Washington State Department of Labor & Industries

Chapter 28: Skilled Nursing, Home Health, and Residential Care

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: All residential care services

General requirements

The insurer covers:

- Proper and necessary residential care services that require **24 hour institutional care** to meet the worker's needs, abilities, and safety, *and*
- Medically necessary hospice care, comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

Services must be:

- Proper and necessary,
- Required due to an industrial injury or occupational disease,
- Requested by the **attending provider**, *and*
- Authorized by an L&I ONC (occupational nurse consultant) or self-insured employer before care begins.

Prior authorization and reauthorization requirements

Initial admission

Residential care services require prior authorization. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator.

Link: For authorization procedures on a self-insured claim, contact the self-insurer.

When care needs change

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for reauthorization of the workers care.

Who must perform these services to qualify for payment

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for twenty-four hour institutional care including:

- Skilled Nursing Facilities (SNF),
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital,
- Critical Access Hospitals (CAHs) licensed by DOH and Veterans Hospitals using swing beds to provide long term care or sub-acute care,
- Adult Family Homes,
- Assisted Living Facilities,
- Secure Residential Facilities,
- Boarding Homes, *and*
- Hospice care providers.

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

TCUs must obtain a separate provider number from L&I.

Services that aren't covered

Adult day care center facilities or assisted living facilities performing adult day care services

Services provided in adult day care center facilities aren't covered by the insurer.

Pharmaceuticals and durable medical equipment (DME)

Residential facilities can't bill for pharmaceuticals or **DME**. Pharmaceuticals and **DME** required to treat the worker's accepted condition must be billed by a pharmacy or **DME** supplier.

Note: Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing drugs or physical therapy using **DME** codes is improper coding and will delay payment while being investigated.

Requirements for billing

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this chapter. All residential care services should be billed on form F245-072-000 (Statement for Miscellaneous Services).

Link: The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125.

Additional information: Residential services review, periodic independent nursing evaluations

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to:

- Onsite review of the worker, and
- Review of **medical records**.

All services rendered to workers are subject to audit by L&I.

Links: For more information, see RCW 51.36.100 and RCW 51.36.110.

Payment policy: Assisted living facilities, adult family homes, and boarding homes

Requirements for the Residential Care Assessment Tool

At the insurers' request, a Residential Care Assessment Tool (form F245-377-000) must be completed by an independent Registered Nurse (RN) or an L&I ONC based in the field:

- Within 30 days of admission, *and*
- At least once per year after the initial assessment.

The insurer will determine the appropriate L&I payment grouping based on the nursing assessment of the worker's **personal care** needs. Services must be proper and necessary and related to the worker's industrial injury or covered under a department medical treatment order. Facilities shouldn't submit bills for the assessment; the nurse who completes the form will bill the Department for their services.

Link: If you are a Nurse Case Manager performing an annual care assessment requested by the department, see Chapter 5: Care Coordination.

Services that can be billed

The insurer will advise the facility of which billing code to use. The 3 levels of care will be applied to all nonskilled nursing facility types. The payment rates are daily payment rates (see table below).

Note: Don't bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

If the **assessment determines the level of care is**…	Then the appropriate **billing code** is…	And the **daily payment rate** is…
Basic level care	**8893H**	**$192.49**
Intermediate level care	**8894H**	**$233.78**
Advanced/Special level care	**8895H**	**$275.03**

Link: For maximum fees (Daily Rates) see the Residential Facility Rates, L&I Payment Group #13 – Assisted Living Facilities, Adult Family Homes and Boarding Homes, on the Residential Facility Rates L&I fee schedule.

Services that can't be billed

L&I won't pay adult family homes or other residential care when the injured worker isn't present, such as when hospitalized or on vacation.

L&I won't pay bed hold fees, admission fees, or any services not defined by the fee schedule.

Payment policy: Attendant home care services

General information

Attendant home care services are proper and necessary **personal care** services provided to maintain the injured worker in his or her residence.

Attendant services support **personal care** or assist with activities of daily living of a medically stable worker with physical or cognitive impairments. Attendant home care services are provided in the workers' home.

Link: See WAC 296-23-246 for details about attendant services.

Prior authorization

All attendant care services require prior authorization.

The insurer will determine maximum hours and type of authorized attendant care based on a nursing assessment of the worker's **personal care** needs.

Services must be proper and necessary and related to the worker's industrial injury or covered under a department medical treatment order.

Attendant care services may be **terminated or not authorized if**:

- Behavior of worker or others at the place of residence is threatening or abusive,
- Worker is engaged in criminal or illegal activities,
- Worker doesn't have the cognitive ability to direct the care provided by the attendant and there isn't an adult family member or guardian available to supervise the attendant,
- Residence is unsafe or unsanitary and places the attendant or worker at risk, *or*
- Worker is left unattended during approved service hours by the approved provider.

The insurer will notify the provider in writing when current approved hours are modified or changed.

Attendant care agency requirements

Attendant care services may be provided by a *home health licensed agency* or a *home care licensed agency*. The agency providing services must be able to provide the type of care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

Attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services.

The agency can bill workers for hours that aren't approved by the insurer if the worker is notified in advance that they are responsible for payment.

Home Health Agencies

Home health agencies provide skilled nursing and therapy related services. Home health agencies must have RN supervision of caregivers providing care to a worker.

Examples of services include nursing and home health aide.

Home Care Agencies

Home care agencies provide non-medical services to people with functional limitations.

Examples of non-medical services include: Activities of daily living, such as assistance with ambulation, transferring, bathing, dressing, eating, toileting, and personal hygiene to facilitate self-care.

Attendant care provider requirements

Caregivers and services provided are dependent on the type of agency license providing the services and the needs of the worker.

Payment limits

Reimbursement for attendant care services includes supervision and training and isn't billed separately (this doesn't include nurse delegation).

Attendant care providers can't bill for services the attendant performs in the home while the worker is away from the home.

The insurer won't pay services for more than 12 hours per day for any 1 caregiver, unless specifically authorized.

The insurer won't pay for care during the time the caregiver is sleeping.

Services that can be billed

HCPCS code	Description	Max fee
S9122	Attendant in the home provided by a certified home care aide or certified nurse assistant per hour	**$43.43**
S9123	Attendant in the home provided by a registered nurse per hour	**$87.29**
S9124	Attendant in the home provided by licensed practical nurse per hour	**$63.06**

Link: To see which codes require prior authorization, see the HCPCS fee schedule.

Documentation requirements

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift,
- Printed name of caregiver, initials, signature and title of each caregiver, and
- Specific care provided and who provided the care.

Chore services

Chore services (housecleaning, laundry, shopping, menu planning and preparation, transportation of the injured worker, errands for the injured worker, recreational activities, yard work, and child care) and other services that are only needed to meet the worker's environmental needs aren't covered.

Link: Chore services aren't a covered benefit. See WAC 296-23-246.

Attendant care services in hospitals or nursing facilities

Attendant care services won't be covered when a worker is in the hospital or a nursing facility unless:

- The worker's industrial injury causes a special need that the hospital or nursing facility can't provide, and
- Attendant care is authorized specifically to be provided in the hospital or nursing facility.

Independent nurse evaluation reports

All RN evaluation reports must be submitted to the insurer:

- Within 15 days of the initial evaluation, *and then*
    - Annually, *or*
    - When requested, *or*
    - When the worker's condition changes and necessitates a new evaluation.

If a current nursing assessment is unavailable, a nursing evaluation will be conducted to determine the level of care and the maximum hours of **personal care** needs the worker requires.

An independent nurse evaluation requested by the insurer may be billed by a Nurse Case Manager or Home Health Agency RN. Home Health Agency RNs bill code **G0162**, 1 unit per 15 minutes. Nurse Case Managers, see Chapter 5: Care Coordination for additional details.

Wound care

When attendant care agencies are providing care to a worker with an infectious wound, prior authorization and prescription from the treating physician are required.

In addition to prior authorization, when caregivers are providing wound care a prescription from the treating provider is required to bill for infection control supplies (HCPCS code **S8301**).

An invoice for the supplies must be submitted with the bill.

Worker travel

Workers who qualify for attendant care and are planning a long-distance trip must inform the insurer of their plans and request specific authorization for coverage during the trip.

The insurer won't cover travel expenses of the attendant or authorize additional care hours.

Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

The worker must coordinate the trip with the appropriate attendant care agencies.

Temporary or respite care

If in-home attendant care can't be provided by an agency, the insurer can approve a temporary stay in a residential care facility or skilled nursing facility.

Temporary or respite care requires prior authorization. The agency providing respite care must meet L&I criteria as a provider of home care services.

The insurer can approve home care services to provide respite (relief) for a spouse or family member who provides either paid or unpaid attendant care.

Note: Spouses won't be paid for respite care.

Spouse attendant care

Spouses may continue to bill for spouse attendant care if they:

- Aren't employed by an agency, *and*
- Provided insurer approved attendant services to the worker prior to October 1, 2001, *and*
- Met criteria in the year 2002.

Link: For more information on laws about spouse attendant care, see WAC 296-23-246.

Spouse attendants may bill up to 70 hours per week. Also:

- Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation, which must be performed yearly, *and*
- If the worker requires more than 70 hours per week of attendant care the insurer can approve a qualified agency to provide the additional hours of care, *and*
- The insurer will determine the maximum amount of additional care based on an RN evaluation.
- Spouse attendants won't be paid during sleeping time.

Services that can be billed

HCPCS code	Description	Max fee
8901H	Spouse attendant in the home per hour	**$16.66**

Documentation requirements

For each day care is provided, chart notes should include documentation to support billing, must be submitted to the insurer and include:

- Begin and end time of caregiver's shift,
- Printed name of caregiver, initials, signature of caregiver, *and*
- Specific care provided.

Payment policy: Home health services

General information

When services become proper and necessary to treat a worker's accepted condition, the insurer will pay for aide, registered nurse (RN)/licensed practical nurse (LPN), physical therapy (PT), occupational therapy (OT), and (ST) speech therapy services provided by a licensed home health agency.

Home health services are multidisciplinary (RN, LPN, nursing aide, PT, OT, speech) assessments and interventions for short-term rehabilitative therapy, home assessments for equipment and safety and long term nursing supervision for wound care, bowel and bladder management.

Most home health services provided are interventions to improve function and safety between hospital care and outpatient care and therapy. These services aren't intended for attendant care delivered in the home. The expectation of home health services is to enable the worker to receive outpatient, rehabilitative or medical services.

The following types of need are examples of when home health therapies may be approved:

- Post injury or post-surgical activity restrictions, restrictions on the ability to use 2 or more extremities, bilateral non-weight bearing restriction, or post-operative infection requiring IV antibiotics;
- Inability to ambulate or inability to maneuver a wheelchair;
- Inability to transfer in or out of a vehicle with or without assistance;
- Inability to safely negotiate ingress or egress of residence;
- Unable to sit (supported or unsupported) or alternate between sitting and standing for up to 2 hours;
- Inability to bathe or dress themselves if they live alone.
- No available transportation service exists due to rural setting; *or*
- No outpatient facilities are available to provide medically necessary care.

Links: For additional information on **home health services**, see WAC 296-20-03001(8) and WAC 296-23-246.

Link: For home infusion services, see Chapter 12: Injections and Medication Administration.

Prior authorization

All home health services require prior authorization.

The insurer will determine maximum hours and type of authorized home health care based on a nursing assessment of the worker's **personal care** needs that are proper and necessary and related to the worker's industrial injury.

All home health services must be requested by a physician. The insurer will only pay for proper and necessary services required to address conditions caused by the industrial injury or disease.

Home health services may be terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

Who must perform these services to qualify for payment

Home health agencies provide skilled nursing and therapy related services. They must be licensed as a home health agency.

Services for which home health agencies may bill include:

- Nursing
- Home health aide
- Physical therapy
- Occupational therapy
- Speech therapy

Providers who perform services for home health agencies must be one of the following: Aide, RN, LPN, PT, OT, or ST.

Services that can be billed

HCPCS code	Description and notes	Max fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day	**$45.83**
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day	**$47.53**
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day	**$47.53**
G0159	Plan of care established by Physical Therapist in the home, 15 min units	**$47.53**
G0160	Plan of care established by Occupational Therapist in the home, 15 min units	**$47.53**
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units	**$47.53**
G0299	Services of skilled nurse RN in the home. 15 min units	**$47.53**
G0300	Services of skilled nurse LPN in the home. 15 min units	**$42.75**
8970H	Home Health Aide Service up to 2 hours	**$86.86**
8971H	Home Health Aide Services each additional 15 minutes	**$10.86**

Payment limits

Home Health Aide Service codes **8970H** and **8971H** can only be billed when there is RN oversight.

Base Rate Code **8970H** is billable once per day and covers up to 2 hours.

Add-on Code **8971H** is only billable with Base Rate Code **8970H**. Each unit of **8971H** equals 15 minutes. Up to 8 units per day are billable.

For **8970H** and **8971H** the insurer follows the timed code policies established by CMS in section 20.2 (reporting of service units with HCPCS), chapter 5 of the Medicare Claims Processing Manual (Internet-Only Manual 100-04).

Documentation requirements

The following documentation is required to be submitted by the home health care provider within 15 days of beginning the services:

- **Attending provider**'s treatment plan and/or orders by the **attending provider**,
- An initial evaluation by the RN or PT/OT (bill using **G0159**, **G0160**, and **G0162** see table above), *and*
- A treatment plan.

Updated plans must be submitted every 30 days thereafter for authorization periods greater than 30 days.

Providers must submit documentation to the insurer to support each day billed that includes:

- Begin and end time of each caregiver's shift,
- Name, initials, and title of each caregiver, *and*
- Specific care provided and who provided the care.

Authorization for continued treatment requires:

- Documentation of the worker's needs and progress, *and*
- Renewed authorization at the end of an approved treatment period.

Durable medical equipment (DME)

Durable medical equipment may require specific authorization prior to purchase or rental. Codes that require prior authorization are noted with a Y in the "PRIOR AUTH" column.

Link: To see which codes require prior authorization, see the HCPCS fee schedule.

Worker responsibilities

The worker is expected to be present and ready for scheduled home health nurse or therapist treatment. The insurer may terminate services if the work isn't present, refuses treatment or assessment.

Payment policy: Hospice care

Requirements for billing

Pharmacy and **DME** are payable when billed separately using appropriate HCPCS codes.

Hospice programs must bill the following HCPCS codes:

If **hospice care is provided in**…	Then bill for services using **HCPCS code**:	Which has a **maximum fee** of:
Nursing long term care facility	**Q5003**	**By report**
Skilled nursing facility	**Q5004**	**By report**
Inpatient hospital	**Q5005**	**By report**
Inpatient hospice facility	**Q5006**	**By report**
Long term care facility	**Q5007**	**By report**
Inpatient psychiatric facility	**Q5008**	**By report**
Place NOS	**Q5009**	**By report**

Payment limits

Hospice claims are paid on a **by report** basis (see table above).

Occupational, physical, and speech therapies are included in the daily rate and aren't separately payable.

Payment policy: In-home hospice services

Prior authorization

In-home hospice services must be prior authorized and may include chore services. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

Services that can be billed

HCPCS code	Description and notes	Max fee
Q5001	Hospice care, in the home, per diem. Applies to in-home hospice care.	**By report**

Payment policy: Skilled nursing facilities

Requirements for the Minimum Data Set Basic Assessment Tracking Form

Within 30 working days of admission, nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker. The completed MDS must be sent to the ONC or SIE/TPA for authorization of the appropriate billing code.

This form or similar instrument will also determine the appropriate L&I payment. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment code to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

Payment policy: Skilled nursing facility and transitional care unit beds

Payment methods

L&I uses a modified version of the Patient Driven Payment Model (PDPM) through the use of Health Insurance Prospective Payment System (HIPPS) skilled nursing facility (SNF) codes for developing nursing home payment rates.

The fee schedule for SNF and transitional care unit (TCU) beds is a series of HIPPS codes tied to a series of 11 local codes. The items covered include:

- Room rates,
- Therapies, *and*
- Nursing components depending on the needs of the worker.

Payment limits

Medications aren't included in the L&I rate.

Prior authorization requirements

A HIPPS code must be sent to an ONC or SIE/TPA for authorization of the appropriate billing code. For a listing of HIPPS and local code combinations as well as maximum fees, see L&I's fee schedule.

Services that can't be billed

L&I won't pay nursing homes or other residential care when the injured worker isn't present, such as when hospitalized or on vacation.

L&I won't pay bed hold fees, admission fees, or any services not defined by the fee schedule.

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
Administrative rules for home health services	Washington Administrative Code (WAC) 296-20-03001(8) WAC 296-20-1102 WAC 296-23-246
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services and professional services	Fee schedules on L&I's website
Minimum Data Set (MDS) Basic Assessment Tracking Form	Medicare's (CMS's) website
Payment policies for **durable medical equipment (DME)**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Payment policies for **physical therapy and occupational therapy**	Chapter 20: Physical Medicine
Payment policies for **supplies**	Chapter 7: Durable Medical Equipment (DME) and Supplies
Statement for Miscellaneous Services form	Statement for Miscellaneous Services form on L&I's website
Washington revised code (state laws) regarding **audits of healthcare providers**	Revised Code of Washington (RCW) 51.36.100 RCW 51.36.110

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.

