Washington State Department of
Labor & Industries

Chapter 27: Rehabilitation Facilities and Programs

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.

Table of Contents Page

Payment policy: Brain injury rehabilitation programs (BIRPs) and services

Prior authorization

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment.

State Fund claims

To determine whether or not to authorize post-acute brain injury rehabilitation for a claim, both an occupational nurse consultant (ONC) and L&I claim manager will review the claim separately. (See Approval criteria, below.)

The Provider Hotline can't authorize brain injury treatment; however, the Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

Self-insured claims

Contact the SIE or TPA for authorization (see Approval criteria, below).

Link: Contact information for the SIE or TPA is available via L&I's self-insured lookup tool.

Approval criteria

Before a worker can receive treatment, all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim,
- The brain injury is related to the industrial injury or is retarding recovery,
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program,
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury, *and*
- The screening evaluation report by the program identifies specific goals to help the worker improve function or compensate for lost function.

Who must perform these services to qualify for payment

Only providers approved by the department can provide post-acute brain injury rehabilitation services for workers.

Providers must maintain CARF accreditation in Outpatient Medical Rehabilitation Program – Interdisciplinary with Brain Injury Specialty designation and provide the Department of Labor and Industries (L&I) with documentation of satisfactory recertification including the latest CARF Accreditation Report. This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account may be inactivated if CARF accreditation expires or this information is not received from the provider. It is the provider's responsibility to notify L&I when an accreditation visit is delayed.

Additional provider requirements include:

- Provide L&I with the program organization structure annually.
- Notify L&I in writing of key organization changes within 30 days.
- New programs must provide L&I contact information with the provider application and be available to provide additional information, as needed.
- For applicable programs, L&I must be notified of substantial material changes to the program description in writing within 30 days.

Providers must send this information to Jason.Fodeman@Lni.Wa.Gov.

Qualifying programs

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation,
- Treatment, *and*
- Follow up.

When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to:

Department of Labor and Industries

Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Specific L&I provider account number required

Providers will be issued a provider-specific ID number (separate from any provider ID they may already have with L&I) which will enable payment via the brain injury program billing codes.

Providers may request a provider application or find out if they have a qualifying provider account number by emailing PHL@Lni.wa.gov.

Services that can be billed

Nonhospital based programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs:

Local code	Description	Maximum fee
8950H	Comprehensive brain injury evaluation	**$5,170.34**
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,172.86**
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$816.87**

Hospital based programs

The following revenue codes and payment amounts for hospital-based outpatient post-acute brain injury rehabilitation treatment programs:

Local rev code	Description	Maximum fee
0014	Comprehensive brain injury evaluation	**$5,170.34**
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	**$1,172.86**
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	**$816.87**

Meals

L&I will reimburse the brain injury provider for 1 **meal** per day provided there is an onsite **meal** offered to the worker, and the worker is participating in more than 4 hours of treatment that day. Don't bill L&I for **meals** not provided to or paid by the worker.

Code	Description	1 unit of service equals…	Maximum fee per unit
5934M	Outpatient Day Program - Lunch	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 brain injury provider should bill L&I their usual and customary charges for the **meal** provided. Reimbursement will be at your usual and customary charge or the **State Rate**, whichever is less.

Services that aren't covered

Brain injury rehabilitation program services performed in the worker's home aren't covered.

Requirements for billing

For State Fund claims billing, providers participating in the Brain Injury Program must bill for brain rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. (See who must perform these services to qualify for payment, above.)

Billing for partial days for the treatment phase

If a worker receives less than the 4 hour minimum per day of treatment under code **8952H**, the clinic can bill only for the percentage of the 4 hours that treatment has been provided.

Example:

- The worker has an unforeseen emergency and has to leave the clinic after 2 hours (50% of the half-day treatment). The clinic would bill **8952H** at the reduced fee of **$816.87** x 50% = **$408.44**

Comprehensive brain injury evaluation requirements

A comprehensive brain injury evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in depth analysis of the worker's cognitive, psychological, emotional, social, physical status and functioning. It must also include review of the workers' **medical records**, assessment of any important associated conditions that may hinder recovery, identification of the worker's family and support resources, and identification of factors that may affect participation. The evaluation must be provided by a multidisciplinary team that includes all of the following:

- Medical physician,
- Psychologist,
- Neuropsychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist, and
- Speech language pathologist

Additional medical **consultations** are referred through the program's physician. For State Fund claims, each **consultation** may be billed under the provider account number of the consulting physician. Services must be preauthorized by an L&I claim manager or the self-insured employer / third party administrator.

Documentation requirements

The following documentation is required of providers when billing for evaluation and/or treatment services within the post-acute brain injury rehabilitation program:

- All daily chart notes including a daily record of a workers' attendance, activities, treatments and progress,
- All test results and scoring,
- Documentation of team meetings and/or care conferences, including participants,
- Documentation of interviews with family, *and*
- Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program.

Progress reports must be sent to the insurer regularly, including all preadmission and discharge reports.

Payment limits

Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation, may be performed in any combination depending on the worker's condition and related needs, and **can't be billed separately**:

- Neuropsychological diagnostic interview(s), evaluation, testing, scoring, and interpretation of results,
- Psychological diagnostic interview(s), evaluation, testing, scoring, and interpretation of results,
- Initial **consultation** and exam with the program's physician,
- Occupational and Physical Therapy evaluations,
- Vocational Rehabilitation evaluation,
- Speech and language evaluation, *and*
- Comprehensive report.

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is **considered part of the provider's administrative overhead**. It includes but isn't limited to:

- Obtaining and reviewing the workers' historical **medical records**,
- Interviewing family members, if applicable,
- Phone contact and letters to other providers or community support services,
- Writing the final report, *and*
- Office supplies and materials required for service(s) delivery.

Treatment

These therapies, treatments, and/or services are included in the Brain Injury Program maximum fee schedule amount for the full day or half-day brain injury rehabilitation treatment and **can't be billed separately**:

- Psychotherapy,
- Behavioral modification,
- Behavioral Health Interventions, see Chapter 17: Mental Health and Behavioral Health Interventions for more details,
- Individual or group therapy,
- Physical therapy and occupational therapy,
- Speech and language therapy,
- Nursing and health education and pharmacology management,
- Activities of daily living management,
- Recreational therapy (including group outings),
- Vocational counseling, *and*
- Follow up interviews with the worker or family.

Ancillary work, materials, and preparation that may be necessary to carry out Brain Injury Program functions and services are considered part of the provider's administrative overhead and **aren't payable separately**. These include, but aren't limited to:

- Daily charting of patient progress and attendance,
- Report preparation,
- Case management services,
- Coordination of care,
- Team conferences and interdisciplinary staffing, *or*
- Educational materials (for example, workbooks and tapes).

Follow up care is included in the cost of the full day or half-day program. This includes, but isn't limited to:

- Telephone calls, *and*
- Therapy assessments.

Payment policy: Mental health residential treatment facilities

General information

Residential treatment facilities for mental health provide high-level care to workers with long-term or severe mental health disorders, or workers with substance-related disorders requiring detoxification and treatment, with 24-hour medical and nursing services. Residential treatment facilities for mental health typically provide less intensive medical monitoring than subacute hospitalization care. Treatment includes a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential treatment facilities for mental health include training in the basic skills of living as determined necessary for each worker. Treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance use disorders are included in this level of care. Adult family homes, skilled nursing facilities, or boarding homes aren't included in this definition.

This policy applies to workers who require admission to a residential treatment facility for mental health services. Workers covered under this policy are either filing the initial claim, or have an open and allowed claim. This includes those who:

- Have an accepted mental health condition, such as occupational posttraumatic stress disorder (PTSD), *or*
- Have mental health treatment authorized, which may include the need for treatment of substance use disorder.

For information on which insurer to bill, see Chapter 2: Information for All Providers.

For additional inpatient or outpatient facility information, see Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs).

For mental health services and authorization requirements, see the information in this chapter. Supplemental information is defined in WAC 296-21-270.

Requirements for PTSD are defined in RCW 51.08.165. For occupational disease requirements, see RCW 51.08.142 and RCW 51.32.185 (presumptive coverage).

Claim filing

The filing of the initial L&I Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) does not require prior authorization. The insurer covers the **initial visit** and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. See Chapter 2: Information for All Providers for additional details on **initial visits**.

For workers where the facility is filing the L&I Report of Accident (ROA) or self-insured Provider's Initial Report (PIR) **and the worker requires treatment**, the following must be submitted to the insurer:

- The ROA or PIR, *and*
- Initial evaluation of the worker, including DSM-5 diagnosis with supporting documentation to support the diagnosis and pre-screening intake, if conducted, *and*
- Request for authorization for ongoing treatment.

The recommended treatment plan and all treatment records must be submitted to the insurer for authorization of ongoing treatment.

Note: Each facility may require their own release of record form, however, the insurer's ROA/PIR requires a signature by the worker to release relevant **medical records**. The insurer determines 'relevant.' The ROA/PIR may be used in lieu of the facility's release of records form.

Claim status

The following are example claim statuses of workers who seek treatment at a residential treatment facility for mental health services:

1. Initial claim filing, evaluation **without** treatment. In this case, the worker may seek initial evaluation from a facility without prior authorization, but may not receive a mental health diagnosis per DSM-5 or require ongoing treatment. The insurer covers the **initial visit** and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility are submitted within 1 year from date of service. See Chapter 2: Information for All Providers for additional details on **initial visits**.
2. Initial claim filing, evaluation **with** treatment. In this case, the worker may seek treatment from a facility and may require ongoing treatment of a DSM-5 diagnosis. The insurer covers the **initial visit** and evaluation so long as the L&I ROA or self-insured PIR and documentation of the initial evaluation conducted by the facility is submitted within 1 year from date of service. Prior authorization is required before initiating treatment. See the Mental Health Services webpage, this chapter, and the prior authorization requirements below for additional details.
3. Established claim. In these cases, an L&I worker's compensation claim is open and allowed and requires prior authorization for treatment. See prior authorization requirements below for additional details.

In order to assist the worker and their providers, the insurer requires timely documentation. See documentation requirements below for additional details.

Treatment beyond the first visit and evaluation won't be paid when a claim is rejected.

Treatment

A referral from either the **attending provider (AP)** or a mental health provider (psychiatrist, psychiatric ARNP, psychologist) is required prior to admission for open and allowed claims.

Prior authorization

Mental health prior authorization treatment requirements apply to claims filed through a residential treatment facility for mental health services. Contact the insurer for prior authorization.

For workers with an open and allowed claim for accepted mental health conditions and treatment has been authorized, the following is required:

Inpatient/Residential treatment:

- An evaluation by the facility, including a treatment plan, must be sent to the insurer for authorization **prior** to initiating treatment. The start date for treatment must be submitted as part of the evaluation.
- Initial authorization is up to 6 weeks. For treatment lasting longer than 6 weeks additional authorization is required. Contact the insurer for prior authorization. An updated treatment plan is required for additional authorization.

Ongoing outpatient treatment:

- Continuation of mental health treatment by the facility in an outpatient setting requires authorization. The facility must submit an updated treatment plan as part of the authorization request. Facilities aren't required to develop an updated treatment plan once the worker has transferred care to an AP.

Discharge:

- Upon discharge, the facility must coordinate and transfer the worker's care back to the AP and/or referring provider. If the worker does not have an AP prior to admission, the facility must help the worker identify an AP prior to discharge and then coordinate and transfer the worker's care to the identified AP. The AP is responsible for managing the overall care of the worker after discharge from a residential treatment facility for mental health services. The worker has the right to choose their AP.

Payment methods

Bill the insurer usual and customary fees.

Washington state facilities will be paid POAC, DRG, or fee schedule amounts. See Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs) for details.

Out of state facilities will be paid at the out-of-state POAC rate. See Chapter 26: Hospitals and Ambulatory Surgical Centers (ASCs) for details.

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for a worker admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via POAC rate.

Who must perform these services to qualify for payment

Washington State residential treatment facilities for mental health services must be certified and licensed by the Washington State Department of Health.

Out of state residential treatment facilities for mental health services must be licensed by the state the facility is located in, and accredited by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or any other state-approved accrediting organization.

See All mental health services for additional details on who can provide mental health services.

Services that can be billed

The insurer covers the following codes with prior authorization:

- **H0035**
- **H0047-H0050**
- **H2035**
- **H2036**
- **S9480**

This is in addition to the codes found in L&I's professional provider fee schedule.

Services that aren't covered

In addition to the codes not covered on the fee schedule, the following services aren't covered:

- **H0031-H0032**
- **H0036-H0040**
- **H0046**
- **H2001**
- **H2010-H2034**
- **H2037-H2038**

Requirements for billing

All charges for hospital inpatient and outpatient services provided to workers must be submitted on a UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications.

Documentation requirements

Per Chapter 2: Information for All Providers, chart notes and any treatment plan updates, must be submitted to the insurer.

In addition to the requirements noted in Chapter 2: Information for All Providers and this chapter, all facilities must provide the insurer with the following documentation:

- Causality statement for the industrial injury or occupational disease (DSM-5 diagnosis) for initial claim filing, *and*
- The initial evaluation from a provider at the facility when the worker is admitted, *and*
- A recommended course of action for the worker, *and*
- Treatment that was provided, *and*
- Progress reports on a bi-weekly basis, *and*
- Discharge summary, including but not limited to, ongoing treatment plan for the worker when they return to their AP and/or mental health provider; assessment of worker's psychological status especially as related to reintegration in the workplace, home and community; and communication with the AP, referring provider, claim manager, assigned vocational counselor or family to support the worker's continued management of mental health condition, *and*
- The worker's full name, *and*
- L&I claim number, *and*
- Time as required per CPT® or HCPC coding, *and*
- Treating provider name, address and telephone number.

Don't fax the treatment plans or chart notes with bills. See Chapter 2: Information for All Providers for details on submitting chart notes and treatment plans to the insurer.

Additional information

Providers may not charge workers for copayments or deductibles. The worker may not be balance billed for any services that are claim related. See RCW 51.04.030(2) and WAC 296-20-020.

Payment policy: Structured, intensive, multidisciplinary program (SIMP)

General information

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP (structured intensive multidisciplinary program).**

For purposes of this policy, a **SIMP** means a chronic pain management program with the following 4 components:

- **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
- **Intensive** means the Treatment Phase is delivered on a daily basis, 6 to 8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
- **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare professionals with expertise in pain management in at least the areas of medicine, psychology, and physical therapy or occupational therapy. The **SIMP** may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits, *and*
- **Program** means an interdisciplinary pain rehabilitation program that provides outcome focused, coordinated, goal oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Prior authorization is required for all workers to participate in a **SIMP** for functional recovery from chronic pain. See details about prior authorization requirements later in this Payment policy section.

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

For the purposes of this policy, a treatment plan means an individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and

addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

For the purposes of this policy, validated tests and instruments are those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

Program design: Phases of an approved SIMP

An approved **SIMP** has 3 phases:

- Evaluation Phase,
- Treatment Phase, and
- Follow up Phase.

See below for details about each of these 3 phases.

1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes treatment plan development and a report. Only 1 evaluation is allowed per authorization but it can be conducted over 1 to 2 consecutive business days. The evaluation is a comprehensive evaluation and must be performed in person by the interdisciplinary team of physician, psychologist, and physical or occupational therapist and may include other specialties as appropriate.

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants (PA-C) can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*
- Review of **medical records** and reports, including diagnostic tests and previous efforts at pain management, *and*
- Assessment of any important associated medical or psychological conditions (often referred to as co-morbid conditions) that may hinder functional recovery from pain, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease, *and*
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs. This must include checking the Prescription Monitoring Program Database *and*
- Psychological and bio-psycho-social assessment by a licensed clinical psychologist using validated tests and instruments for use with individuals with chronic pain, *and*
- Identification of the worker's family and support resources and perceived social support, *and*

- Identification of the worker's reasons and motivation for participation and improvement, and goals from the program *and*
- Identification of factors that may affect participation in the program, *and*
- Assessment of pain and function using validated tests and instruments; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
    - Activities of Daily Living (ADLs),
    - Range of Motion (ROM),
    - Strength,
    - Stamina, *and*
    - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the **SIMP** vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for **SIMP** workers section of this chapter), *and*
- A summary report of the evaluation and a preliminary recommended treatment plan. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6 to 8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical and/or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities or daily activites guided by a physical and/or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the **attending provider**, claim manager, family, employer, vocational rehabilitation counselor and community resources as needed to accomplish the goals set forth in the treatment plan, *and*

- **Education and skill development** on the factors that contribute to pain, responses to pain, and effective pain management, *and*
- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using validated tests and instruments consistent with those at evaluation, *and*
- **Ongoing assessment** of important associated conditions, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment. This must include checking the Prescription Monitoring Program Database, *and*
- **Performance** of real or simulated work or daily functional tasks, *and*
- **SIMP vocational services**: these may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and* a discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase.
- At time of discharge, the **SIMP** physician must call the **attending provider** to discuss the worker's treatment in the program, progress, barriers, and discharge plan. *and*
- **A summary report** at the conclusion of the Treatment Phase that addresses all the following questions:
  - To what extent did the worker meet their treatment goals?
  - What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?
  - What changes if any, have occurred in the worker's pain level and functional capacity as measured by validated tests and instruments (consistent with the tools used during evaluation)?
  - What changes if any, have occurred in the worker's ability to self-manage pain?
  - What is the status of the worker's readiness to return to work or daily activities?
  - What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
  - How much and what kind of follow up care does the worker need?

3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into their job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), or
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

- Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.
- Non face-to-face services are when the **SIMP** provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in their community, activity levels, and support systems,
- What was done during the Follow up Phase,

- What resulted from the follow up care, and
- Measures of pain and function using validated tests and instruments (consistent with the tools used during the **SIMP** program)

This summary report must be submitted at the 1, 3, and 6 month marks; if applicable.

Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with validated tests and instruments, *and*
- Evaluating whether the worker is adherent to their home and work program that was developed at the conclusion of the Treatment Phase, *and*
- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing important associated conditions and psychological status especially as related to reintegration in the workplace, home, and community, *and*
- Assessing level and type of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical and/or occupational therapist, *and*
- Adjusting the worker's home and work program for self-management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*
- Teaching new techniques or skills that weren't part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the **attending provider**, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued self-management of chronic pain, *and*
- Making recommendations for assistance or accommodations in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in their community to learn about the worker's current status and needs and help them find the needed resources, *and*
- Holding case conferences with the:
- Interdisciplinary team of clinicians, *and/or*
- Worker's **attending provider**, *and/or*
- Other individuals closely involved with the worker's care and functional recovery.

Follow up Phase special considerations

When determining what follow up services the worker needs, **SIMP** providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a **SIMP** provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the **SIMP** provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*
- If a **SIMP** provider wishes to coordinate the delivery of physical and/or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

Link: More information about Helping Workers Get Back to Work is available online.

Prior authorization

General referral and prior authorization requirements

All **SIMP** services require prior authorization by the claim manager and a referral from the worker's **attending provider**. An occupational nurse **consultant**, claim manager, or insurer-assigned vocational counselor may recommend a **SIMP** evaluation for the worker, but only the **attending provider** can make a referral.

Note: Only the **attending provider** can refer a worker for a **SIMP** evaluation.

SIMP referral

SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the **attending provider** refers a worker to a **SIMP**, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the **SIMP** provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the **SIMP** provider recommends the worker move on to the Treatment Phase, the **SIMP** provider must provide the insurer with a report and treatment plan as described under the Evaluation Phase, *or*

- **Doesn't meet the requirements**, the **SIMP** provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*
  - The goals the worker must meet before they can return and participate in the program, *also*
  - If the worker is found to have important associated conditions during the Evaluation Phase that prevent them from participating in the Treatment Phase, the **SIMP** provider must either treat the worker or recommend to the worker's **attending provider** and the claim manager what type of treatment the worker needs.

Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

SIMP provider requirements

To provide functional restoration / chronic pain management program services to eligible workers, **SIMP** service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see General information section earlier in this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, *and*
- Ensure care is coordinated regularly amongst the interdisciplinary team, *and*
- Communicate and coordinate with providers claim managers, family, employer and vocational counselor, who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's **attending provider**, *and*
- Inform the claim manager if the worker:
  - Stops services prematurely,
  - Has unexpected adverse occurrences, or
  - Doesn't meet the worker requirements (see Worker requirements section below)
- Communicate with the worker during treatment to ensure they understand and follow the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*

- Provide the insurer with the required documentation in a timely manner (Evaluation Summary Report, all daily chart notes, Treatment Phase Summary Report including the discharge care plan, Follow up visit notes, and Follow Up Summary Report).
  - Documentation of team meetings and/or care conferences must include participants
- Coordinate the worker's transition and reintegration back to their home, community, and/or employment.
- Provide the Department with the **SIMP** organization structure annually.
- Notify the Department in writing of key organization changes within 30 days.
- New programs must provide the Department contact information with the provider application and be available to provide additional information, as needed.

  For applicable programs, the Department must be notified of substantial material changes to the program description in writing within 30 days. Providers must maintain CARF accreditation and provide the Department with documentation of satisfactory recertification including the latest CARF Accreditation Report. This information is required to be submitted to the Department within 30 days of receipt of the report. A provider's account will be inactivated if CARF accreditation expires or this information isn't received from the provider. It is the provider's responsibility to notify the Department when an accreditation visit is delayed.

  For any existing **SIMP** provider wanting to add a new site to the **SIMP** program, they must provide the L&I's Provider Accounts and Credentialing unit with a copy of the completed *CARF OCForm_Relocation_Expansion_Elimination* to be added to your provider account file. Additionally, **SIMP** provider must provide the Department with contact information for the new site and be available to provide additional information, as needed.

Worker requirements

A worker must make a good faith effort to participate and adhere to the treatment plan prescribed for them by the **SIMP** provider. To complete a **SIMP** successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of their treatment plan, *and*
- Be psychologically stable enough to understand and follow instructions and to fully engage in treatment, including between session work, and work toward the goals that are part of their treatment plan, *and*
- Agree to be evaluated and adhere to treatment prescribed for any important associated conditions that may hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and/or other unmanaged chronic disease), *and*
- Attend each day and each session that is part of their treatment plan. Sessions may be made up if, in the opinion of the provider, it wouldn't interfere with the worker's progress toward treatment plan goals, *and*
- Cooperate and adhere to their treatment plan, *and*
- Not pose a threat or risk to themself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help their transition back to home, community, and/or workplace.

Services that can be billed

SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table. The fee schedule applies to workers only in an outpatient program:

Description	Local code	Duration / limits	Units of service	Maximum fee
SIMP Evaluation Services	**2010M**	1 evaluation per authorization, which may be conducted over 1 to 2 consecutive business days.	Bill only 1 unit for evaluation even if conducted over 2 days	**$1,343.26**
SIMP Treatment Services, each 6-8 hour day	**2011M**	Not to exceed 20 treatment days (6-8 hours per day).	1 day equals 1 unit of service	**$860.39** per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community	**2014M**	Not to exceed 4 hours per day and not to exceed 24 hours total (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.81** per minute (**$108.60** per hour)
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community	**2015M**	Not to exceed 40 hours (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.41** per minute (**$84.60** per hour)

Description	Local code	Duration / limits	Units of service	Maximum fee
Outpatient Day Program - Lunch for **meal** reimbursement	**5934M**	Worker must be onsite for treatment of more than 4 hours. Prior authorization required. Don't bill for **meals** not provided to or paid for by the worker.	1 **meal** per authorized person	**State Rate** (includes taxes & gratuity)
Mileage for traveling to and from the worker's community	**0392R**	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

Requirements for billing

Outpatient functional restoration / chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form (F245-127-000).

Billing for partial days for the treatment phase

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the worker was scheduled for less than 8 hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill **$860.39** x 25% = **$215.10**

Payment limits

SIMP evaluation services

Only 1 evaluation per authorization is allowed, which may be conducted over the course of 1 to 2 days consecutive business days. If the evaluation is conducted over a 2 day period, bill only 1 unit and span the dates.

SIMP treatment services

These services can't exceed 20 treatment days (6-8 hours per day).

SIMP follow up services

Face-to-face services (local code **2014M**) can't:

- Exceed 4 hours per day, *and*
- 24 hours total.

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Note: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit.

Payment policy: Vocational services for SIMP workers

General information

This policy is for workers participating in **SIMP**-related vocational services.

For non-**SIMP** vocational services, see Chapter 25: Vocational Services.

Prior authorization

Prior to authorizing participation in a **SIMP**, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

- Is working, *or*
- Is scheduled to return to work, *or*
- Has been found employable or not likely to benefit from vocational services.

Requirements for a Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with **SIMP** treatment and the claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the **outcomes** listed in the Return to Work Action Plan **must be included** with the Treatment Phase summary report.

If a vocational counselor is assigned, the **SIMP** will coordinate with vocational counselor as needed to agree upon a Return to Work Action Plan with a return to work goal.

Note: Don't forget to include the outcomes from the Return to Work Action Plan in your Treatment Phase Summary Report.

Return to Work Action Plan roles and responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the **SIMP** vocational counselor, the **attending provider**, and the worker are involved.

The specific roles and responsibilities of each are as follows:

The SIMP vocational counselor will:

- Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
- Present the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the **SIMP** recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.

The insurer assigned vocational counselor will:

- Co-develop the Return to Work Action Plan with the **SIMP** vocational counselor, *and*
- Attend the functional restoration / chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
- Negotiate with the **attending provider** when the initial Return to Work Action Plan isn't approved in order to resolve the **attending providers** concerns, *and*
- Obtain the worker's signature on the Return to Work Action Plan, *and*
- Communicate with the **SIMP** vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
- Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

The attending provider will:

- Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
- Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
- Communicate with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.

The worker will:

- Participate in the selection of a return to work goal, *and*
- Review and sign the final Return to Work Action Plan, *and*
- Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

Link: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for billing procedures	Washington Administrative Code (WAC) 296-20-125
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Crime Victims Compensation Program contact information	**Phone**: 1-800-762-3716 (toll free) **Fax**: 1-360-902-5333 Crime Victims on L&I's website
Fee schedules for all healthcare services	Fee schedules on L&I's website
Return to work: "Helping Workers Return to Work"	Helping Workers Return to Work on L&I's website
Self-insured claims authorization from the self-insured employer (SIE) or their third party administrator (TPA)	Contact list of SIE/TPAs on L&I's website
Worker refuses to cooperate with care plan: Legal issues defined in Washington state laws	Revised Code of Washington (RCW) 51.32.110

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.