Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 30: Vocational Services

Effective July 1, 2022

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

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Definitions

The following terms are utilized in this chapter and are defined as follows:

Note: The term “provider” in the following definitions includes vocational rehabilitation counselors.

By Report (BR): A code listed in the fee schedule as BR doesn’t have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

Link: For the legal definition of By Report, see WAC 296-20-01002.

Distant site: The location of the provider who performs telehealth services. This provider is not at the originating site with the worker.

Originating site: The place where the worker is located when receiving telehealth. For the purposes of this policy, the worker may be at home when receiving telehealth.

Telehealth: Face-to-face services delivered by a qualified provider through a real-time, two-way, audio video connection. These services aren’t appropriate without a video connection.

Payment policy: Billing by referral type

Prior authorization

All vocational services require prior authorization.

Vocational services are authorized by referral type. The State Fund uses six referral types:

- Vocational recovery,
- Assessment,
- Plan development,
- Plan implementation,
- Forensic, *and*
- Stand-alone job analysis.

Each referral is a separate authorization for services.

Option 2 vocational counseling and job placement services are authorized when the department accepts a worker's Option 2 election. For more information on Option 2 services, see Option 2 Vocational Services.

How insurers will pay

Insurers will pay:

- Interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate, *and*
- Forensic evaluators at 120% of the VRC professional rate.

All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. For more information, see the payment policy for Fee caps later in this chapter.

Link: For more detailed information on billing, consult the Statement for Miscellaneous Services (F245-072-000).

Services that can be billed

The following several tables show billing codes by referral type.

Vocational recovery

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0800V	Vocational recovery services (VRC)	**$10.19**
0801V	Vocational recovery services (intern)	**$8.69**
0802V	Vocational recovery services extension (VRC)	**$10.19**
0803V	Vocational recovery services extension (intern)	**$8.69**

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0810V	Assessment services (VRC)	**$10.19**
0811V	Assessment services (Intern)	**$8.69**

Vocational evaluation, pre-job and job modification consultation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0821V	Vocational evaluation (VRC)	**$10.19**
0823V	Pre-job or job modification consultation (VRC)	**$10.19**
0824V	Pre-job or job modification consultation (Intern)	**$8.69**

Plan development

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0830V	Plan development services (VRC)	**$10.19**
0831V	Plan development services (Intern)	**$8.69**

Plan implementation

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0840V	Plan implementation services (VRC)	**$10.19**
0841V	Plan implementation services (Intern)	**$8.69**

Forensic services

The VRC assigned to a forensic referral must directly perform **all the services** needed to resolve the vocational issues and make a supportable recommendation.

Exception: Vocational evaluation services may be billed by a third party if authorized by the insurer.

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0881V	Forensic services (Forensic VRC)	**$12.19**

Stand-alone job analysis

The codes in the following table are used for **stand-alone and provisional job analyses**. (Also see Payment limits, below.)

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
0808V	Stand-alone job analysis (VRC)	**$10.19**
0809V	Stand-alone job analysis (intern)	**$8.69**
0378R	Stand-alone job analysis (non-VRC)	**$10.09**

Payment limits

Stand-alone job analysis

For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager.

Bills for dates of service beyond the 15th day won't be paid.

Travel, wait time, and mileage

L&I supports in-person meetings to encourage effective engagement, collaborative problem solving, and delivery of quality vocational services.

The vocational provider may bill, round trip, from their primary branch office to their destination for that referral. The primary branch office is designated by the vocational provider on their Vocational Provider and Firm Application (F252-088-000),

When submitting bills, the vocational provider should:

- Round to the nearest number if necessary.
- Bill all services for the same worker, for the same date of service, on one bill form.

For example:

VRC travels from primary branch office to attending provider's (AP) office to meet with the worker and the AP. VRC will bill the round trip time and miles from their primary branch office to the AP's office.

Splitting travel when there is more than one claim

If traveling for more than one claim (per worker or for multiple workers), the vocational provider can bill a round trip from their primary branch to include their destinations for the multiple referrals. For out of state cases, VRC may only bill from the branch office nearest the worker.

- Split charges equally between all claims, rounding to the nearest number if necessary.
- For two claims, bill half to each claim.
- For three or more claims split the charges accordingly (three claims = by thirds, four claims = by fourths)

For example:

VRC travels from their primary branch office to a meeting with worker on Referral A, then to onsite job analysis meeting on Referral B, then to a meeting at AP's office on Referral C, and then back to their primary branch office. VRC will bill a third of the total time and mileage under each referral.

Code	Description	Maximum fee
0891V	Travel/wait time (VRC or forensic VRC) 1 unit = 6 minutes	**$5.11** per 6 minutes
0892V	Travel/wait time (intern) 1 unit = 6 minutes	**$5.11** per 6 minutes
0893V	Professional mileage (VRC) 1 unit = 1 mile	**State rate**
0894V	Professional mileage (intern) 1 unit = 1 mile	**State rate**
0895V	Air travel (VRC, Intern, or forensic VRC)	**By Report**
0896V	Ferry charges (VRC, intern or forensic VRC)	**By Report**
0897V	Hotel charges (VRC, intern or forensic VRC) out-of-state only	**By Report**

Vocational evaluation and related codes for non-vocational providers

Certain non-vocational providers may deliver the above services with the following codes:

Code	Description	Maximum fee
0389R	Pre-job or job modification consultation, 1 unit = 6 minutes	**$12.28** per 6 minutes
0390R	Vocational evaluation, 1 unit = 6 minutes	**$10.09** per 6 minutes
0391R	Travel/wait (non-VRC), 1 unit = 6 minutes	**$5.56** per 6 minutes
0392R	Mileage (non-VRC), one unit = 1 mile	**State rate**
0393R	Ferry charges (non-VRC) Requires documentation with a receipt in case file	**State rate**

When a worker has two or more open claims requiring time-loss compensation and vocational services, the insurer may make a separate but concurrent vocational referral for each claim. In such cases, vocational evaluators are expected to split the billing equally amongst the referrals. When providing vocational evaluation on multiple referrals and/or claims, follow these instructions:

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims.
- If there are three (or more) claims, the vocational evaluation bills are to be split accordingly (three claims = by thirds, four claims = by fourths), based on the number of concurrent referrals received.

Payment policy: Fee caps for vocational services

Fee cap policy for referrals

Vocational services are subject to fee caps. Travel, wait time, and mileage charges aren't included in the fee cap for any referral type.

If the **description** of the fee cap referral is…	Then the **applicable codes** are:	And the **maximum fee** is:
Vocational recovery referral cap, per referral	**0800V**, **0801V**	**$7,168.90**
Assessment referral cap, per referral	**0810V**, **0811V**	**$7,168.90**
Plan development referral cap, per referral	**0830V**, **0831V**	**$6,854.57**
Plan implementation referral cap, per referral	**0840V**, **0841V**	**$7,771.08**
Stand-alone job analysis referral cap, per referral	**0808V**, **0809V**, **0378R**	**$522.78**

Fee cap policy for vocational evaluation services

The fee cap for vocational evaluation services applies to multiple referral types and is allowed once per claim.

For example, if **$698.00** of vocational evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment under another referral type.

If the **description** of the service is…	Then the **applicable codes** are:	And the **maximum fee** per claim is:
Vocational evaluation services	**0821V**, **0390R**	**$1,499.96**

Fee cap exceptions for vocational recovery, AWA, and plan implementation referrals

Exception codes must be used to authorize an extra number of billable hours.

Any use of these exception codes requires prior authorization by the vocational services specialist (VSS) for State Fund claims, or for self-insured claims, by the self-insured employer or its third-party administrator (if applicable).

Vocational recovery referrals

For vocational recovery referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$999.23.**

Code	Description	Maximum fee
0802V	Vocational recovery services exception (VRC)	**$10.19** per 6 minutes
0803V	Vocational recovery services exception (intern)	**$8.69** per 6 minutes

AWA referrals

For AWA referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$999.23**.

Code	Description	Maximum fee
0812V	Assessment services exception (VRC)	**$10.19** per 6 minutes
0813V	Assessment services exception (intern)	**$8.69** per 6 minutes

Plan implementation referrals

For plan implementation referrals, there are exception codes for VRCs and for interns, with an additional fee cap of **$2,309.49**.

Code	Description	Maximum fee
0842V	Plan implementation services exception (VRC)	**$10.19** per 6 minutes
0843V	Plan implementation services exception (intern)	**$8.69** per 6 minutes

Fee cap considerations

When nearing the fee cap, the vocational provider may request a fee cap exception. Once approved, they may bill the exception code(s) up to the additional cap.

The vocational provider may request a new referral when they are nearing the fee cap exception.

L&I may close the original referral using the outcome code ADMX and create a new referral. This decision will be made on a case-by-case basis. If a new referral isn't created, the vocational provider must submit a closing report.

- Providers won't be able to enter a fee cap reached closure outcome with their closing report. Only L&I can enter this closure code.

If both the original fee cap and the fee cap exception are spent, and a new referral isn't granted, the vocational provider must notify the VSS or the self-insured employer or its third-party administrator (if applicable) of the situation. The vocational provider must submit a closing report.

Flat rate policy for 30-day progress reports

There is a **$50** flat rate for each 30-day progress report. Progress report fees do not count toward professional hour fee caps.

Code	Description	Flat rate
0910V	30-day progress report (VRC)	**$50.00** per 30-day progress report
0910V	30-day progress report (intern)	**$50.00** per 30-day progress report

How to submit bills

You can only bill one progress report per referral every 30 days.

To bill for more than one progress report for the same referral on the same invoice, use separate line items of one unit and $50 each for each date of service. If you bill for more than one report on the same line, all but one will be denied.

If the worker has multiple claims with open referrals, you should bill the progress report under the most recent claim. If time-loss is only involved in one claim, progress reports should be billed under that claim.

Link: For more information, see WAC 296-19A.

Payment policy: Job Modification and Pre-Job Accommodation

Prior authorization

Prior authorization is required for services provided by an occupational therapist (OT), physical therapist (PT) and ergonomic specialist.

- The need for a job modification or pre-job accommodation must be identified and documented by L&I, the attending health-care provider, treating occupational or physical therapist, employer, worker, or assigned vocational rehabilitation counselor.
- Consultations for a specific job modification or pre-job accommodation must be preauthorized after the need has been identified.

Who must perform these services to qualify for payment

Consultations

The provider of a job modification or pre-job accommodation consultation must be a:

- Licensed occupational therapist or physical therapist, *or*
- Vocational rehabilitation provider, vocational rehabilitation provider intern, *or*
- Ergonomic specialist.

Telehealth

When the consultant is unable to go onto the worksite, **telehealth** may be used as an alternative method to complete the consultation. Qualified PT or OT providers may have to be licensed in the state where the worker is receiving **telehealth** services, per that state's licensing requirements.

Services that can be billed

In some cases, the department may reimburse for consultation services.

Code	Description	Activities	Maximum fee
0823V	**Pre-job or job modification consultation** Vocational Rehabilitation Provider	Discussing/consulting about modifications to a job. This may include: • Exploring ways a job may be modified within the individual's abilities and the needs of the employer. This may include modifying time, duties, environment, and/or use of alternative equipment. • Discussing available L&I benefits to include stay at work, preferred worker, and job modification with the employer, worker, and/or attending provider. • Communication with others about modifying a job to include the worker, employer, health-care providers, vocational provider, insurer, and/or vendor. • Documenting findings and recommendations, • Instruction in work practices (such as body mechanics, ergonomic principles), • Obtaining bids, • Completing and submitting the Job Modification/Pre-job Assistance Application and any associated follow up, and • Assisting an employer with accessing return to work incentives.	**$10.19** per 6 minutes

Code	Description	Activities	Maximum fee
0824V	**Pre-job or job modification consultation** Vocational Rehabilitation Provider Intern	Same as above	**$8.69** per 6 minutes
0389R	**Pre-job or job modification consultation, analysis of physical demands** OT, PT, Ergonomic Specialist	Same as above Analyzing job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only).	**$12.28** per 6 minutes
0391R	**Travel/wait time** (non-VRC)	Traveling to work/training site or to an equipment vendor to meet with the worker as part of direct consultation services.	**$5.56** per 6 minutes
0392R	**Mileage** (non-VRC), per mile.	Mileage to work/training site or to an equipment vendor to meet with the worker as part of direct consultation services.	**State rate**
0393R	**Ferry charges** (non-VRC).	Ferry travel if required to travel to work/training site as part of direct consultation services.	**State rate**

Authorized equipment vendors

The following codes can be billed by equipment vendors:

Code	Description	Activities	Maximum fee
0380R	**Job modification**	Equipment/tools: • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work area modification or reconfiguration.	Maximum allowable for **0380R** is **$5,000.00** per job or job site.
0385R	**Pre-job accommodation**	Equipment/tools: • Installation, • Set up, • Basic training in use, • Delivery (includes mileage), • Tax, • Custom modification/ fabrication. Work/training area modification or reconfiguration.	Maximum allowable for **0385R** is **$5,000.00** per claim. Combined costs of **0380R** and **0385R** for the same return to work goal can't exceed **$5,000.00.**

Obtaining equipment from consultants

Consultants may supply the equipment/tools only if:

- Custom design and fabrication of unique equipment or tool modification is required, *and*
- Prior authorization is obtained, *and*
- Proper justification and cost estimates are provided.

Services that aren't covered

- Performing services as described in WAC 296-19A-340.
- Services prior to any communication with those directly involved in claim.

Payment limits

The combined costs of both codes **0380R** and **0385R** for same return to work goal can't exceed **$5,000.00**.

For self-insured claims, pre-job accommodations can't be approved. However, self-insured employers may pay any pre-job accommodation expenses for injured workers who no longer work for them.

Links: Additional information regarding Job Modifications and Pre-Job Accommodations is available online.

Payment policy: Option 2 vocational services

The insurer may pay for authorized Option 2 vocational counseling and/or job placement services if the worker's training plan was approved on or after July 31, 2015.

Option 2 vocational counseling services include, but aren't limited to:

- Help in accessing available community services to assist the worker with reentering the workforce
- Assistance in developing a training plan
- Coaching and guidance as requested by the worker
- Interests and skills assessment, if the worker requests or agrees such is needed to reach the worker's training or employment goals
- Other services directly related to vocational counseling, such as job readiness and interview practice

Option 2 job placement services may include, but aren't limited to:

- Help in developing an action plan for return to work
- Job development, including contacting potential employers on the worker's behalf
- Job search assistance
- Job application assistance
- Help in obtaining employment as a preferred worker, if certified, up to and including educating the employer on preferred worker incentives
- Other services directly related to job placement, such as targeted resume development and referral to community resources such as WorkSource

Link: More information on Option 2 vocational services is available online.

Limits

Interns can't provide Option 2 vocational services

Option 2 vocational services must be provided within five years following the date of the department's order confirming the worker's Option 2 election

Total of all payments for all Option 2 vocational services for a worker won't exceed 10 percent of the worker's maximum Option 2 training fund, nor will the total exceed the remaining balance of the worker's Option 2 training fund at the time payment is made

Option 2 travel and wait time aren't payable; other services that aren't payable are listed in WAC 296-19A-340.

Reports

To receive payment for Option 2 vocational services, the VRC must provide the insurer with a copy of a summary of services, signed by the worker and VRC, with each billing. State Fund claims require form F280-063-000 and self-insured claims require form F280-064-000.

Billing

The VRC can't bill the worker directly for Option 2 vocational services.

For self-insured claims, contact the self-insured employer or its third-party administrator for billing instructions.

For State Fund billing, use referral number **9999999** and the billing codes below:

Code	Description (1 unit = 6 minutes for all codes)	Max fee per unit
R0399	Option 2 vocational counseling (VRC)	**$10.19**
R0398	Option 2 job placement services (VRC)	**$10.19**

Note: The VRC can't bill the insurer for completing the Option 2 vocational services summary form.

Payment policy: Quality Assurance

General information

Quality assurance activities: For the State Fund, vocational firms must perform quality assurance (QA) activities to comply with WAC 296-19A-210.

Services that can be billed

Payment is allowed for QA activities regarding claims listed on the department-provided, randomized list of claims. QA activities include, but aren't limited to:

- Following the department's validation guidance and reporting requirements while completing department-provided validation template(s).
- Discussing validation results with the vocational rehabilitation counselor assigned to the claim to reinforce quality work and to support continued improvement.

Limits

A vocational firm's everyday business operations are not considered quality assurance activities. The activities outlined in WAC 296-19A-340 are considered overhead and the department won't pay for these services.

Aggregate data collection and reporting are not payable. For the purposes of this policy, data in this context refers to numbers. Specific examples include QA elements published by the department such as the number of:

- Open vocational recovery referrals.
- Engagement activities for a worker.
- Meetings with identified claim parties.

Payment policy: Special services, non-vocational providers

Prior authorization

Code **0388R** (for special services provided during AWA, plan development, and plan implementation) requires prior authorization.

For State Fund claims, VRCs must contact the VSS or claim manager (CM) to arrange for prior authorization. For self-insured claims, contact the self-insured employer or its third-party administrator (if applicable) for prior authorization.

Link: A list of SIE/TPAs is available online.

Who must perform these services to qualify for payment

A non-vocational provider can use the R codes. A vocational provider delivering services for a referral assigned to a different payee provider may also use the R codes.

Services that can be billed

L&I established procedure local billing code **0388R** to be used for special services provided during AWA, plan development and plan implementation, such as:

- Commercial driver's license (CDL),
- Pre-employment physical examinations,
- Background checks,
- Driving abstracts,
- Fingerprinting,
- College placement testing and enrollment fees.

Code **0388R** has a description of "Plan, providers," and pays **By Report**.

Requirements for billing

Code **0388R** must be billed by a medical or a miscellaneous non-physician provider on a **Statement for Miscellaneous Services** billing form (F245-072-000). The referral ID and referring vocational provider account number must be included on the bill.

As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you):

- You can't bill as a vocational provider (provider type **68**), *and*
    - You must either use another provider account number that is authorized to bill the ancillary services codes (type **34**, **52**, or **55**), *or*
    - Obtain a miscellaneous services provider account number (type **97**) and bill the appropriate codes for those services.

These providers use the **Statement for Miscellaneous Services** billing form but must include the following specific information to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, *and*
- The service provider ID for the assigned vocational provider in the Name of physician or other referring source box at the top of the form, *and*
- The non-vocational provider's own provider account numbers at the bottom of the form.

Payment limits

Code **0388R** can't be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

For code **0388R**, there is a limit of 1 unit per day, per claim.

Payment policy: Additional requirements for all vocational services providers

Inappropriate referral: ADMA billing

Vocational providers may use ADMA outcome *VRC or firm declines referral* for up to 14 days after the referral assignment. This outcome is to be used when the referral isn't appropriate. Examples include:

- Conflict of interest, or
- Concerns about capacity.

Prior to entering an ADMA outcome, the VRC or firm needs to contact the claim manager to discuss the reasons for declining the referral.

A maximum of three professional hours may be billed for reviewing the file and preparing a brief rationale. The VRC sends the rationale using an EVOC message.

Preferred worker certification for workers who choose Option 2

Vocational providers must consider assisting a worker in obtaining preferred worker certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining preferred worker certification for up to 14 days after an Option 2 selection has been made.

Insurer Activity Prescription Form (APF), 1073M

For State Fund claims, healthcare providers won't be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

Employers can obtain physical capacity information by:

- Using completed APFs available on the department's Claim and Account Center, *or*
- Requesting an APF through the claim manager when updated physical capacity information is needed.

Other VRC requests to attending providers for return to work information

Attending providers may respond to requests regarding return to work issues. Examples include:

- Return to work decisions based on a functional capacity evaluation (FCE),
- Request for worker to participate in FCE,
- Job modification or pre-job modification reviews,
- Proposed work hardening program,
- Plan for graduated, transitional, return to work.

Resume Services (State Fund claims only)

A resume isn't only an important job-seeking tool; it's also an opportunity to engage the worker in thinking about return to work. L&I encourages vocational providers to develop a resume with workers who are in an open vocational referral, within the following parameters:

- Participation of the worker is voluntary.
- The VRC assigned to the referral meets in-person with the worker to develop the resume. If that isn't possible, the assigned VRC may provide resume services telephonically, by **telehealth**, or by email. The VRC:
    - Ensures the resume accurately reflects the workers work experience and education and includes volunteer experience, other relevant information, and/or hobbies, if applicable.
    - Gives the worker copies of the resume in format(s) that meet the worker's needs such as paper and/or digital copies.
    - Coordinates a referral to L&I WorkSource partnership staff and encourages the worker to take the resume to WorkSource and register for assistance in finding a job. The VRC may accompany the worker to WorkSource if the worker prefers.
    - Sends the resume to the claim file with the Resume Cover Sheet (F242-418-000) and documents the resume service activities in the next vocational report.
- A cover letter may be developed as part of these services.
- The service is available once per referral.
- For each referral, L&I pays a maximum of **$330.88** for VRC and/or intern time.

Code	Description	Maximum fee
0844V	Resume services (VRC)	**$10.19** per 6 minutes
0845V	Resume services (intern)	**$8.69** per 6 minutes

Services that can't be billed

Billable services don't include performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals (except for activities noted in WAC 296-19A-340). Activities associated with reports (other than composing or dictating complete draft of the report) not billable include:

- Editing, revising, or typing,
- Filing,
- Distributing or mailing.

Also not billable is time spent on any administrative and clerical activity to include:

- Typing,
- Copying,
- Faxing, mailing, or distributing,
- Filing,
- Payroll,
- Recordkeeping,
- Delivering or picking up mail.

Vocational evaluation

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing,
- Interest testing,
- Work samples,
- Academic achievement testing,
- Situational assessment,
- Specific and general aptitude and skill testing.

A provider (vocational or non-vocational) who administers and/or interprets and reports on vocational evaluation and evaluation results must ensure that he or she is qualified to administer and/or interpret and report on the evaluations in regard to the specific instrument(s) being used.

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation, and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational evaluation is not covered during a vocational recovery referral.

Test administration billing

When billing for testing services on multiple referrals and/or claims, test administration time must be split equally in whole units, charging the same dollar amount on each claim/referral. For example, if a provider performs 4.5 hours of appropriate group testing for three workers, then billing for each worker shouldn't exceed 1.5 hours.

Vocational providers

Vocational providers (provider type **68**) must use procedure code **0821V** to bill for vocational evaluation services. Use code **0821V** for:

- The formal testing itself, *or*
- A meeting that is directly related to explaining the purposes or findings of testing.

Non-vocational providers

Non-vocational providers must use procedure code **0390R**. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, *and*
- Service provider ID for the assigned vocational provider in the Name of the physician or other referring source box at the top, *and*
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form,
- Obtain the vocational referral ID number from the VRC and place on the billing form,
- Obtain the VRC's service provider number and place in the Name of the physician or other referring source box at the top, *and*
- Place the school's provider account number at the bottom of the form.

Retraining plans that exceed statutory benefit limit

The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit. Additional vocational assistance can only be considered following previous retraining attempts that depleted available money and/or time.

The VSS won't approve a plan with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers may not develop or submit such a plan.

How to bill when multiple providers work on a single referral

Multiple providers may deliver services on a single referral if they have the same payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where a provider covers the caseload of an ill provider.

When more than one provider works on a referral, each provider must bill separately for services delivered on the referral, and each provider must use:

- His/her individual provider account number, *and*
- The payee provider account number, *and*
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the assigned provider's performance rating.

Split billing across multiple referrals

When a worker has two or more open time loss claims, the insurer may make a separate referral for each claim. In cases where the insurer makes two (or more) concurrent referrals for vocational services, vocational providers are expected to split the billing. When providing vocational services on multiple referrals and/or claims, follow these instructions:

- To accurately capture the work done without overbilling, combine billable hours over a larger interval of work (up to the entire billing period) rather than bill for each single activity.

Examples:

- A provider has two open referrals for the same worker and the provider bills once per week. They provided a total of 90 minutes during this billing period. They would bill eight units under each claim.
- A provider has two open referrals for the same worker and the provider bills daily. They provided a total of 40 minutes during this billing period. They would bill four units under each claim.

- If the total of all work done during the billing period isn't an even number of units, round to the nearest even whole number of units, then divide by the number of claims as directed above.
- If there are three (or more) claims requiring time loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (three claims = by thirds, four claims = by fourths), based on the number of concurrent referrals received. These requirements also apply when billing for testing services. For example, if provider performs 4.5 hours of testing for a worker with more than one claim and referral, the billing must be split equally among the claims.

Note: Vocational providers must document multiple referrals and split billing for audit purposes.

Appropriate timing of outcome recommendations for State Fund claims

State Fund has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral. The VRC must complete the report before a *VocLink Connect* outcome recommendation is made to State Fund. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which isn't complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include VRC no longer available and VRC or firm declines referral.

In all other cases, the paper report must be submitted to the claim file when the recommendation is submitted. The VRC should confirm the report was received in the claim file for billing and payment.

Submitting a vocational assessment or retraining plan for self-insured claims

Answers to the following common questions can be found in various WACs:

- What is the Self-Insurance Vocational Reporting Form? (WAC 296-15-4302)
- What must the self-insurer do when an assessment report is received? (WAC 296-15-4304)
- When must a self-insurer submit a vocational rehabilitation plan to the department? (WAC 296-15-4306)
- What must the vocational rehabilitation plan include? (WAC 296-15-4308)
- What must the self-insurer do when the department denies the vocational rehabilitation plan? (WAC 296-15-4310)
- What must the self-insurer do when the vocational rehabilitation plan is successfully completed? (WAC 296-15-4312)
- What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? (WAC 296-15-4314)

Change in status: Responsibilities of service providers and firms

The insurer must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status includes:

- VRC or intern ends their association with a firm, *or*
- VRC assigned to a referral is no longer available to provide services on the referral(s), *or*
- Firm closes.

Change in status responsibilities apply to both State Fund and Self-Insurance vocational providers. Forms for reporting change in status are available on L&I's website.

Link: For more information, see WAC 296-19A-270.

Failure to report change in status

A firm or service provider that fails to notify L&I of changes in status may be in violation of WAC and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in WAC 296-19A-270.

Approved plan services that occur prior to plan start date

The insurer may cover these are services/fees prior to a plan start date:

- Registration fees billed as retraining tuition (billing code **R0310**), *and*
- Books, supplies, and equipment (billing code **R0312**), *and*
- Rent, food, utilities, and furniture rental. Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, **0301R**, isn't payable prior to a plan start date. Travel that occurs prior to a plan start date is generally:

- To a jobsite to evaluate whether a particular job goal is reasonable, *or*
- To a school to pay for registration, books or look over the campus.

These types of trips aren't part of a retraining plan and should be billed by the worker under **V0028**. Travel to appointments with the VRC is also billed under **V0028**.

Selected plan procedure code definitions

L&I has defined the following retraining codes:

- **R0312**, Retraining books, equipment, and supplies are consumable goods such as:
    - Books,
    - Paper,
    - Pens,
    - CDs,
    - Disposable gloves,
    - Calculator,
    - Software,
    - Survey equipment,
    - Computers,
    - Welding gloves & hood,
    - Professional uniforms, including shoes,
    - Bicycle repair kits,
    - Mechanics tools.
- **R0390**, Retraining childcare. Providers must be licensed. If a worker is unable to attend training without the use of training funds to pay child care, all anticipated childcare needs must be identified by the VRC in the proposed retraining plan. The total cost of the identified childcare, in addition to other allowable costs, must fit within the statutory retraining benefit limit.

The insurer doesn't have the authority to purchase:

- Glasses,
- Hearing aids,
- Dental work,
- Clothes for interviews,
- Other items as a way to remove barriers during retraining.

Reimbursement for food

The insurer reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan with authorized board and lodging.

Food charges combined in weekly or monthly date spans aren't allowed.

Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable.

Note: The provider and/or the worker should also retain a copy of receipts.

The vocational provider must review billed food charges:

- To remove inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.), *and*
- To ensure each date of purchase is itemized on the bill.

The worker won't be reimbursed over the monthly allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker doesn't exceed their monthly allotment for food.

The vocational provider will:

- Review the receipts, *and*
- Deduct personal and other non-covered items, *and*
- Sign the Statement for Retraining and Job Modification Services form (F245-030-000).

Once the vocational provider signs the **Statement for Retraining and Job Modification Services** form, the insurer will assume the provider has:

- Reviewed the bill and receipts, *and*
- Removed inappropriate charges, *and*
- Verified the charges are within the workers per diem allotment for that month.

Mileage on Plan Time/Cost/Travel Encumbrance

The insurer reimburses mileage only in whole miles.

Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Plan Time/Cost/Travel Encumbrance form (F245-454-000) should be referred to the VSS.

Link: For more information, see WAC 296-19A.

Telehealth services

In-person visits are preferred for vocational services, however, **telehealth** may be an appropriate alternative in certain situations where vocational services can be completed via two-way audio and visual connection.

The following services should have priority for in-person meetings when possible:

- Job analyses,
- Plan development rights and responsibilities,
- Initial meetings with the worker.

Note: Per WAC 296-19A-090, for plan development services, the initial meeting between the assigned vocational rehabilitation provider and the worker must be in person.

Q3014 is payable only to vocational providers who are renting their office space for telehealth purposes. Vocational providers may be reimbursed for renting their office space for workers who need a **telehealth** visit with a medical provider. In these circumstances, no other service may be provided to the worker by the vocational provider. Bill using **Q3014** if providing this service. When a provider bills Q3014 on the same day they render in-person care to a worker, separate documentation is required for both the in-person visit and the Q3014 service. The **originating site** provider billing **Q3014** must submit separate documentation indicating who the **distant site** provider is and that the service is separate from the in-person visit that occurred on the same day.

Telehealth procedures

Telehealth procedures and services that aren't covered include:

- Purchase, rental, installation, or maintenance of telecommunication equipment or systems, *and*
- Telehealth transmission, per minute (HCPCS code **T1014**).

Telehealth locations

Q3014 isn't covered when:

- The **originating site** provider performs another service during a **telehealth** visit, *or*
- The worker is at home, *or*
- Billed by the **distant site** provider, *or*
- The provider uses audio only.

The worker won't be reimbursed for using home as an **originating site**, or for any other **telehealth** related services.

For services delivered via **telehealth**, bill the applicable codes as if delivering care in person. The same limits noted in this payment policy apply regardless of how the service is rendered to the worker.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for corrective action for failure to notify about changes in status	Washington Administrative Code (WAC) 296-19A-270
Administrative rules for vocational services	WAC 296-19A
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare and vocational services	Fee schedules on L&I's website
Job modifications and pre-job accommodations policies	Job modifications on L&I's website Pre-job accommodations on L&I's website
L&I's Claim and Account Center	Claim and Account Center
Quality assurance by vocational firms	Vocational Firm Quality Assurance Plan
Statement for Miscellaneous Services	F245-072-000 on L&I's website
Option 2 Vocational Services	WAC 296-19A-631, 633, 635, 637 Option 2 details on L&I's website Self-Insured Option 2 Vocational Services Summary State Fund Option 2 Vocational Services Summary
Services that aren't covered	WAC 296-19A-340
Statement for Retraining and Job Modification Services form	F245-030-000 on L&I's website

If you're looking for more information about…	Then see…
Notify L&I of changes in status	Email Private Sector Rehab Services PSRS@LNI.WA.GOV
Vocational Provider and Firm Application	F252-088-000 on L&I's website

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**