervals. In addition to the paper remittance advice, providers can choose to receive their statements electronically or through their authorized clearinghouses. Through Provider Express Billing (PEB) providers and clearinghouses can retrieve electronic remittance advices. For more information about how to obtain remittance advices electronically go to: www.electronicbilling.lni.wa.gov.

You may also review the explanation associated with your processed bill. The 3 digits explanation of benefits (EOB) on your remittance advice explains how L&I processed your bill and how to make corrections. To see what your EOB means use the EOB lookup utility at:

Lni.wa.gov/ClaimsIns/Providers/Billing/EOB/default.asp.

STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO BOX 44263
OLYMPIA, WA 98504-4263

* *
* A WARRANT IS INCLUDED IN THIS ENVELOPE. *
* *

BLMC8200-R001
REPORT DATE: XX/XX/XXXX
PAGE 1
REMITTANCE ADVICE: 000000
PAYEE NAME: XXXXXXXXXXXXXXXXX
PAYEE NUMBER: 0000000
WARRANT REGISTER: 00000
WARRANT DATE: XX/XX/XXXX

**- NEWSLETTER UPDATE –
ELECTRONIC PDF VERSION OF PROVIDER’S REMITTANCE ADVICE.**

BEGINNING MARCH 15, 2010 THE DEPARTMENT WILL MAKE AVAILABLE A COPY OF YOUR PAPER REMITTANCE ADVICE (RA) FOR DOWNLOAD AS A PDF FILE. THE PDF VERSION OF THE REMITTANCE ADVICE WILL BE AV AVAILABLE FOR 90 DAYS AFTER ITS CREATION DATE. AFTER 90 DAYS, THE PDF VERSION WILL BE ARCHIVED BUT MAY BE RESTORED FOR DOWNLOAD BY CONTACTING THE DEPARTMENT’S ELECTRONIC BILLING UNIT (EBU).

THE PDF VERSION OF THE REMITTANCE ADVICE IS AN EXACT COPY OF THE PAPER RA IN AN ELECTRONIC FORMAT AND IS IN ADDITION TO THE EDI 835 RA AND PROPRIETARY RA FILES AVAILABLE TO PROVIDERS ON REQUEST.

ALL ELECTRONIC VERSIONS OF THE REMITTANCE ADVICE CAN BE ACCESSED USING THE DEPARTMENT’S PROVIDER EXPRESS BILLING (PEB) WEBSITE.

IF YOU ARE NOT A CURRENT USER OF PEB, YOU WILL NEED TO REGISTER WITH PEB TO HAVE ACCESS TO THE PDF VERSION OF THE REMITTANCE ADVICE. TO REGISTER, DO THE FOLLOWING:

GO TO SECUREACCESS WASHINGTON (SAW) [HTTP://SECUREACCESS.WA.GOV/](http://SECUREACCESS.WA.GOV/) AND REGISTER BY CREATING AN ACCOUNT. ONCE REGISTERED WITH SAW, LOGIN TO YOUR SAW ACCOUNT AND DO THE FOLLOWING: ADD SERVICES. SELECT AGENCY-DEPT OF LABOR AND INDUSTRIES. SELECT APPLY FOR PROVIDER EXPRESS BILLING. SELECT I AM A FIRST TIME VISITOR AND CONTINUE. ENTER YOUR CONTACT INFO AND CONTINUE. READ/ACCEPT ACCESS AGREEMENT AND CONTINUE. SELECT RELATIONSHIP OF PEB PROVIDER. ENTER YOUR PROVIDER ACCOUNT NUMBER FOR REQUEST ACCESS BY PROVIDER ID. READ/ACCEPT ACCESS MANAGER ROLE FOR YOUR ORGANIZATION. AN ACCESS ACTIVATION CODE WILL BE GENERATED. CONTACT THE EBU AT 360-902-6511 OR EBULIN@LNI.WA.GOV FOR YOUR ACTIVATION CODE OR IF YOU NEED ASSISTANCE.

THE PROVIDER’S ADDRESS
INFORMATION WILL GO
IN THIS AREA OF THE COVER PAGE.

REPORT DATE: XX/XX/XXXX
PAGE 2

REMITTANCE ADVICE: 000000
PAYEE NAME: XXXXXXXXXXXXXXXXX
PAYEE NUMBER: 0000000
WARRANT REGISTER: 00000
WARRANT DATE: XX/XX/XXXX

******* REMITTANCE ADVICE LEGAL NOTICE *******

INITIAL PAYMENTS OR ADJUSTMENTS RESULTING IN INCREASED PAYMENTS MADE ON THIS REMITTANCE ADVICE WILL BECOME FINAL SIXTY (60) DAYS AFTER RECEIPT UNLESS:

1) A WRITTEN REQUEST FOR RECONSIDERATION IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 3) AN APPEAL IS FILED WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA, WITHIN THAT TIME.

ADJUSTMENTS MADE TO PREVIOUS PAYMENTS ON THIS REMITTANCE ADVICE RESULTING IN DECREASED PAYMENTS WILL BECOME FINAL TWENTY (20) DAYS AFTER RECEIPT UNLESS:

1) A WRITTEN REQUEST FOR RECONSIDERATION IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 3) AN APPEAL IS FILED WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA, WITHIN THAT TIME.

ADJUSTMENT AND/OR RECONSIDERATION REQUESTS MUST BE SENT TO THE DEPARTMENT OF LABOR AND INDUSTRIES, PO BOX 44291, OLYMPIA, WA 98504-4291

APPEALS MUST BE SENT TO THE BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, OLYMPIA, WA 98504-2401 OR SUBMITTED ON AN ELECTRONIC FORM FOUND AT [HTTP://WWW.BIIA.WA.GOV/](http://www.bii.wa.gov/).

1: FOR INFORMATION ON BILLS IN PROCESS: CALL 1-800-831-5227 2: FOR INFORMATION ON FINALIZED BILLS: CALL 1-800-848-0811

CLAIM NUMBER	NAME	SERVICE I	DATES FROM TO	UNIT OF SERVICE	P REV I	PROC DRG	M1 M2 M3 M4	APC NDC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES
SERVICE PROVIDER NAME		XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX											
SERVICE PROVIDER NUMBER		XXXXXXX	NPI		XXXXXXXXXX								
BILLS IN PROCESS - INPATIENT BILL													
AA11111	XXXXXXXXXX	X	000000 000000			D 000/00			0000.00	0.00	0.00	0.00	
PAT ACCT/ RX NUM/ TEST SR		2500-209898	I CN-	9999999999999999	***BILL TOTAL . . .				0000.00	0.00	0.00	0.00	559
AA11111	XXXXXXXXXX	X	000000 000000			D 000/00			00000.00	0.00	0.00	0.00	
PAT ACCT/ RX NUM/ TEST SR		2500-209898	I CN-	9999999999999999	***BILL TOTAL . . .				00000.00	0.00	0.00	0.00	559
BILLS PENDING TOTALS - INPATIENT BILL				*NUMBER OF BILLS-		2	00000.00	0.00	0.00	0.00	0.00		
DENIED BILLS - OUTPATIENT BILLS													
AA11111	XXXXXXXXXX	X	000000 000000	1		D 000 11111			000.00	0.00	0.00	0.00	
PAT ACCT/ RX NUM/ TEST SR		2500-209898	I CN-	9999999999999999	***BILL TOTAL . . .				000.00	0.00	0.00	0.00	280
DENIED BILL TOTALS - OUTPATIENT BILL				*NUMBER OF BILLS-		1	000.00	0.00	0.00	0.00	0.00		
BILLS IN PROCESS - OUTPATIENT BILL													
AA11111	XXXXXXXXXX	X	000000 000000	1		D 000 11111			000.00	0.00	0.00	0.00	
PAT ACCT/ RX NUM/ TEST SR		2500-209898	I CN-	9999999999999999	***BILL TOTAL . . .				000.00	0.00	0.00	0.00	H16
AA11111	XXXXXXXXXX	X	000000 000000	20		0000 11111			000.00	0.00	0.00	0.00	
PAT ACCT/ RX NUM/ TEST SR		2500-209898	I CN-	9999999999999999	***BILL TOTAL . . .			00617	000.00	0.00	0.00	0.00	
BILLS PENDING TOTALS - OUTPATIENT BILL				*NUMBER OF BILLS-		2	00000.00	0.00	0.00	0.00	0.00	0.00	
**TOTAL FOR SERVICE PROVIDER NUMBER		XXXXXXX	NPI		XXXXXXXXXX	XXXXXXXX. XX	XXXXXX. XX	XXXXXX. XX	XXXXXX. XX	XXXXXX. XX			
SERVICE PROVIDER NAME		XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX											
SERVICE PROVIDER NUMBER		XXXXXXX	NPI		XXXXXXXXXX								

PAYMENTS AND PAYMENT DENIALS RECEIVED HERE BECOME FINAL IN SIXTY DAYS, OR , PROVIDER REPAYMENTS ORDERED HERE BECOME FINAL IN TWENTY DAYS, UNLESS: (1) YOU FILE A WRITTEN REQUEST FOR RECONSIDERATION WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR (2) YOU FILE AN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA WITHIN THAT TIME.



Washington State Department of
Labor & Industries

1: FOR INFORMATION ON BILLS IN PROCESS: CALL 1-800-831-5227 2: FOR INFORMATION ON FINALIZED BILLS: CALL 1-800-848-0811

CLAIM NUMBER	NAME	SERVICE FROM	DATES TO	UNIT OF SERVICE	P REV I	PROC DRG/	M1 MDC	M2 NDC	M3	M4	APC	BILLED CHARGES	TAX OR ALLOWED	NON-COVID CHARGES	PAYABLE	EOB CODES	
BILLS SUMMARY FOR ALL SERVICE PROVIDERS																	
** PAID BILL TOTALS -	XXXXXXXXXXXX											333	55555.00	55555.00	0.00	55555.00	
** DENIED BILL TOTALS -	OUTPATIENT BILL											333	55555.00	0.00	0.00	0.00	
** BILLS PENDING TOTALS -	INPATIENT BILL											333	55555.00	0.00	0.00	0.00	
** RETURNED BILL TOTALS -	XXXXXXXXXXXX											333	55555.00	0.00	0.00	0.00	
** BILLS PENDING TOTALS -	OUTPATIENT BILL											333	55555.00	0.00	0.00	0.00	
															*** TOTAL WARRANT AMOUNT ***	55555.00	
*** BILLS PAID MTD		000	*** AMOUNT PAID MTD		00,000.00	*** BILLS PAID YTD		000	** AMOUNT PAID YTD		00,000.00						
*** BILLS DENIED MTD		00	*** BILLS DENIED YTD		00												

*****THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE: *****

- 280 DENIED. CLAIM ID BILLED IS NOT ACTIVE. CALL 1-800-831-5227 TO CONFIRM THE ID BEFORE REBILLING.
- 559 ACTIONS IS BEING TAKEN. DO NOT SEND REBILL, ADJUSTMENT OR APPEAL UNTIL YOU RECEIVE NOTICE OF PAYMENT DECISION. AFTER 60 DAYS CALL L&I 800-848-0811.
- H16 SUSPENDED. CLAIM NUMBER IS MISSING OR INVALID ON BILL. CALL 1-800-831-5227 TO CONFIRM CLAIM NUMBER BEFORE REBILLING.

PAYMENTS AND PAYMENT DENIALS RECEIVED HERE BECOME FINAL IN SIXTY DAYS, OR , PROVIDER REPAYMENTS ORDERED HERE BECOME FINAL IN TWENTY DAYS, UNLESS: (1) YOU FILE A WRITTEN REQUEST FOR RECONSIDERATION WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR (2) YOU FILE AN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA WITHIN THAT TIME.

****SEE PAGE 2 FOR MORE DETAILS****

Request review of L&I policies regarding code edits

Important: Providers who have concerns about individual bills or a claim decision need to follow the process outlined in [File a Protest](#).

Providers can request that L&I review its policies by submitting their concerns in writing provided:

- a) The policy is related to professional services (as such it applies to all organizations that bill for professional services), and
- b) There is a conflict between a provider's Coding Policy and L&I's policy and both policies are based on a nationally recognized industry standard source such as the American Medical Association (AMA), CPT coding guidelines and conventions, local and regional Medicare policies, nationally recognized bundling edits, including CMS's National Correct Coding Initiative (NCCI), or nationally recognized physician academy and society guidelines. The conflict may result from a difference in the two nationally recognized sources or a difference in interpretation of the same nationally recognized source.

Specific examples of policy questions include but may not be limited to the following:

- Bundled services
- Pre- and post-operative visits in the global period
- Incidental and mutually exclusive
- Modifier validity
- Assistant surgeon necessity

This doesn't apply to medical policies or benefit determinations. Specific examples include but may not be limited to the following.

- Eligibility, coverage, and benefits limitations
- Medical necessity policy
- No pre-certification
- Fee schedule or reimbursement allowances
- Waiting periods
- Coordination of benefits for workers compensation
- Situations where a governing WAC is in place
 - Per Washington Administrative Code [296-20-010](#), L&I's payment policy supersedes HCPCS Level I and II codes
- State or federal requirements
- Non-FDA approved (experimental/investigational service)
- Contractual issues, e.g. patient cost share, referrals

Providers requesting that L&I review its policies need to follow the process below.

Provider will:

1. Submit their concerns in writing to L&I

Address: Health Services Analysis
Program Manager for Healthcare
Policy and Payment Methods
PO Box 44322
Olympia, WA 98504

The provider's requests should include the following information:

- a) Description of the issue that gives L&I a clear picture of the provider's concerns.
 - b) Explanation of why the provider doesn't agree with L&I's current policy or interpretation, include the supporting alternative policy information and the source where it can be found.
 - c) Person's name/number as the point of contact within the provider's organization.
 - d) As appropriate:
 - Relevant codes or code combination examples.
 - Specifics about associated bills that have been denied, e.g. EOB(s).
 - Note: since the request is related to policy review, L&I doesn't need/require bill specific information. Since this is considered patient confidential information, they shouldn't be submitted on an unsecured web site or unencrypted email.
2. Respond, within 15 calendar days, to requests from L&I for additional supporting documentation.

L&I will review the request to ensure that it falls within scope of this Best Practice Recommendation and that all necessary information is provided. If L&I requests additional supporting materials, provider organizations should submit them within 15 calendar days. The review can't be considered without this information.
 3. Provide significantly different information when submitting subsequent requests for review of the same policy.

Once a request for review of a specific policy has been submitted and a decision has been made by L&I, additional requests related to that same policy will no longer be processed by L&I unless supporting documentation is submitted that provides significantly different information than was submitted with the initial request.

L&I will:

1. Respond within 60 calendar days upon the receipt of the provider's request, unless additional supporting documentation is required from the provider organization.
2. The request will be carried out with a spirit of collaboration with the provider.
3. The outcome will be formally communicated to the organization requesting the review.

Contacts

Cashier's office

Cashier's Office
PO Box 44835
Olympia WA 98504-4835

Crime Victims Compensation Program

800-762-3716

Electronic Billing Unit

360-902-6511

Federal claims

206-398-8100

Call for questions about claims with the US Department of Labor.

Interactive Voice Response

800-831-5227

Call for claim numbers, status information, diagnosis codes, procedure codes, drug restrictions, injured workers, provider information, and employer information.

L&I EOB Lookup Tool

www.Lni.wa.gov/ClaimsIns/Providers/Billing/EOB/default.asp

L&I Medical Aid Rules and Fee Schedule (MARFS)

Select the appropriate year. Select the appropriate tab for either the Fee Schedules or the Billing and Payment Policies.

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/

L&I Quick Fee Lookup Tool

The tool is below year selection for MARFS. Enter the billing code ID and select the appropriate year.

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/

L&I Warehouse

You can request copies of the L&I Provider Toolkit which includes the Medical Aid Rules and Fee Schedules (MARFS) and all billing forms from the warehouse.

Fax: 360-902-4525

Email: whsemail@Lni.wa.gov

NPI

Register for your NPI at:

nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

Office of Information and Assistance

Call for worker questions about their claim.

800-LISTENS (547-8367)

Preferred Drug List

Call for authorization for prescription medication for a non-preferred drug and to verify diagnosis.

Become a Preferred Drug List endorser. Register online at www.rx.wa.gov/tip.html.

888-443-6798

Provider Credentialing

360-902-5140

Fax: 360-902-4484

Provider Hotline

Call for billing or remittance advice problems, authorizations other than inpatient, to verify diagnosis or procedure codes.

800-848-0811

Self-Insurance Section

360-902-6901

Third Party

360-902-5100

Utilization review (Qualis)

800-541-2894

Fax: 877-665-0383

For more information, visit our website: www.Lni.wa.gov