

**Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims**

Chapter 20: Nurse Case Management

Effective July 1, 2022

Note for MARFS 2022

L&I is in the process of revising this payment policy. [Sign up for GovDelivery](#) to stay informed of changes. We will notify providers via GovDelivery if this policy is revised prior to July 2023.



Link: Look for possible [updates and corrections](#) to these payment policies on L&I's website.



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Definitions

The following terms are utilized in this chapter and are defined as follows:

By Report (BR): A code listed in the fee schedule as “BR” doesn’t have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must supply a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.



Link: For the legal definition of By Report (BR), see [WAC 296-20-01002](#).

Nurse case management (NCM): A collaborative process used to meet a worker’s healthcare and rehabilitation needs. The nurse case manager:

- Works with the attending provider, worker, allied health personnel, and insurer’s staff to assist in locating a provider (primarily for out-of-state claims) and/or with coordination of the prescribed treatment plan, and
- Organizes and facilitates timely receipt of medical and healthcare resources and identifies potential barriers to medical and/or functional recovery of the worker, and
- Communicates this information to the attending provider, claim manager, and ONC to develop a plan for resolving or addressing the barriers.



Payment policy: Case management records and reports

Requirements for reports

Nurse case management reports must be completed **monthly**.

Optional reporting templates available are **Nurse Case Management Initial Care Management Plan** ([F245-442-000](#)) and **Nurse Case Management Progress Report** ([F245-439-000](#)).

Initial assessment, monthly, progress, and closure reports must include all of the following information:

- Type of report (initial, progress, or closing), *and*
- Worker name and claim number, *and*
- Report date and reporting period, *and*
- Worker date of birth and date of injury, *and*
- Contact information, *and*
- Diagnoses, *and*
- Reason for referral, *and*
- Current medical status, *and*
- Recommendations for future actions, *and*
- Actions taken and dates, *and*
- Ability to positively impact a claim, *and*
- Health care provider(s) name(s) and contact information, *and*
- Psychosocial/economic issues, *and*
- Vocational profile, *and*
- Hours incurred to date on the referral, *and*
- Amount of time spent completing the report.

Requirements for records

Case management records must:

- Be created and maintained on each claim, *and*
- Present a chronological history of the worker's progress in NCM services, *and*
- Be submitted within 30 days of the date of service, *and*
- Include **index to: NCM** in the lower right footer of the report.

Requirements for case notes and reports

Case management notes and reports must be created when a service is rendered and must specify:

- When the service was provided, *and*
- What type of service was provided using local billing codes, *and*
- Description of the service provided including subjective and objective data, *and*
- How much time was spent providing each service.

Payment limits

Payment is restricted to:

- Up to 2 hours (20 units) for **initial reports**, and
- Up to 1 hour (10 units) for **progress and closure reports**.



Payment policy: Nurse case management (NCM)

Prior authorization

NCM services

Prior authorization by the worker's claim manager and L&I's ONC is required for NCM services. Contact the insurer to make a referral for NCM services.

Workers must meet one or more of these criteria to be selected to receive NCM services:

- Catastrophic work-related injuries not managed under the Catastrophic Project, *and/or*
- Moved out of state and need assistance locating a provider, *and/or*
- Medically complex conditions, *and/or*
- Barriers to successful claim resolution.

Expenses

The claim manager must give prior authorization to reimburse for expenses for:

- Parking,
- Ferry,
- Toll fees,
- Cab,
- Lodging, *and/or*
- Airfare

These expenses correspond to local billing code **1225M** and have a payment limit of **\$725.00**.

Who must perform these services to qualify for payment

To qualify for payment, NCM services must be performed by a registered nurse:

- With case management certification, *and*
- Who is aware of resources in the worker's location.

Examples of case management certification include but are not limited to:

- Certification of Disability Management Specialists (CDMS)
- Commission for Case Manager Certification (CCMC or CMC)
- Certified Rehabilitation Registered Nurse (CRRN)
- Certified Occupational Health Nurse (COHN)
- Certified Occupational Health Nurse-Specialist (COHN-S)

NPIs for NCMs

Effective January 1, 2022, NCMs are required to submit a National Provider Identifier (NPI) through the ProviderOne portal. NPIs are unique 10-digit numbers used for identifying specific providers. NPIs are used by medical providers nationwide.

If you do not have an NPI number, go to the [National Provider Identifier Standard](#) section of the Centers for Medicare and Medicaid Services (CMS) website. Registering for an NPI number is free and does not require an SSN. Assistance with submitting the NPI is available [on L&I's ProviderOne website](#).

Services that aren't covered

Expenses that aren't covered include:

- Nurse case manager training,
- Supervisory visits,
- Postage, printing and photocopying (except medical records requested by L&I),
- Telephone/fax equipment,
- Clerical activity (for example, faxing documents, preparing documents to be mailed, organizing documents, email, etc.),
- Travel time to post office or fax machine,
- Wait time exceeding 16 hours per referral,
- Email communications with department staff,
- Fees related to legal work, such as deposition and testimony, *and*
- Any other administrative costs not specifically mentioned above.



Note: Legal fees may be charged to the requesting party, but not the claim.

Requirements for billing

Local billing codes

Nurse case managers must use the following local billing codes to bill for NCM services, including nursing assessments:

- **1220M** (Phone calls, per 6 minute unit),
- **1221M** (Visits, per 6 minute unit),
- **1222M** (Case planning, per 6 minute unit),
- **1223M** (Travel/Wait, per 6 minute unit – 16 hour limit per referral.)
- **1224M** (Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager), which pays at the **state rate**, and
- **1225M** (Expenses – parking, ferry, toll fees, cab, lodging, and airfare – at cost or state per diem rate – meals and lodging. Requires prior authorization from the claim manager – \$725 limit), which pays **By Report**.
- **9918M** (Online communications) view [Chapter 10](#) for details about using this code.

Billing units

When billing the local codes for NCM services (listed above), units are whole numbers only (don't use tenths of units), and 1 unit of service equals:

- Each traveled mile, *or*
- Each 6 minutes of phone calls, visits, case planning, or travel/wait time (see table below), *or*
- Each related travel expense (see **1225M**).

| If the time is... | Then bill: |
|-----------------------|------------|
| 6 minutes-11 minutes | 1 unit |
| 12 minutes-17 minutes | 2 units |
| 18 minutes-23 minutes | 3 units |
| 24 minutes-29 minutes | 4 units |
| 30 minutes-35 minutes | 5 units |
| 36 minutes-41 minutes | 6 units |
| 42 minutes-47 minutes | 7 units |
| 48 minutes-53 minutes | 8 units |
| 54 minutes-59 minutes | 9 units |
| 60 minutes | 10 units |

Payment limits

NCM services

NCM services are capped at 75 hours of service per referral, including professional and travel/wait time.

Pre-authorization is required for continued NCM work beyond the initial authorization. An additional 25-hour extension may be granted after staffing with the insurer. For State Fund claims, please contact the ONC. Further extensions may be granted in exceptional cases, contingent upon review by the insurer, and will also require prior authorization.

Expenses

Local billing code **1225M** has a payment limit of **\$725.00**.



Links to related topics

| If you're looking for more information about... | Then see... |
|---|--|
| 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 services | Fee schedules on L&I's website |
| General Provider Billing Manual | F245-432-000 |
| Nurse Case Management Initial Care Management Plan | F245-442-000 |
| Nurse Case Management Progress Report | F245-439-000 |

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email PHL@lni.wa.gov