Washington State Department of
Labor & Industries

Chapter 1: Introduction

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

General information: About MARFS and this manual

What is MARFS?

The Medical Aid Rules and Fee Schedules (MARFS) is a package of information about how workers' compensation insurers in Washington State pay for healthcare and vocational services provided to injured workers and crime victims.

MARFS encompasses three things:

- **Medical aid rules** published in the Washington Administrative Codes (WACs) for industrial insurance (workers' compensation),
- **Fee schedules** for healthcare and vocational professional provider and facility services, *and*
- This **payment policies manual**.

What is in this manual?

This manual contains 27 chapters of payment policies for healthcare and vocational services provided by individual professional providers or facilities and 4 appendices containing information that's broadly applicable to the entire manual.

A payment policy for a specific service may include information about:

- Prior authorization,
- Who must perform specific services to qualify for payment,
- Services that can be billed or that aren't covered,
- Requirements for billing,
- Documentation requirements,
- Payment limits, *and/or*
- Other information, such as payment methods, background information on coverage decisions, unique requirements, and examples to illustrate billing procedures.

Note: Not every payment policy includes all of these elements. See the fee schedules for prior authorization requirements.

Beyond this introductory chapter, in this manual you will find:

- One chapter on **general policies and information** for all providers,
- Twenty-three chapters for **professional services**, which contain payment policies for individual professional healthcare and vocational providers, and interpreters, and
- Three chapters for **facility services**, which contain payment policies for healthcare facilities,
- Four appendices, which contain commonly used **definitions**, **modifiers**, **place of service codes**, and **reports and forms**.

Note: Within each of the services sections, the chapters appear alphabetically.

What part of MARFS isn't in this manual?

This manual doesn't include:

- Fee schedules, which contain the maximum fees (payment amounts) for the authorized billing codes providers use to bill for services,
- The field key, which explains the column headings and abbreviations that appear in the fee schedules,
- Medical aid rules, which are L&I-specific WACs, *and*
- Updates and Corrections, which contain any changes to policies and fees that occur between annual publications of this manual.

Link: Medical Aid Rules are available in Title 296 WAC on the Washington State Legislature's website.

How do I know if a policy is current?

The policies in this manual are updated and published annually on June 1, and are effective for services provided from the start of the fiscal year (July 1) until the next publication of this manual.

Sometimes fee or policy changes occur between publications of this manual. Such changes are communicated to providers through L&I's Medical Provider News email listserv and are also documented on an Updates & Corrections page on L&I's website.

Link: For information about how to join the email listserv, see the "General information: All payment policies and fee schedules" section of Chapter 2: Information for All Providers.

General information: About the layout and design

How is each chapter organized?

Payment policies for general types of services are organized into individual chapters. Each chapter contains:

- A title page with a **Table of Contents** for the chapter,
- Followed by **payment policies** for specific services, or **general information**, *and*
- At the end of the chapter, a table with links to **related topics**.

Some policies also include definitions of key terms used in that policy. Definitions which apply to the entire manual appear in Appendix A.

Section headers throughout MARFS chapters include:

- **General information** sections, which are collections of information broadly applicable to the topic of the chapter and should be reviewed by all readers,
- **Payment policies**, which are the sets of rules governing when and how providers are paid, *and*
- **Supplemental payment policies**, which are subsections of larger policies that apply to a specific topic or group of providers.

Visual cues

Visual cues and icons appear consistently throughout the payment policies manual. The following is a list of these icons and visual cues, with descriptions of how they are used:

Special terms

Certain terms used throughout this manual have a unique definition. These words are called out with **a special blue color and bold format**. You can find the definitions of these terms in Appendix A: Definitions.

Bulleting

Bullet lists are used to:

- organize complex information, *and*
- break it up into manageable pieces.

Link 

Direct links to related information that may be of interest and assistance are provided. These include links to other chapters within the payment policies manual, helpful websites, forms and documents, or specific WACs and RCWs.

Note 

Notes appear throughout the manual to draw attention to useful information.

Table of Contents 

This icon appears next to the Table of Contents.

General information 

This icon appears next to general information sections.

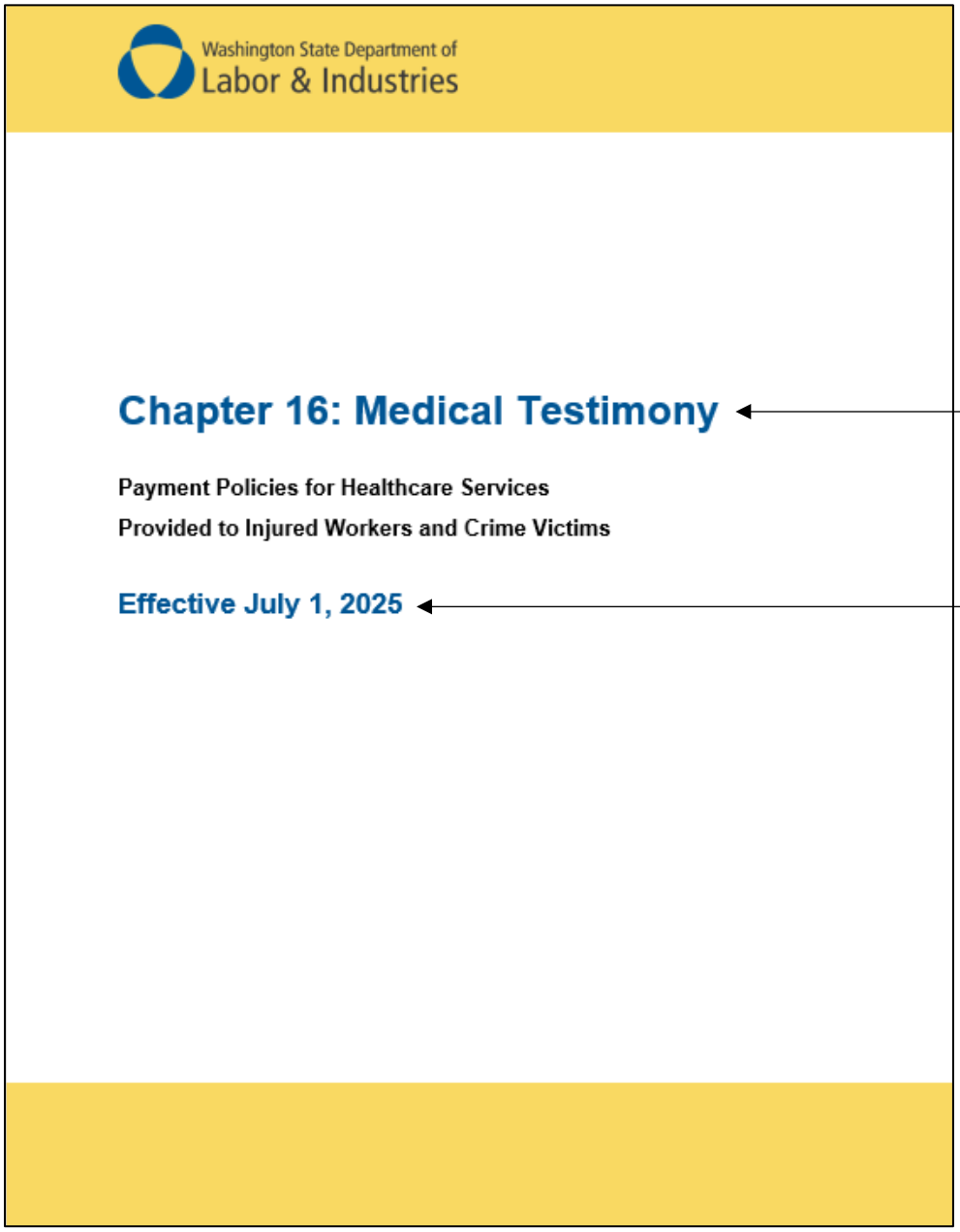
Payment policy 

This icon appears next to each payment policy.

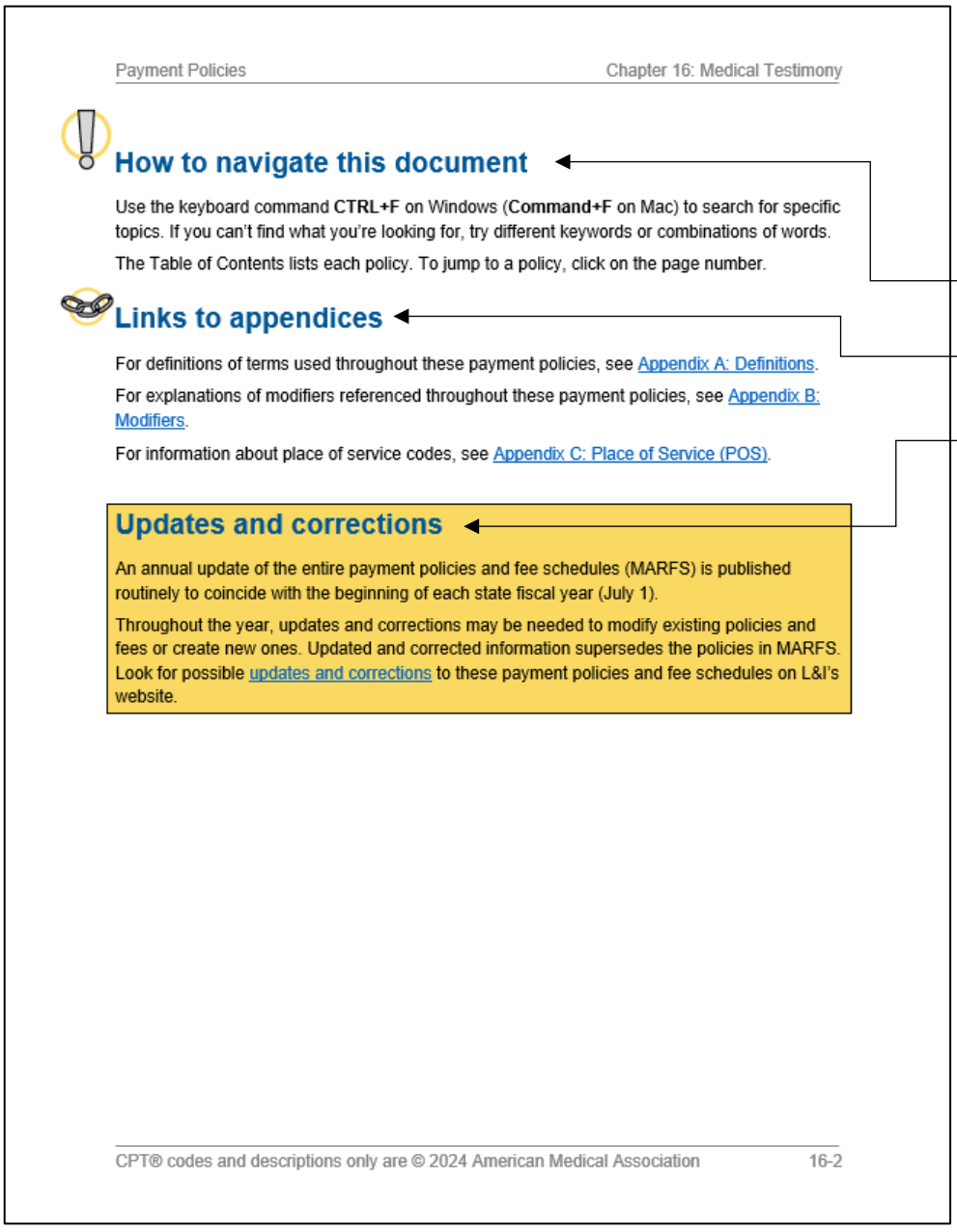
Sample pages

Below are illustrations of actual chapter content to show how information appears throughout.

Sample title page

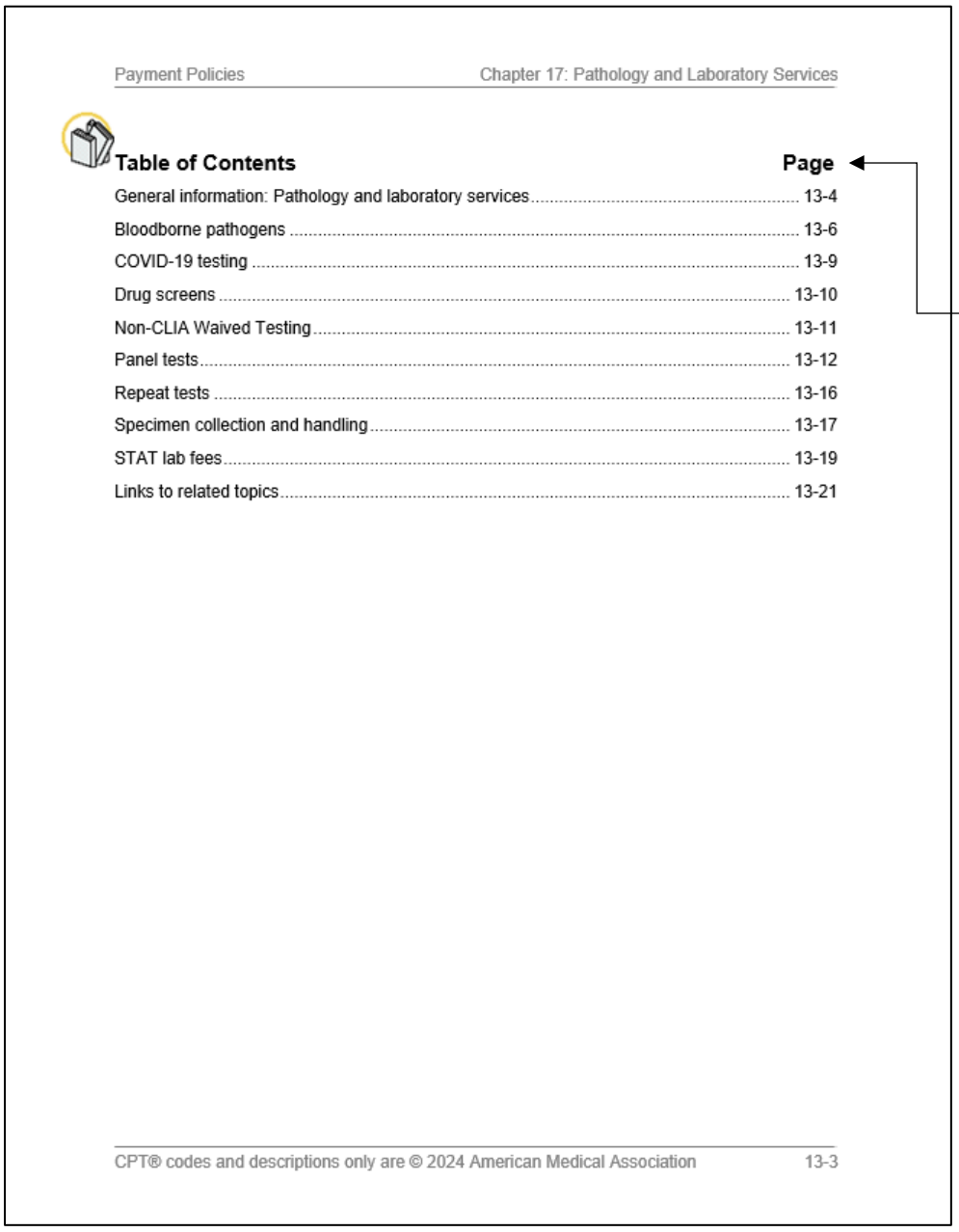


Sample navigation page



Every chapter contains navigation advice, links to the appendices, and a link to updates and corrections.

Sample table of contents



Payment Policies Chapter 17: Pathology and Laboratory Services

Table of Contents **Page**

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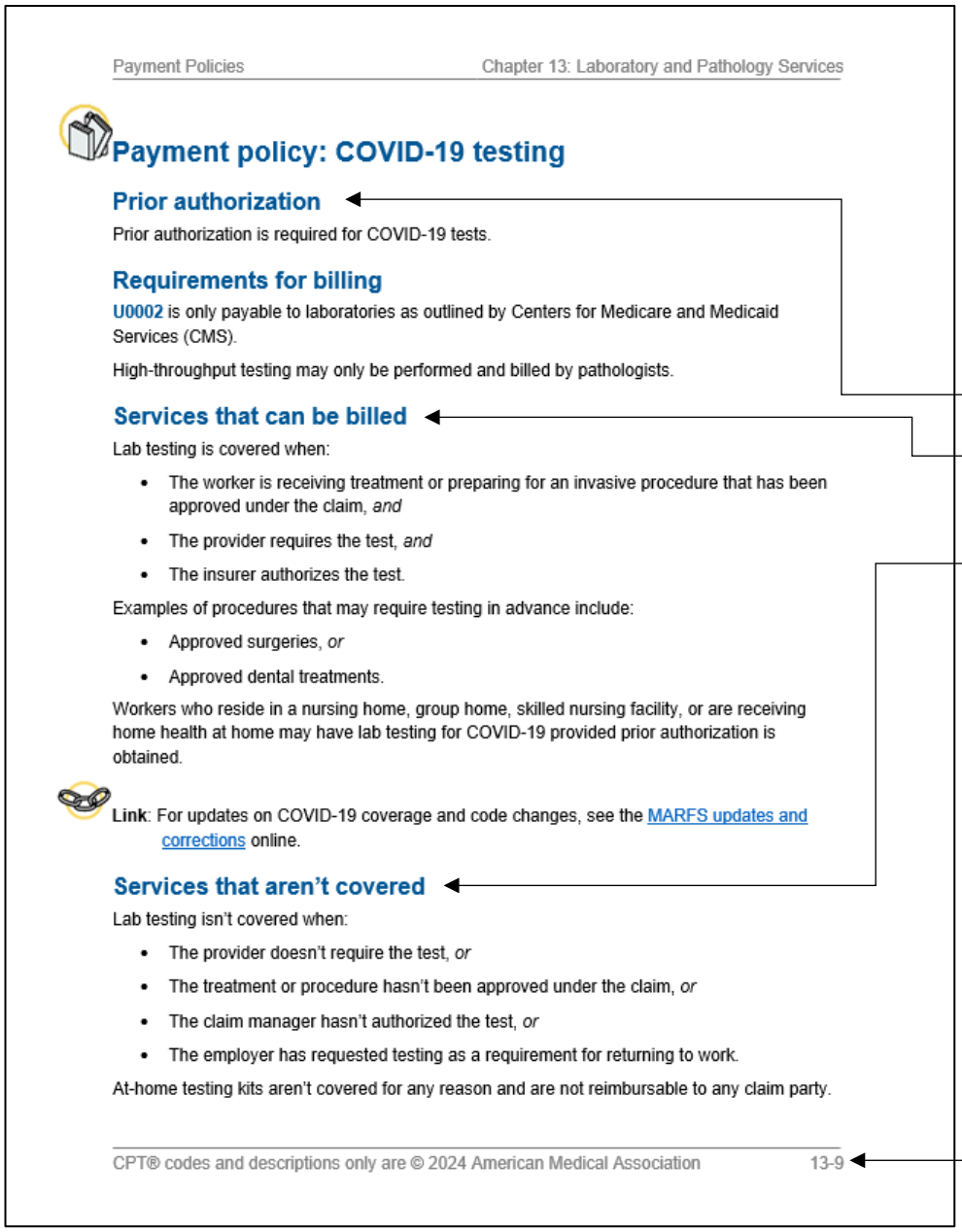
Policies are arranged alphabetically (in most cases). Click on a page number to jump to that section.

Sample payment policy page



Payment Policies Chapter 13: Laboratory and Pathology Services

Payment policy: COVID-19 testing

Prior authorization

Prior authorization is required for COVID-19 tests.

Requirements for billing

U0002 is only payable to laboratories as outlined by Centers for Medicare and Medicaid Services (CMS).

High-throughput testing may only be performed and billed by pathologists.

Services that can be billed

Lab testing is covered when:

- The worker is receiving treatment or preparing for an invasive procedure that has been approved under the claim, *and*
- The provider requires the test, *and*
- The insurer authorizes the test.

Examples of procedures that may require testing in advance include:

- Approved surgeries, *or*
- Approved dental treatments.

Workers who reside in a nursing home, group home, skilled nursing facility, or are receiving home health at home may have lab testing for COVID-19 provided prior authorization is obtained.

Link: For updates on COVID-19 coverage and code changes, see the MARFS updates and corrections online.

Services that aren't covered

Lab testing isn't covered when:

- The provider doesn't require the test, *or*
- The treatment or procedure hasn't been approved under the claim, *or*
- The claim manager hasn't authorized the test, *or*
- The employer has requested testing as a requirement for returning to work.

At-home testing kits aren't covered for any reason and are not reimbursable to any claim party.

CPT® codes and descriptions only are © 2024 American Medical Association 13-9

Each policy contains information relevant to the policy topic. Carefully review all sections of a policy before performing services or billing.

Pages are numbered with the chapter number first, then the page number.

General information: Highlights of policy changes since July 1, 2024

These highlights are intended for general reference. This isn't a comprehensive list of all the changes in the payment policies or fee schedules.

For complete code descriptions and lists of new, deleted, or revised codes, refer to the 2024 CPT© and HCPCS coding books.

Washington Administrative Code (WAC) and payment changes

The following changes to WACs and payment rates occurred:

- Cost of living adjustments were applied to **RBRVS** and anesthesia services and/or local codes,
- The **RBRVS** conversion factor is **$58.33**, which includes a cost of living adjustment of 1%,
- WAC 296-20-135 increases the anesthesia conversion factor to **$3.91** per minute (**$58.65** per 15 minutes), and,
- WAC 296-23-220 and WAC 296-23-230 increases the maximum daily cap for physical and occupational therapy services to **$149.45**, and
- WAC 296-23-250 set a daily cap for massage therapy of 75% of the daily cap for PT/OT services. The rate for July 1, 2025 is **$112.09.**

Policy & fee schedule additions, changes, and clarifications

Most chapters throughout MARFS have been renamed, renumbered, or both.

Professional services chapters

Chapter 3: Attending Providers clarifies the role and expectations for **attending providers**. This chapter encompasses several provider types and various restrictions that may apply. It also includes a new policy for **consultation** services. A separate policy specific to physical medicine services for **attending providers** (**1044M**) was added.

Chapter 5: Care Coordination includes significant updates to telephone call codes and updates to align online communications. Nurse case management services also received an update that includes new billing codes, revised reporting requirements, and changes to authorization limits.

Chapter 7: Durable Medical Equipment (DME) and Supplies clarifies the invoice requirements for prosthetic and orthotic services.

Chapter 17: Mental Health and Behavioral Health Interventions (BHI) now includes Activity Coaching (PGAP). Policies in this chapter clarify who may treat mental health conditions. Neuropsychological and psychological testing and evaluation policies further clarify who may perform these services, and includes a new section on how to bill.

Chapter 18: Other Services includes a new policy on claimant (worker) reimbursement. Changes were made to the obesity policy to allow nutritionists to create a weight loss plan.

Chapter 20: Physical Medicine includes updates to the chiropractic care services policy, clarifying the use of visit codes.

Chapter 24: Telehealth, Remote, and Mobile Services now includes a policy on mobile clinics and virtual reality devices. Clarifications have been made to **telehealth**, audio-only, and other related service policies throughout the chapter.

Facility services chapters

In the facility services chapters, fees including Hospital rates have been updated.

The insurer is continuing to update the outpatient code editor (OCE). Notices of future updates will be posted on the Updates & Corrections page on L&I's website.

Fee schedules

With the exception of the comma-delimited files, the Field Keys are integrated into the fee schedules.

The following fee schedules, factors, and rates have been updated:

- Ambulatory surgery center (ASC) fees,
- Dental fees,
- **Durable medical equipment** fees,
- Hospital ambulatory payment classification (APC) rates,
- Hospital percent of allowed charge (POAC) factors,
- Hospital rates,
- Interpreter fees,
- Laboratory fees,
- Pharmacy fees,
- Professional fees,
- Prosthetics and orthotics fees, *and*
- Residential fees.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for industrial insurance (workers' compensation)	Washington Administrative Code (WAC) Title 296
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 professional services	Fee schedules on L&I's website

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.

