Washington State Department of
Labor & Industries

Chapter 15: Lodging, Transportation, and Travel

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout these payment policies, see Appendix A: Definitions.

For explanations of modifiers referenced throughout these payment policies, see Appendix B: Modifiers.

For information about place of service codes, see Appendix C: Place of Service (POS).

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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Payment policy: All ambulance services

General information

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated.

Payment is based on the level of medically necessary services provided, not only on the vehicle used.

Proper facilities

The insurer pays the provider for ambulance services to the nearest place of proper treatment.

To be a place of proper treatment, the facility must:

- Be generally equipped to provide the needed medical care for the worker, *and*
- Have a bed available when inpatient medical services are required.

Who must perform these services to qualify for payment

Ambulance providers may only bill the codes using the table in the “Services that can be billed” section in this specific payment policy.

Ambulance providers can’t bill codes listed in the Taxis, wheelchair van and other transportation services payment policy under their ambulance provider account.

Ambulance providers who separately provide non-medical transportation services (e.g. wheelchair vans) should reference the *Who must perform these services* section under the Payment policy: Taxi, wheelchair van and other transportation services section later on in this chapter.

How mileage is paid

The insurer pays for mileage (ground and/or air) based only on loaded miles, which are the miles traveled from the pickup of the worker(s) to their arrival at the nearest place of proper treatment**.**

Vehicle and crew requirements

To be eligible to be paid for ambulance services for workers, the provider must meet the criteria for vehicles and crews established in WAC 246-976 Emergency Medical Services and Trauma Care Systems and other requirements as established by the Washington State Department of Health for emergency medical services.

Key sections of this WAC include:

- **General**: WAC 246-976-260 Licenses required,
- **Ground ambulance vehicle requirements**:
  - WAC 246-976-290 Ground ambulance vehicle standards,
  - WAC 246-976-300 Ground ambulance and aid vehicles—Equipment,
  - WAC 246-976-310 Ground ambulance and aid vehicles--Communications equipment,
  - WAC 246-976-390 Trauma verification of prehospital EMS services,
- **Air ambulance services**: WAC 246-976-320 Air ambulance services,
- **Personnel**:
  - WAC 246-976-182 Authorized care,
  - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines.

Services that can be billed

HCPCS code	Description	Fee schedule
A0425	Ground mileage, per statute mile	**$15.71** per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	**$778.53**
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	**$808.05**
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	**$425.28**
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	**$680.47**
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	**$6,943.39**
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	**$8,072.69**

HCPCS code	Description	Fee schedule
A0433	Advanced Life Support, Level 2 (ALS 2)	**$1,169.56**
A0434	Specialty care transport (SCT)	**$1,382.20**
A0435	Fixed wing air mileage, per statute mile	**$38.64** per mile
A0436	Rotary wing air mileage, per statute mile	**$89.79** per mile
A0999	Unlisted ambulance service	**By report** restrictions: 1. Reviewed to determine if a more appropriate billing code is available, *and* 2. Reviewed to determine if medically necessary.

Requirements for billing

Multiple patient transportation

The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

The provider must use HCPCS code modifier **–GM** (Multiple patients on one ambulance trip) for the appropriate mileage billing codes.

Payment limits

Multiple patient transportation

The insurer pays the appropriate base rate for each worker transported by the same ambulance.

When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported.

Arrival of multiple providers

When **multiple providers** respond to a call for services:

- Only the provider that transports the worker(s) is eligible to be paid for the services provided, *and*
- No payment is made to the other provider(s).

Emergency air ambulance transport

Air ambulance transportation services, either by helicopter or fixed wing aircraft, will be paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that couldn't have been provided by ground ambulance, *or*
- The point of pickup is inaccessible by ground vehicle, *or*
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

Non-emergency transport

Only medical providers may arrange for non-emergency ambulance transportation if the following medical necessity requirements are met.

Non-emergency transportation by ambulance is appropriate if:

- The worker is bed confined (unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair) and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated, *or*
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Non-emergency transportation may be provided on a **scheduled** (repetitive or non-repetitive) or **unscheduled** basis:

- **Scheduled**, nonemergency transportation may be repetitive (for example, services regularly provided for diagnosis or treatment of the worker's accepted medical condition) or non-repetitive (for example, single time need).
- **Unscheduled** services generally pertain to nonemergency transportation for medically necessary services.

The insurer reserves the right to perform a post audit on any non-emergency ambulance transportation billing to ensure medical necessity requirements are met.

Note: Workers can't arrange non-emergency ambulance transportation.

Payment policy: Lodging providers

General information

A lodging provider is a company, person, or group offering temporary housing, such as hotels, motels, and other temporary short-term rental locations. This policy describes how lodging providers should document and bill for services provided to claimants (workers and crime victims).

Lodging providers must have an active L&I provider account number to be paid for lodging and **meals**.

Note: This policy applies to lodging providers only. If you are a claimant who needs reimbursement, see L&I's Expense Reimbursement webpage or contact your claim manager.

For the purposes of this policy, an authorized companion is a person authorized by L&I to accompany the claimant and share their accommodations for the authorized stay.

How to apply for an L&I provider account number

All lodging providers new to L&I and ProviderOne must apply for an L&I account through ProviderOne. Follow the step-by-step guide for Facility, Agency, Organization or Institution (FAOI) to complete your ProviderOne application.

Allow 60-90 days for application review. L&I will notify you of our decision when the review is complete.

Tips for success

- In step 1, mark 'No' on the dropdown for "All Medical Providers are federally mandated to have an NPI." Lodging providers aren't required to have an NPI.
- Upload a copy of your IRS W9 (wet signature required) and the Provider Agreement. Incomplete applications can't be processed and will delay payments.
- If you don't add your EFT/Direct Deposit information in ProviderOne (Step 17), L&I payments will be mailed to the 'Pay to' address.

To update an existing L&I provider account (such as changing your mailing address or billing information), log into your ProviderOne account and follow the Provider Modification Guide (F248-486-000) to make your updates.

If ownership of the business changes, you need to follow the steps above to obtain a new L&I provider account.

Link: For additional assistance, contact LNIProviderOne@Lni.wa.gov.

Expected claimant conduct

Claimants are expected to follow all lodging provider rules and policies. It is the expectation of the insurer that no additional visitors are to be staying in the authorized room without prior approval by the insurer.

Prior authorization

Reimbursement for lodging and **meals** requires prior authorization from the insurer. The claimant is responsible for obtaining authorization for their stay and **meals**. The lodging provider will be provided with a hotel voucher detailing what has been authorized upon booking.

Requirements for billing

Claim Type	Claims begin with…	To bill, you can:	To submit documentation, you can:
State Fund	A, B, C, F, G, H, J, K, L, M, N, P, X, Y or Z followed by six digits, *or* Double alpha letters (example AA) followed by five digits.	Submit a Statement for Miscellaneous Bill Form (F245-072-000) via mail to the address on the form (**Don't fax bills!**), *or* Use our free Provider Express Billing system. For more information and help with direct entry billing visit L&I's Provider Express Billing webpage.	Fax it to **360-902-4567**, *or* Mail it to: Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291
Self-Insured	S, T, or W followed by six digits, *or* Double alpha letters (example SA) followed by five digits.	Use the Self Insured Employer Look Up Tool or call **360-902-6901** for more information on where to submit your bills and documentation.	

Claim Type	Claims begin with…	To bill, you can:	To submit documentation, you can:
Crime Victims	V followed by six digits, or Double alpha letters (example VA) followed by five digits.	Submit a Statement for Miscellaneous Bill Form (F800-076-000) via mail to the address on the form or fax to **360-902-5333**, *or* Use our free Provider Express Billing system. For more information and help with direct entry billing for crime victims use the Crime Victims Direct Entry Billing Guide.	Fax it to **360-902-5333**, *or* Mail it to: Crime Victims Compensation Program PO Box 44520 Olympia, WA 98504-4520

Documentation must be submitted separately from bills. Please be sure to include the claimants' name and claim number in the upper right hand corner of each page.

Once your bill is processed, you will receive a remittance advice (RA) with your payment detailing each claimant's name, claim number, dates of service and payment amount for the bills submitted.

Lodging providers have 1 year from the date the expenses are incurred to bill.

Link: For more information, see WAC 296-20-1103, WAC 296-20-125, L&I's State Fund claims Expected payment dates webpage, and the Crime Victims Current payment schedule.

For further assistance with billing state fund claims, contact Provider Hotline at PHL@Lni.wa.gov or Provider Support and Outreach at ProviderFeedback@Lni.wa.gov. For Crime Victims claims, email CrimeVictimsProgramM@Lni.wa.gov or call **1-800-762-3716**.

Services that can be billed

Lodging

Code	Description	1 unit of service equals…	Maximum fee per unit
5936M	**Lodging provider reimbursement.** Requires authorization from the insurer prior to stay.	1 night	**State Rate** + taxes and state fees

Note: Routine housekeeping can't be billed separately. These charges are included within the maximum fees for lodging provider reimbursement.

Meals

Lodging providers may bill the insurer for up to 3 **meals** per day (breakfast, lunch, and dinner) per authorized person, only when onsite **meals** are offered and provided to the claimant and any authorized companion as part of approved lodging. Don't bill the insurer for **meals** not provided. See the table below for billing codes.

Code	Description	1 unit of service equals…	Maximum fee per unit
5937M	Lodging provider reimbursement (Breakfast)	1 **meal** per authorized person	**State Rate** (includes taxes & gratuity)
5938M	Lodging provider reimbursement (Lunch)	1 **meal** per authorized person	**State Rate** (includes taxes & gratuity)
5939M	Lodging provider reimbursement (Dinner)	1 **meal** per authorized person	**State Rate** (includes taxes & gratuity)

Current **State Rates** can be found on the Office of Financial Management's (OFM) website.

The lodging provider should bill the insurer their usual and customary charges for the **meal**(s) provided. Reimbursement will be at the usual and customary charge or the **State Rate**, whichever is less.

Note: For information regarding medical provider reimbursement of outpatient day program **meals** provided to claimants in an approved brain injury rehab program (BIRP) or structured, intensive, multidisciplinary program (**SIMP**), see Chapter 26: Rehabilitation Facilities and Programs.

Parking

The insurer will reimburse the lodging provider for parking while in approved lodging, provided there are parking accommodations that are not free to the general public. Don't bill the insurer for parking not provided to the claimant.

Code	Description	1 unit of service equals…	Maximum fee per unit
0402A	Parking (Claimant/Lodging Provider).	1 stay	**By report**

Fees

Taxes and state fees are payable in addition to the per diem rate for lodging. Taxes and gratuity is payable within per diem for **meals**.

Code	Description	1 unit of service equals…	Maximum fee per unit
5933M	Lodging provider – Late cancellation fee.	1 stay	**$103.02**

Lodging providers may bill the insurer **5933M** as a cancellation fee if the insurer or the claimant fails to provide 24-hour notice of cancellation for either an entire stay or the claimant checks out before the final day of the reservation. Per WAC 296-20-010(5), the cancellation fee is only payable if the stay was arranged as part of an **independent medical examination (IME)** or other department-arranged appointment. The lodging provider must contact the claim manager for prior approval and determination of responsibility before billing the cancellation fee. When billing, the lodging provider must include proof of late cancellation (such as date, time and method of cancellation). **5933M** is only payable once per scheduled stay.

The lodging provider may bill a claimant for a non-covered late cancellation if their established policy equally applies to all guests per WAC 296-20-010(6). L&I can't provide the worker's billing address.

Extending the claimant's stay

If the stay is extended by the insurer due to a change in the claimant's medical appointments, the insurer will reimburse for the additional lodging and **meals**, provided prior authorization has been obtained. It is the claimant's responsibility to contact the claim manager (CM) to request authorization to extend the stay.

Out-of-state lodging providers

Out-of-state lodging providers may be reimbursed for lodging and/or **meals** provided to Washington State claimants. The rate will be based on the location of the lodging provider and the U.S. General Services Administration's rates for lodging and/or **meals** for that location.

Documentation requirements

Each lodging provider must submit documentation along with their billing to include a folio or list of charges with:

- The date span, *and*
- The claimant's name, *and*
- L&I claim number(s), *and*
- Total charge for the date span, *and*
- Number of units (nights) stayed.

If **meals** were provided to the claimant, include an itemized list of **meals** broken out into breakfast, lunch, and dinner by date and charge.

The lodging provider must retain itemized receipts for no less than 1 year, and provide them to the insurer along with their bill and upon request.

Link: For more information, see RCW 19.48.020.

Services that can't be billed

The insurer won't reimburse lodging providers for the following:

- Complimentary **meals** (such as breakfast) supplied to the general public, or
- Lodging and/or **meals** paid for by the claimant or their authorized companion, or
- Incidental fees, or
- Additional cleaning fees above and beyond routine housekeeping for damage to the room, or
- Cancellations made by the **lodging provider**, or
- Any expenses incurred by a claimant's authorized companion except for **meals**, or
- Lodging, **meals** and/or fees outside the authorized period.

The lodging provider may bill the claimant directly for:

- Lodging and/or **meals**, if the claimant prefers to pay themselves, *or*
- Incidental fees, *or*
- Additional cleaning fees above and beyond routine housekeeping for damage to the room, *or*
- Lodging, **meals** and/or fees outside the authorized period or above per diem if worker is notified in advance of the charge.

Don’t bill the insurer for these services. For the purposes of this policy only, lodging providers are reimbursed the maximum per diem rate for **meals**, or billed amount, whichever is less. It is the responsibility of the claimant to cover costs beyond this rate.

It is up to the lodging provider’s discretion to accept reservations for claimants without a debit card, credit card, or cash for additional charges not covered by the insurer. Please contact the claim manager (CM) as soon as possible if this situation arises.

Link: For more information, see RCW 51.04.030(2) and WAC 296-20-020.

Payment limits

L&I reserves the right to revoke a lodging provider’s account number should lodging conditions not meet standards (clean, safe, etc.) in accordance with state and federal laws.

Payment policy: Mileage and travel expenses for nurse case managers

General information

The mileage and travel expense codes exist to reimburse nurse case managers (NCMs) for costs associated with driving, attending visits with providers and workers, and performing other necessary travel duties while completing a nurse case management referral or annual assessment.

Prior authorization

Mileage

Prior authorization is not required.

Travel expenses

For State Fund, prior authorization from an ONC is required.

For Self-Insurance, prior authorization from the insurer is required.

Failure to obtain prior authorization may result in denial of bills or recoupment of payment.

Services that can be billed

Code	Description and notes	Maximum fee
1224M	**Mileage, per mile**. 1 unit = 1 mile Mileage is paid on a portal-to-portal basis (from your office to the next address related to the referral) and does not include side trips.	State Rate
1225M	**Travel expenses.** Prior authorization is required. NCMs may bill for case-related travel costs resulting from parking, ferries, tolls, cabs, lodging, and airfare. An itemized receipt is required.	By report

Mileage and travel expenses must be incurred while in the course of performing a nurse case management visit (1221M) or billing travel/wait time (1223M) related to an active referral.

Documentation requirements

Mileage

For each trip, submit an invoice to the claim file that includes:

- Worker's name,
- Claim number,
- Travel date and time,
- Starting address,
- Ending address,
- Number of miles, *and*
- Reason for the trip (such as "attend appointment with worker" or "one-on-one visit with provider").

For multiple trips made on the same date of service for the same worker, you may combine all trips into a single invoice and bill, but you must clearly note each trip separately on your invoice.

Separate documentation is required for each date of service. Do not use reports or case notes as documentation for mileage billing.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your documents are properly entered into L&I's systems.

Travel expenses

Submit an itemized receipt to the claim file when billing.

Please include the phrase "index: NCM" in the bottom corner of each page to ensure your documents are properly entered into L&I's systems.

Payment policy: Provider mileage

Prior authorization

Prior authorization is required for a provider to bill for mileage.

The round trip mileage must exceed 14 miles.

Note: Reimbursement for provider mileage is limited to extremely rare circumstances.

Requirements for billing

To bill for preauthorized mileage:

- Round trip mileage must exceed 14 miles, *and*
- Use local billing code **1046M** (Mileage, per mile, allowed when round trip exceeds 14 miles), which has a maximum fee of **$5.96** per mile.

Services that can’t be billed

1046M isn’t payable to mobile clinics or providers who use mobile clinics for care. For details, see Chapter 24: Telehealth, Remote, and Mobile Services.

Payment policy: Taxi, wheelchair van and other transportation services

General information

The insurer pays for transportation services when workers require transportation to medical appointments or **Independent Medical Exam**s (IMEs) when an insurer provided trip ticket is given to the provider. These are non-medical (non-ambulance) transportation services.

For workers who require medical transportation services (ambulance), see Payment policy: All ambulance services.

Who must perform these services

The following provider types may provide non-medical transportation:

- Taxis,
- Wheelchair vans (may be known as cabulances),
- Buses, *or*
- Airlines.

Ambulance providers who provide non-medical transportation services (e.g. wheelchair vans) must have a separate provider account to bill the insurer for non-medical transportation services. Such providers must separately bill their usual and customary charges for non-medical transportation services they provide under their appropriate provider account.

Emergency and non-emergency ambulance services must use the procedure codes in Payment policy: All ambulance services.

Prior authorization

Other transportation services including taxi and wheelchair services are payable when pre-authorized by the insurer.

Requirements for billing

All bills must be submitted to the insurer within a year from date of service. See Chapter 2: Information for All Providers for details.

Taxi providers may bill the insurer **1269M** for a worker missed appointment no show for an insurer arranged **Independent Medical Exam** (**IME**) or an insurer arranged **consultation**. For the insurer's authority to reimburse taxi providers for an insurer arranged **IME** or an insurer arranged **consultation** no show, see WAC 296-20-010(5). No other no show fees will be reimbursed by the insurer to taxi providers. A copy of F248-374-000 noting the worker missed the trip as well as a copy of the department provided trip ticket is required for payment. The insurer must confirm the worker missed the arranged trip for an **IME** to reimburse the provider.

Taxi providers may bill a worker for a missed appointment no show other than for an insurer arranged **IME** or an insurer arranged **consultation**, see WAC 296-20-010(6).

To bill **1270M**, taxi providers must have completed a trip for an insurer arranged **IME** or insurer arranged **consultation**.

See "Services that can be billed" for additional billing codes.

Services that aren't covered

- Local code **0414A** for direct claimant taxi reimbursement (not payable to taxi and other transportation service providers).
- Pick up charges that aren't part of a provider's usual and customary fees.
- Unloaded Miles.

How mileage is paid

The insurer pays for mileage based on loaded miles, which are miles traveled from the pickup of the worker(s) to their arrival at the medical or vocational authorized destination only.

Documentation requirements for billing

Taxis

To be eligible to be paid for non-emergent transportation services for workers, the provider must submit F248-374-000. A copy of the department provided trip ticket must be attached to this form to validate the insurer's approval of services.

All other transportation

To be eligible to be paid for non-emergent transportation services for workers, the provider must provide an itemized statement (invoice) documenting the following:

- Claim number
- Worker name (name of worker transported)
- Date of trip
- Pick up time
- Pick up address
- Destination (drop off) address (note that the destination must be the nearest place of proper treatment)
- **Wait time**
- Drop off time
- Driver name (First, Last)
- Driver operator or cab number
- Rates (see WAC 296-20-01002 Definitions - "**By report**")
- Total cost of trip

Note: For transportations other than taxis, a trip ticket (if provider by the department) may be used as an itemized statement.

Services that can be billed

HCPCS Code	Description	Fee schedule
A0100	Taxi, non-emergency	**By report**
A0110	Transportation and bus, intra or interstate carrier, non-emergency	**By report**
A0120	Mini-bus, mountain area transports, or other transportation systems, non-emergency	**By report**
A0130	Wheel-chair van, non-emergency	**By report**
A0140	Air travel (private or commercial) intra or interstate, non-emergency	**By report**
A0170	Transportation ancillary: parking fees, tolls, other	**By report**
0304R	Vocational Retraining Plan Transportation (Taxi)	**By report**
1269M	Taxi no show fee for insurer arranged **Independent Medical Examination (IME)** or insurer arranged **consultation** 1 unit per claimant per day authorized	**$55.55**
1270M	Insurer arranged **Independent Medical Examination (IME)** or insurer arranged **consultation** Transportation (Taxi) Services	**By report**

Note: For all **by report** (BR) procedure codes, providers must bill their usual and customary charges and describe in detail any service rendered. The insurer may adjust reimbursement for BR procedures when such action is indicated. The provider may be required by the insurer to furnish additional documentation to validate any specific charge is part of their usual and customary fees. For the legal definition of **by report** (BR), see WAC 296-20-01002.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for ambulance services	Washington Administrative Code (WAC) 246-976
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers Chapter 21: Reports and Forms
Fee schedules for all healthcare professional services (including ambulance services)	Fee schedules on L&I's website
Payment policy for mobile clinics	Chapter 24: Telehealth, Remote, and Mobile Services

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

