Chapter 491-05 WAC
BILLING PROCEDURES

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WAC

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WAC 491-05-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

"Claimant" means any person, firm, corporation, partnership, association, agency, institution, or other legal entity seeking reimbursement or payment for services related to the treatment of an injured participant.

"Doctor" or "doctor" means a person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry.

"Municipality" includes any county, city, town or combination thereof, fire protection district, local law enforcement agency, or any emergency medical service district or other special district, authorized by law to protect life or property within its boundaries through a fire department, emergency workers, or reserve officers.

"Firefighter" or "firefighter" means any reserve officer (as defined in RCW 41.24.010), emergency worker (as defined in RCW 41.24.010), or firefighter who is a member of any fire department of any municipality but shall not include firefighters who are eligible for participation in the Washington law enforcement officers' and firefighters' retirement system or the Washington public employees' retirement system, with respect to periods of service rendered in such capacity.

"Emergency worker" means any emergency medical service personnel, regulated by chapters 18.71 and 18.73 RCW, who is a member of an emergency medical service district but shall not include emergency medical service personnel who are eligible for participation in the Washington public employee's retirement system, with respect to periods of service rendered in such capacity.

"Reserve officer" means the same as defined by the Washington state criminal justice training commission under chapter 43.101 RCW, but shall not include enforcement officers who are eligible for participation in the Washington law enforcement officers' and firefighters retirement system or the Washington public employee's retirement system, with respect to periods of service rendered in such capacity.

"Local board" means: (a) For matters affecting firefighters, a firefighter board of trustees created under RCW 41.24.060; (b) for matters affecting an emergency worker, an emergency medical service district board of trustees created under RCW 41.24.330; or (c) for matters affecting reserve officers, a reserve officer board of trustees created under RCW 41.24.460.

"Pain management policy" means that certain policy #2012-001, approved by the state board and effective as of April 20, 2012.

"Participant" means: Any firefighter, reserve officer, or emergency worker who is or may become eligible for relief under RCW 41.24, or whose beneficiary may be eligible to receive any such benefit.

"Practitioner" means any person defined as a "doctor" under these rules, or licensed to practice one or more of the following professions: Audiology; physical therapy; occupational therapy; pharmacy; prosthetics; orthotics; psychology; nursing; advanced registered nurse practitioners; certified medical physician assistants or osteopathic physician assistants; and massage therapy.

"Provider" means any person, firm, corporation, partnership, association, agency, institution, or other legal entity providing any kind of services related to the treatment of an industrially injured worker. It includes, but is not limited to, hospitals, medical doctors, dentists, chiropractors, vocational rehabilitation counselors, osteopathic physicians, pharmacists, podiatrists, physical therapists, occupational therapists, massage therapists, psychologists, naturopathic physicians, and durable medical equipment dealers.

"State board" means the state board for volunteer firefighters and reserve officers.

[Statutory Authority: RCW 41.24.290. WSR 15-01-063, § 491-05-010, filed 12/11/14, effective 1/11/15.]

WAC 491-05-020 Purpose. This chapter sets forth the procedures necessary for providers and claimants to receive payment for services and materials provided to participants.

[Statutory Authority: RCW 41.24.290. WSR 15-01-063, § 491-05-020, filed 12/11/14, effective 1/11/15.]

WAC 491-05-030 What is required for payment of medical services and materials? All medical services must be provided in accordance with the Washington state department of labor and industry's medical aid rules, fee schedules, and these rules and any state board policy, including but not limited to the pain management policy. The state board and/or local boards may reject bills for services rendered in violation of these rules or policies. Participants may not be billed for services rendered in violation of these rules.

(1) Practitioners must use the current national standard Health Insurance Claim Form (as defined by the National Uniform Claim Committee). Hospitals must use the current National Uniform Billing form (as defined by the National Uniform Billing Committee) for institution services and the current national standard Health Insurance Claim Form (as defined by the national Uniform Claim Committee). All other providers must contact the state board for guidance on proper billing.

(2) Prior to submission to the state board, all bills must first be submitted to the local board of the participant's municipality for processing.

(3) All providers seeking payment must complete the most recent versions of the following forms, and be assigned a statewide vendor number by the office of financial management:

(a) Statewide payee registration Washington state; and

(b) Request for Taxpayer Identification Number and Certification (I-9).

(4) Bills must specify the date and type of service, the appropriate procedure code, the condition treated, and the charges for each service.

(5) Bills submitted to the local board must be completed to include the following:

(a) Participant's name and address;

(b) Participant's date of birth;

(c) Date of injury;

(d) Name of participant's department;

(e) Referring doctor's name;

(f) Area of body treated, including ICD-9-CM code(s), identification of right or left, as appropriate;

(g) Date(s) of service;

(h) Place of service;

(i) Type of service;

(j) Appropriate procedure code, hospital revenue code, or national drug code;

(k) Description of service;

(l) Charge;

(m) Units of service;

(n) Tooth number(s);

(o) Total bill charge;

(p) The name and address of the practitioner rendering the services;

(q) Tax ID number of the practitioner or provider wishing payment;

(r) Date of billing; and

(s) Submission of supporting documentation required under subsection (7) of this section.

(6) Responsibility for the completeness and accuracy of the description of services and charges billed rests solely with the practitioner rendering the service, regardless of who actually completes the bill form.

(7) Bills must be received by the state board within two years of the date of service to be considered for payment. As such, providers are urged to bill on a monthly basis.

(8) The following supporting documentation is required when billing for services, as applicable:

(a) Laboratory and pathology reports:

(b) X-ray findings;

(c) Operative reports;

(d) Office/chart notes;

(e) Consultation reports;

(f) Special diagnostic study reports;

(g) Special or closing exam reports; and

(h) All other reports as required by the labor and industry's medical aid rules, fee schedules, and state board policy.

(9) The following considerations apply to rebills:

(a) Providers that do not receive payment or notification from the state board or a local board within one hundred twenty days, services may be rebilled.

(b) Rebills must be submitted for services denied if a claim is rejected and subsequently allowed. In this instance, the rebills must be received within one year of the date of the state board's decision to allow the claim.

(c) Rebills should be identical to the original bill: Same charges, codes, and billing date.

(d) In cases where a provider rebills, the notation "REBILL" must be on the bill.

(e) For providers that submit a rebill due to a coding error, the rebill must contain the corrected coding, and be accompanied by documentation stating that it is a rebill, the date of service, and the original codes it was billed under.

[Statutory Authority: RCW 41.24.290. WSR 15-01-063, § 491-05-030, filed 12/11/14, effective 1/11/15.]

WAC 491-05-040 What is required for the payment of prescriptions? To receive payment for prescriptions, all billing must be done in accordance with these rules and any state board's policy, including but not limited to the pain management policy for prescriptions. The state board or local boards may reject payment of prescriptions in violation of these rules or policies.

(1) Billing for opioids must be done in accordance with state board's pain management policy. A copy of the policy can be obtained through the state board. Opioids will only be covered in accordance with the policy.

(2) Bills directly from a pharmacy require the following information for payment:

(a) The name of the pharmacy;
(b) The participant's name;
(c) The participant's date of birth;
(d) Date of injury;
(e) Prescribing doctor's name;
(f) The name of the medication;
(g) The dosage of the medication;
(h) The frequency of the medication;
(i) The total amount of medication dispensed;
(j) The date the medication was dispensed; and
(k) The total amount due for the medication.

(3) If the participant is requesting reimbursement for a medication already filled, the following information is required for payment:

(a) The name of the pharmacy;
(b) The participant's name;
(c) The participant's date of birth;
(d) Date of injury;
(e) Prescribing doctor's name;
(f) The name of the medication;
(g) The dosage of the medication;
(h) The frequency of the medication;
(i) The total amount of medication dispensed;
(j) The date the medication was dispensed;
(k) The total amount due for the medication;
(l) Proof of payment for the medication; and
(m) Claimant's signature block completed in full on the invoice voucher.

(4) If a municipality is requesting reimbursement for a medication that it reimbursed a participant for, the following information is required for payment:

(a) The name of the pharmacy;
(b) The participant's name;
(c) The participant's date of birth;
(d) Date of injury;
(e) Prescribing doctor's name;

(f) The name of the medication;
(g) The dosage of the medication;
(h) The frequency of the medication;
(i) The total amount of medication dispensed;
(j) The date the medication was dispensed;
(k) The total amount due for the medication;
(l) Proof of payment by the participant for the medication and payment by the department to the participant for the medication; and
(m) Claimant's signature block completed in full on the invoice voucher.

(5) If a municipality is requesting reimbursement for a medication that it paid a pharmacy directly for, the following information is required for payment:
(a) The name of the pharmacy;
(b) The participant's name;
(c) The participant's date of birth;
(d) Date of injury;
(e) Prescribing doctor's name;
(f) The name of the medication;
(g) The dosage of the medication;
(h) The frequency of the medication;
(i) The total amount of medication dispensed;
(j) The date the medication was dispensed;
(k) The total amount due for the medication;
(l) Proof of by the department to the pharmacy for the medication; and
(m) Claimant's signature block completed in full on the invoice voucher.

[Statutory Authority: RCW 41.24.290. WSR 15-01-063, § 491-05-040, filed 12/11/14, effective 1/11/15.]