Washington State Department of
Labor & Industries

Chapter 21: Reports and Forms

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 reports and forms

General information

This chapter is not a comprehensive list of all reports and forms. Many L&I forms are available and can be downloaded from L&I's website and all reports and forms may be requested from the Provider Hotline by emailing PHL@Lni.wa.gov. There you can also find Spanish versions of these documents.

For more information on the reports and forms listed in this appendix, see WAC 296-20-06101.

Who must complete the document to qualify for payment

Some reports and forms are restricted to certain provider types or their role in the claim. Refer to the specific report for details on who must complete the form to qualify for payment.

Links: For more information on the differences between an **attending provider** type and an **AP** on the claim, see Chapter 3: Attending Providers.

Requirements for billing

To bill for a special report or form required by the insurer, use the appropriate CPT® or local billing code. The fees listed in the fee schedules for these reports and forms include postage for sending documents to the insurer. The insurer may send a special report or form. In these cases, the provider must complete the special report or form as requested.

Documentation requirements

In addition to the specific reports and forms requirements noted in this chapter, the documentation must also include:

- The name and title of the person completing the form (either with a hand-written signature, signature stamp, or electronic signature), *and*
- The date it was completed.

These are required even if the report or form doesn't have a field for it.

All documentation to support the service billed must be received by the insurer prior to submitting your bill or within 30 days of the date of service, whichever comes first. The insurer may recoup, deny, or reduce a provider's level of payment for a specific visit or service if the required documentation provided doesn't match the procedure code billed, or is not proper and necessary. Refer to WAC 296-20-015.

Changes to **medical records** after bill submission won't be considered in determining appropriate payment.

Links: For more information on documentation requirements, see Chapter 2: Information for All Providers and WAC 296-20-01002.

Payment policy: Attending Provider type reports and forms

Who must complete to qualify for payment

Only **attending provider (AP)** types with a valid provider number may sign and complete the following forms. Some forms are restricted to only the **AP** on the claim, while others may also be completed by **consultants** or concurrent care providers, which are also **attending provider** types.

Requirements for billing

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Activity Prescription Form (APF) (F242-385-000)	**1073M**	Only **attending provider** types, acting as the **AP** on the claim, a concurrent care provider, or a **consultant.** APFs are only payable to psychologists when they are the **AP** on a mental health only claim. Can be submitted with Report of Accident (ROA/PIR) when there are work related physical restrictions, or when documenting a change in the worker's medical status or capacities. **APFs aren't payable when submitting reopening applications.** An office visit isn't required to complete an APF in certain circumstances. Limit of 1 per provider, per worker, per day. Up to 6 within first 60 days. Up to 4 times per 60 days thereafter. Insurer will review for determination of additional allowances over the limit. When requested by the insurer, properly completed APFs are payable, even if the limits have been reached. **1073M** can't be billed with **9918M** or **9919M** when the communications are to transmit or simply reiterate the information on the the APF.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
AP Final Report	**1026M**	**Must be requested by insurer or submitted by the AP**. Only the **AP** on the claim can sign and be paid for completion of this form. Limit of 1 per day.
AP response to VRC/ Employer request about RTW	**1074M**	**AP response to written communication with vocational counselors and employers**, such as questionnaires. Only the **AP** on the claim can sign and be paid for completion of this form. A copy of the written communication must be sent to the insurer. Not payable when performed on the same day as a team conference, office visit, or online communication with a VRC or employer.
AP Concurrence of Independent Medical Exam (IME)	**1063M**	**Must be requested by insurer.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or a concurrent care provider can sign and be paid for completion of this form. Not payable to Master Level Therapist (MLT). Limit of 1 per request. The **AP** must respond to the request using the letter sent by the claim manager.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
AP Supplemental Review of IME with written report	**1065M**	**Must be requested by insurer.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or a concurrent care provider can sign and be paid for completion of this form. The **AP** must submit a separate report of the **IME** review. This report expands upon the provider's response from **1063M** and can't refer only to a prior chart note. Limit of 1 per request.
Loss of Earning Power (LEP) (F242-209-000)	**1027M**	**Must be requested by insurer.** Only the **AP** on the claim may sign and be paid for completion of this form. Limit of 1 per day.
Occupational Disease History Report (F242-071-000 or for hearing loss F262-013-000)	**1055M**	**Must be requested by insurer.** Only **APs** may sign and be paid for completion of this form. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s). Visit our website for instructions. Limit of 1 per worker.
Review of FCE Reports/ Summary	**1097M**	**Must be requested by insurer, employer, or vocational counselor.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or an **IME** examiner can sign and be paid for completion of this form. Limit of 1 per day, per provider, per worker

Payment policy: Brief emotional/behavioral screens & risk assessments

General information

This policy covers initial or repeat screening (such as the PHQ-9, GAD-7, or PCL-5) to determine if a worker should be referred for mental health treatment.

These assessments aren't for diagnosing a mental health condition, but may be necessary to determine the need for more in-depth assessment or further intervention.

Service that can be billed

Use CPT® code **96127** for brief emotional/behavioral screens and risk assessments. Bill 1 unit per standardized instrument. Includes scoring and documentation.

Payment limits

CPT® code **96127** is limited to 3 assessments per day, per provider, with a maximum of 6 assessments per provider, per worker.

Brief emotional/behavioral screens & risk assessments can't be billed separately from active mental health treatment, including during psychotherapy or mental health evaluation. Monitoring of diagnosed mental health conditions, including provider time associated with these types of screens, is already included within mental health services. For re-assessments during active treatment of a diagnosed mental health condition, use the appropriate evaluation CPT® code.

Payment policy: Job analysis (JA) or job descriptions

General information

Job analyses (JA) and **job descriptions** identify the physical requirements of a potential job for the worker. The **AP** reviews the **JA** or **job description(s)** to determine whether the worker can perform a specific job. The provider sends the insurer (and vocational provider, if applicable) a response, indicating whether the worker can perform the job described or not. If not, the provider must specify any modifications needed to enable the worker to do the job.

Within their scope of practice, **APs** must review the physical and/or mental requirements documented in the **job description** or **job analysis** of any **job offer** submitted by the employer of record and determine whether the worker can perform that job. The provider must send a copy of each **job description** or **job analysis** reviewed to the insurer.

Note: Reviews requested by other than the department, self-insurer, Third Party Administrator (TPA), employer or vocational counselor (for example, attorneys or workers) won't be paid.

Requirements for billing

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Review of Job Descriptions or JA or **On-the-job recovery agreement (OTJ-RA)**	**1038M**	**Must be requested by insurer, employer or vocational counselor.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or an **IME** examiner can sign and be paid for completion of both forms. Psychologists can only sign and complete when there is a covered mental health condition on the claim. Not payable to **IME** examiner when **IME** performed on the same day. Limit of 1 per day.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Review of Job Descriptions or JA or **On-the-job recovery agreement (OTJ-RA), each additional review**	**1028M**	**Must be requested by insurer, employer or vocational counselor.** Only **attending provider** types, acting as the **AP** on the claim, a **consultant**, or an **IME** examiner can sign and be paid for completion of both forms. Psychologists can only sign and complete when there is a covered mental health condition on the claim. **IME** examiner limits – Day of exam, may be billed for each additional **JA** after the first 2. After day of exam, may be billed for each additional JA after the initial (**1038M**).

Payment policy: Reports and forms for all providers

Requirements for billing

If the **report or form** is…	Then bill using this **code**...	Also, be aware of these **special notes** about the report or form:
30-Day Report	**99080**	1 per provider, per 30 days, per claim. Per WAC 296-20-0555, when treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and accepted industrial conditions. Not payable for records required to support billing, for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Not payable if the report is completed as part of another service.
60-Day Report	**99080**	1 per provider, per 60 days, per claim. Not required unless requested by the insurer or if legible comprehensive chart notes are submitted and include the required information per WAC 296-20-06101. Not payable for records required to support billing, for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Not payable if the report is completed as part of another service.

If the **report or form** is…	Then bill using this **code**...	Also, be aware of these **special notes** about the report or form:
Department of Transportation (DOT) Medical Examination & Certification	**99499**	For performing a DOT Medical Examination and completing the certification form. Must be conducted by a licensed "medical examiner" with the Federal Motor Carrier Safety Administration (FMCSA); MD, DO, ND, ARNP, PA eligible in Washington State. Prior authorization required. Limit of 1 per day.
Provider Review of Video Materials with written report	**1066M**	**Must be requested by insurer.** Report must include actual time spent reviewing the video materials, and findings and observations gained from the review. Limit of 1 per provider, per day. Not payable in addition to CPT® code **99080** or local codes **1104M** or **1198M**.
Special Report	**99080**	**Must be requested by insurer or vocational counselor.** Not payable for records or reports required to support billing or for review of records included in other services, or for treatment of Behavioral Health Interventions (BHI). Don't use this code for forms or reports with assigned codes. Bill this code for starring a work history form. Can't be billed with **1055M**. Limit of 1 per day.

Opioid forms

Providers who are prescribing opioids to injured workers within their scope of practice may complete and bill for the following forms.

If the **report or form** is…	Then bill using this **code**...	Also, be aware of these **special notes** about the report or form:
Opioid Request Form for Chronic Pain	**1078M**	Chronic phase (>12 weeks) and ongoing chronic opioid therapy requirements, see WAC 296-20-03057 and WAC 296-20-03058.
Subacute Opioid Request Form for Pain with Documentation	**1077M**	Use when copies of all required screenings (urine drug test, risk of opioid addiction, current or former substance use disorder and depression, if indicated) are submitted with the form – increased reimbursement. Opioid requirements for the subacute phase (6-12 weeks), see WAC 296-20-03056.
Subacute Opioid Request Form for Pain without Documentation	**1076M**	Use when results of screenings are documented in the medical record but aren't submitted with the form. Opioid requirements for the subacute phase (6-12 weeks), see WAC 296-20-03056.

Payment policy: Report of Accident (ROA/PIR/SIF-2)

General information

Filing of a State Fund Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) to initiate an L&I claim is required for work-related injuries, illnesses, or conditions requiring treatment beyond basic first aid as defined in WAC 296-800-099. If the worker, employer, or provider have reason to believe the injury or illness is work-related, a ROA/PIR is required. For self insured employers, the worker must also complete an SIF-2 to assist in claim initation.

The provider who completes and signs the ROA/PIR is listed as the **AP** on the claim until a written transfer of care is received.

No employer, worker, or provider can exempt themselves from filing a ROA/PIR by any contract, agreement, rule, or regulation, when an injury or occupational disease has occurred.

Workers have the right to file a claim if they have reason to believe their injury or illness is work-related, even if the provider and/or employer disagrees.

Providers who first treat an injured worker must inform them of their rights to file a workers compensation claim, if they have not already filed one. Even if the worker objects after hearing their rights, the provider is still required file a ROA/PIR under penalty of law, within 5 days of treatment.

A ROA is always required if the worker has received any treatment, is hospitalized, disabled from work, or has died as an apparent result of a work accident and injury.

Per WAC 296-20-065, the selection of a provider is the worker's choice by law. The employer or their designee may not direct or require the worker to use a specific medical provider.

In accordance with RCW 51.48.060, failing to comply with all ROA requirements may result in penalties.

Link: For more information, see Deciding When to File an Accident Report on L&I's website, WAC 296-20-025, RCW 51.48.095, RCW 51.28.025, and RCW 51.28.020.

Who must complete to qualify for payment

Only **attending provider (AP)** types with a valid provider number may sign and complete these forms.

Mental health only claims

Clinical psychologists (PhD or PsyD) can only complete and sign these forms when the sole condition(s) on the claim is a psychiatric condition. Mental health only claims do not include those that have previously had a physical condition, which has since been resolved.

Requirements for billing

Bill only 1 ROA or PIR per claim, using local code **1040M**.

Submit the ROA or PIR to the insurer immediately following the **initial visit** (which the ROA and PIR calls “This exam date”).

Examinations to complete an ROA/PIR

A ROA/PIR can **only** be filed as part of an in-person physical examination of the injured worker by an **attending provider**. The examination necessary to complete a ROA/PIR **can’t** be done via **telehealth**, except for mental health only claims. For more information on distant and **originating site** restrictions, see the **telehealth** policies in Chapter 9: Evaluation and Management (E/M) and Chapter 17: Mental Health and Behavioral Health Interventions (BHI).

How to file

For **state fund claims**, complete the ROA using the instructions on the paper form. These forms aren’t available for download. See F242-130-000 (English) for information on how to order paper copies. Fax completed ROAs to **360-902-6690** or **800-941-2976.** Hot ROA fax for hospital admissions is **360-902-4980**.

Providers now have the option to file State Fund ROAs online via FileFast or through Health Information Exchange (HIE). Online filing of the State Fund accident report reduces delays in claim management. Benefits of filing a ROA online include:

- Immediate confirmation of receipt.
- Faster authorization for treatment and prescription refills.
- Increased accuracy (reduces common mistakes).
- The provider is instantly assigned to the claim.
- Pharmacists can fill additional prescriptions.
- Quick access to the claim.
- $10 additional reimbursement for online filing (code **1040M**).

To ensure correct payment and qualify for the $10 financial incentive, make sure the ROA/PIR form is filled out completely. All information voluntarily provided by the worker in the Worker and Employer sections and all fields in the provider section of the ROA must be completed and included in electronic data submissions.

Note: When filing State Fund ROAs via FileFast make sure to add the $10 web incentive to your billed charge.

For **self insured claims**, complete the PIR using instructions on the back of form. An electronic version of the form is available here: F207-028-000. If you need additional space, attach the information to the application, and include the claim number at the top of the page.

If the **report or form** is…	Then bill using this **code**…	Also, be aware of these **special notes** about the report or form…
Report of Accident (ROA) Workplace Injury, or Occupational Disease – State Fund (F242-130-000 or electronically via FileFast)	**1040M**	**Must be initiated by the worker or by an AP**. Only **APs** may sign and be paid for completion of these forms. Payment delays may occur until claim determination is made. Limit of 1 per claim. For more on billing procedures, see WAC 296-20-125. For filling out the ROA, see L&I's website. For self insured employers, the worker must also complete an SIF-2 to assist in claim initation. See L&I's website for more information on ordering SIF-2 Forms.
Provider's Initial Report (PIR) – Self Insured (F207-028-000)		
Application to Reopen Claim (F242-079-000)	**1041M**	**Must be initiated by the worker or by the insurer**. Only **APs** may sign and be paid for completion of this form. Payment delays may occur until claim determination is made. Limit of 1 per request. For more on reopenings, see WAC 296-20-097.

Payment Limits

Reimbursement amount is based on the date the healthcare provider includes in box 15b of the paper ROA, and in box 3 of the PIR, Attending Health Care Provider section, (This exam date). If that box is blank, the department's payment system will look at box 16 of the paper ROA (Signature of the health care provider) and the self-insurer will look at box 13, (Date) in the Attending Health Care Provider section.

ROAs/PIRs submitted within 5 business days after an injured worker's **initial visit** are paid at a higher rate than ROAs/PIRs submitted after 5 business days. The insurer pays for completion of ROAs/PIRs on a graduated scale based on when they are received by the insurer following the "**Initial visit**"/"This exam date" (box 15b on the paper ROA form, and box 3 on the PIR form). **L&I's State Fund payment system automatically reduces the ROA payment for ROAs received more than 5 business days from "This exam date".**

Max Fee when submitted via:	Within 5 days	6-8 days	9 days or more
Paper or fax	**$46.47**	**$36.47**	**$26.47**
FileFast/HIE – State Fund only (additional $10 incentive; add on to your billed charges when submitting)	**$56.47**	**$46.47**	**$36.47**

Link: Information about online filing options is available on our FileFast website or by calling **877-561-3453**.

Information is available online about filing through the Health Information Exchange (HIE).

Additional payment incentive on State Fund claims

Payments are increased for participation in the Centers of Occupational Health and Education (COHE). Providers must bill their usual and customary charges, even when eligible for payment incentives.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for information in this chapter	Washington Administrative Code (WAC) 296-20-01002 WAC 296-20-015 WAC 296-20-025 WAC 296-20-06101 WAC 296-20-065 WAC 296-20-097 WAC 296-20-03056 WAC 296-20-03057 WAC 296-20-03058 WAC 296-20-125 WAC 296-800-099
Activty Prescription Form (APF) information	Activty Prescription Form webpage
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions	Chapter 2: Information for All Providers
Centers for Occupational Health and Education (COHE) payment incentive information	COHE webpage
Fee schedules for all healthcare services	Fee schedules on L&I's website
FileFast	FileFast
L&I forms	L&I's website
Occupational Disease History Report instructions	How to Bill for an Occupational Disease History Report
Payment policies for attending providers	Chapter 3: Attending Providers

If you're looking for more information about…	Then see…
Payment policies for evaluation and management (E/M) services	Chapter 9: Evaluation and Management (E/M)
Payment policies for mental health services	Chapter 17: Mental Health and Behavioral Health Interventions (BHI)
Penalty for failing to file accident reports and assist injured workers	Revised Code of Washington (RCW) 51.28.025 RCW 51.48.060
Penalty adjusted for inflation	RCW 51.48.095
Report of Accident information	Deciding When to File an Accident Report

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.