



Washington State Department of
Labor & Industries
Division of Occupational Safety and Health

Mental Health Fee Schedule and Billing Guidelines

*A Manual for Providers Billing the
Crime Victims Compensation Program*



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Please visit our Web site: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/

Bill forms • Application forms • Treatment authorization forms • CVCP Mental Health Treatment Guidelines

INTRODUCTION

Welcome to the **Crime Victims Compensation Program** Mental Health Fee Schedule and Billing Guideline Manual. This publication has been developed to assist mental health providers and their billing staff when submitting reports and bills to our program.

Because we want to offer the best product possible to our providers, we welcome any feedback you may have on how we could improve this manual to better fit your needs. All feedback received will be reviewed and taken under consideration.

KNOW WHO YOU ARE BILLING

The Crime Victims Compensation Program is a payer of last resort, which provides financial, medical, and mental health benefits to victims of crime. As a payer of last resort, public, private insurance and similarly available federal funds such as Medicaid, Veterans Administration or Indian Health Service must be billed first per 42 U.S. Code Section 10602(e) must be billed first. All rules of primary insurance must be followed. Claimants are required to use providers covered by their primary insurance. All co-payments, deductibles or out of pocket expenses not covered by primary insurance should be included in your bills to Crime Victims. **Insurance Explanation of Benefits (EOBs) must be attached when the claimant has any other insurance.**

Crime Victims claim numbers are either six digits preceded by a “V” or five digits preceded by a “VA thru VZ”. Send all bills for Crime Victims claims to:

**Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520**

Local (360) 902-5355 or 800-762-3716

The Crime Victims Compensation Program and service providers are joined in a cooperative process for payment of provider billings. In order to process the billings promptly and correctly, the bills must be completed correctly as described. Improperly completed bill forms will be returned to the provider for correction and resubmission.

Completed bill forms **must** be typed or printed and legible.

GETTING PAID FOR CRIME VICTIMS COMPENSATION PROGRAM SERVICES

CRIME VICTIMS COMPENSATION PROGRAM PROVIDER ACCOUNT NUMBER

To receive payment for the services you provide to a crime victim, you must have an active Crime Victims Compensation Program provider account number. All providers who treat a crime victim, even in group practices, must have an individual Crime Victims Compensation Program provider account number.

The provider account number is tied to the Tax Identification Number (Social Security Number or Employee Identification Number issued by the IRS) you identify on your Provider Account Application and Form W-9 (Request for Taxpayer Identification Number and Certification).

To apply for a Crime Victims Compensation Program provider account number complete a Provider Account Application and Form W-9. The application is available through our website www.lni.wa.gov/FormPub/results.asp?Keyword=crime%20victims (form number F800-053-000) or call/write Crime Victims Compensation Program at the address below.

When you return the completed Provider Account Application and required documents, your application will be reviewed and your eligibility confirmed. Once confirmed, you will be notified, in writing, of your Crime Victims Compensation Program provider account number.

If any information on your application changes, such as your address, federal tax identification number or business status, you must notify the Crime Victims Compensation Program. If we do not have the most current information, your payments could be delayed. Please use the Provider Accounts Change Form for Crime Victims Compensation (form number F800-089-000). This form is available through our website www.lni.wa.gov/FormPub/results.asp?Keyword=crime%20victims or call/write Crime Victims Compensation Program at the address below.

**CVCP Provider Accounts
PO Box 44520
Olympia WA 98504-4520**

(800) 762-3716

All applications and updates should be sent to the address above.

If you have any questions about your eligibility, what services are covered, or what to do if you treated a crime victim before receiving your Crime Victims Compensation Program provider account number, call the Program at (800) 762-3716.

REPORTS AND DOCUMENTATION

Pre-authorization for mental health sessions beyond the first six sessions is required.

The department must have complete, timely, and accurate reports in order to determine if the treatment is appropriate, necessary, and helping the victim recover from the crime injury. (WAC 296-31-045) If you treat a client with an allowed claim, you must follow department rules governing reporting and billing requirements.

Mental Health Reporting Forms *must* be submitted timely and contain the required information in order for bills to be paid *and* for additional sessions to be authorized (WAC 296-31-060 and WAC 296-31-070). The claim manager will review the required report for detail and timeliness prior to preauthorizing payment for additional sessions. *You may expect the claim manager to respond to the request for additional sessions within five working days of receiving the required report.*

Please remember that **you cannot bill the client if your bills are denied.** (WAC 296-31-080(8))

Please plan ahead when submitting the required reports to ensure they will be received timely. Planning ahead will help avoid interruption for payment of services.

You may also expect the claim manager to request independent reviews or evaluations for clients who require longer-term treatment, i.e. adults needing more than 30 sessions and children more than 40.

**Effective March 1, 2003, preauthorization for payment is contingent on the detail and timely submission of required reports.*

MENTAL HEALTH REPORTING FORMS

Six sessions or less

Form I – Initial Response and Assessment

This form must be completed.

More than six sessions

Form II - Initial Response and Assessment

This form must be submitted no later than the sixth session. It is not necessary to complete Form I.

Form II must be completed even if the clinician has seen the victim for more than six sessions prior to filing for the Crime Victims Compensation Program application for benefits.

Seven sessions and beyond

Form III - Treatment Progress Note

This form is a progress report.

Form IV – Treatment Report

Submit this form halfway through the additional preauthorized sessions. Additional preauthorized sessions are contingent on the detail provided.

This form is used if more than 30 sessions are anticipated for adults or more than 40 sessions for children.

Form V – Treatment Report

Submit this form halfway through the additional preauthorized sessions. Additional preauthorized sessions are contingent on the detail provided.

This form is used if more than 50 sessions are anticipated for adults or more than 60 for children.

Termination Report

Form VI - Termination Report

Submit this form on all clients at the time when treatment has been discontinued for any reason. Submit this report within 60 days of the client's last session.

SUBMITTING BILLS TO CRIME VICTIMS COMPENSATION PROGRAM

When you bill the Crime Victims Compensation Program for services provided to a crime victim, you must include the victim's **claim number** and your Crime Victims Compensation Program **provider account number** in the appropriate boxes described in the instructions.

Charges must be submitted on Labor and Industries approved billing forms. We can accept photocopies or facsimiles.

If you have questions on a Crime Victims Compensation Program claim, please call the Program at (800) 762-3716.

Paper Billing Tips

- To ensure prompt payment, always include the crime victim's **claim number** and your Crime Victims Compensation Program **provider account number** on all bills and correspondence.
- Attach primary insurance EOBs to the bill.
- Make sure all forms are filled out completely.
- If your bill form is not completed correctly, payment may be delayed, denied or your bill may be returned. If your bill is returned, it must be corrected and sent back to the Program as a new bill.
- Any requests for reconsideration of partially paid bills must be submitted on the *Provider Request for Adjustment* form, along with supporting documentation.

What bill form do I use?

Bills must be submitted on the *Statement for Crime Victim Mental Health Services* form (F800-025-000) or *Statement for Crime Victim Miscellaneous Service* form (F800-076-000) or the *CMS-1500 Health Insurance Claim* form (F245-127-000). The CMS-1500 Health Insurance Claim form is a nationally accepted form.

To request changes on a bill already submitted to the department, you must wait until your remittance advice shows your bill paid or partially paid. You then submit a *Provider's Request for Adjustment* form (F800-064-000).

Bill forms are furnished by the department at no charge to providers. The forms are available through our website www.lni.wa.gov/FormPub/results.asp?Keyword=crime%20victims or by contacting the Crime Victims Compensation Program at 1-800-762-3716 or the Labor and Industries office nearest you.

To order forms, please provide your full name, address, Crime Victims Compensation Program provider number, quantity needed, and form number.

BILLING CODES AND MODIFIERS

The department's fee schedules are based on the federal Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS) Level I and II codes and modifiers. Level III codes are agency unique "local codes".

Level I codes

also referred to as CPT[®] codes and are developed and updated annually by the American Medical Association. These codes consist of five numbers (e.g. 90801).

Level I modifiers

consist of two numbers (e.g. -22). These modifiers are developed and updated annually by the AMA. **The department does not accept the five digit modifiers listed in CPT[®] books.**

Level II codes

are referred to as HCPCS (pronounced "Hick-Picks") and are developed and updated annually by the AMA. **Level II codes are not applicable for use in the Crime Victims Compensation Program Mental Health Treatment Rules and Fees publication.**

Level II modifiers

consist of two letters (e.g. -AA) or one number (e.g. -E1). These are updated annually by the AMA. **Level II modifiers are not applicable for use in the Crime Victims Compensation Program Mental Health Treatment Rules and Fees publication.**

Level III or "local" codes

are used to identify agency unique services. They consist of four numbers followed by one letter. **Codes consisting of four numbers followed by a "C" are unique to the Crime Victims Compensation Program.**

Level III modifiers

consist of one number and one letter (e.g. -1M). The department updates Level III (local codes) and modifiers as needed.

MENTAL HEALTH MODIFIERS

Services may be modified under certain circumstances. When applicable, a modifier can be used to report the modifying circumstances.

Modifiers that affect payment:

-22 Unusual services

When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure code. Payment varies based upon report.

-52 Reduced services

Under certain circumstances, a service or procedure is partially reduced or eliminated at the provider's election. Under these circumstances, the service provided can be identified by its usual procedure code and the addition of modifier -52 signifying that the service is reduced.

UNLISTED SERVICES OR PROCEDURES

A covered service or procedure may be provided that does not have a reimbursement level listed in the fee schedule. When reporting such a service, the appropriate unlisted procedure code may be used. When a procedure is rendered, a special report is required as supporting documentation. No additional reimbursement is made for the supporting documentation.

GENERAL REMINDERS

All fees listed are the maximum fees allowable. Providers shall bill their usual and customary fee for services. If the usual and customary fee for any particular service is lower to the general public than listed in the fee schedules, the provider must bill the department at the lower rate. The department will pay the lesser of the billed charge or the fee schedules maximum allowable.

To report individual psychotherapy, use the time frames listed in the CPT[®] codes for each unit of service. Do not report time in 15 minute increments. When billing these codes, do not bill more than one unit per day. When the time frame is exceeded for a specific code, bill the code with next highest time frame.

Procedure codes and fees for mental health services are found at:

<http://www.lni.wa.gov/ClaimsIns/CrimeVictims/MentalHealthFees/Default.asp>

*THE VALUES LISTED FOR PROCEDURES FOR WHICH A REPORT IS REQUIRED
INCLUDE THE REPORT FEE. DO NOT BILL SEPARATELY FOR THESE REPORTS.*

Facility charges are not payable when a provider elects to use hospital facilities or other outpatient facilities in lieu of maintaining a private office.

MENTAL HEALTH PAYMENT POLICIES

Procedure codes and fees for mental health services are found at:

<http://www.lni.wa.gov/ClaimsIns/CrimeVictims/MentalHealthFees/Default.asp>

The following service are not covered:

(refer to the CPT[®] for complete descriptions)

90845

96103

96120

The following services are bundled and are not payable separately:

(refer to the CPT[®] for complete descriptions)

90885

90887

90889

The following limits apply to these procedure codes:

90801 is limited to only one occurrence every six months, per patient, per provider.

96100 has a 4 hour maximum.

96117 has a 12 hour maximum.

Consultations

A consultation is considered to include those services provided by a mental health provider whose opinion or advice is requested by the attending mental health provider, or agency in the evaluation and/or treatment of a claimant's illness.

Consultations are not payable to the attending (treating) provider. Case management or case staffing with the same office is not considered to be a consultation.

When the consultant assumes the continuing care of the claimant, any subsequent service(s) provided by the consultant will no longer be considered a consultation.

Consultations for mental health evaluation of a claimant may include assessments of the claimant and exchange of information with the attending provider and other informants such as nurses or family members, and preparation of a report. The consultant is responsible for submitting a copy of their report and bill to the department.

Neuropsychological Testing

The following three codes may be used if appropriate when performing neuropsychological evaluation. Reviewing records and/or writing and submitting a report is included in these codes and may not be billed separately. See the current CPT[®] book for a complete description of each code listed below.

- 90801 This code is limited to once every 6 months.
 This code can be billed in addition to code 96117.
- 96100 This code may be billed per hour up to a 4 hour maximum.
- 96117 This code may be billed per hour up to a 12 hour maximum.

Pharmacological Evaluation and Management

Pharmacological evaluation is payable only to psychiatrists and advanced registered nurse practitioners with a specialty in psychiatric and mental health nursing and prescriptive authority. If a pharmacological evaluation is conducted on the same day as individual psychotherapy, bill the appropriate psychotherapy code with an Evaluation and Management component. Do not bill the individual psychotherapy code and a separate Evaluation and Management code. No payment will be made for psychotherapy and pharmacology management services performed on the same day, by the same practitioner, on the same patient.

Copies of Medical Records

Providers may bill for copies of medical records requested by the department using HCPCS code S9982. Payment for S9982 includes all costs, including postage. S9982 is not payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care to the worker may bill HCPCS code S9982. The department will pay for requested copies of medical records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury. If the department requests records from a health care provider, the department will pay for the requested services. Payment is per copied page.

Site of Service Payment Differential

The site of service differential is based on the Federal Centers for Medicare and Medicaid Services' payment policy and establishes distinct maximum fees for services performed in facility and non-facility settings.

For current fees, please go to our web site at:

<http://www.lni.wa.gov/ClaimsIns/CrimeVictims/MentalHealthFees/Default.asp>

Services Paid at the Rate for Facility Settings

When services are performed in a facility setting, the department makes two payments, one to the professional provider and another to the facility. The payment to the facility includes:

- Resource costs such as labor
- Medical supplies
- Medical equipment.

To avoid duplicate payment of resource costs, these costs are excluded from the rates for facility settings.

Professional services will be paid at the rate for facility settings when the department also makes a payment to a facility. The following place of service codes will be paid at the rate for facility settings:

| Place of Service Code | Place of Service Description |
|-----------------------|--|
| 05 | Indian Health Service Free-standing Facility |
| 06 | Indian Health Service Provider-based Facility |
| 07 | Tribal 638 Free-standing Facility |
| 08 | Tribal 638 Provider-based Facility |
| 21 | Inpatient hospital |
| 22 | Outpatient hospital |
| 23 | Emergency room-hospital |
| 26 | Military treatment facility |
| 31 | Skilled nursing facility |
| 51 | Inpatient psychiatric facility |
| 52 | Psychiatric facility partial hospitalization |
| 56 | Psychiatric residential treatment center |
| 61 | Comprehensive inpatient rehabilitation facility |
| 62 | Comprehensive outpatient rehabilitation facility |
| 99 | Other unlisted facility |
| (none) | (Place of service code not supplied) |

Services Paid at the Rate for Non-Facility Settings

When services are provided in non-facility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the rate for non-facility settings.

Professional services will be paid at the rate for non-facility settings when the department does not make a separate payment to a facility. The following place of service codes will be paid at the rate for non-facility settings:

| Place of Service Code | Place of Service Description |
|-----------------------|--|
| 11 | Office |
| 32 | Nursing facility |
| 33 | Custodial care facility |
| 50 | Federally qualified health center |
| 53 | Community mental health center |
| 54 | Immediate care facility/mentally retarded |
| 55 | Residential substance abuse treatment center |
| 71 | State or local public health clinic |
| 72 | Rural health clinic |

Services Requiring Prior Authorization

The following services require preauthorization:

| |
|--|
| Inpatient hospitalization |
| Concurrent treatment |
| Special programs |
| Independent evaluation |
| Referrals for services or treatment not in the CVCP fee schedule |
| Sessions beyond 30 and 50 for adult clients |
| Sessions beyond 40 and 60 for child clients |
| |
| Adult self defense, Code 0112C |
| Child self defense, Code 0133C |
| Day treatment for seriously ill person less than eighteen years of age, Code 0114C |
| Case Aid, Code 0117C |
| |
| Codes 90804 through 90829 |
| Codes 90846, 90847 |
| Codes 90849, 90853, 90857 |
| Code 90865 |
| Codes 90870, 90871 |
| Code 90880 |
| Code 90882 |
| Codes 96100 through 96117 |

Requests for authorization must be in writing and include a statement of:

- The condition(s) diagnosed.
- ICD-9-CM and/or DSM-III-R or DSM-IV codes.
- The relationship of the condition(s) diagnosed to the victimization.
- An outline of the proposed treatment program, its length and components, procedure codes and expected prognosis.

Local Codes and Description

| LOCAL CODES | DESCRIPTION |
|----------------------|--|
| | |
| Administrative codes | |
| 0101C | Telephone conference with or about claimant for therapeutic or diagnostic purposes. Requires written justification, identification of parties involved, report of conference and department authorization (excludes other reporting required by law, i.e., child protective services). |
| 1039M | Time loss notification form |
| 1040M | Completion of application for benefits form. |
| 1041M | Completion of reopening application form. Diagnostic studies associated with the reopening exam will be allowed in addition to this fee. |
| 1046M | Provider mileage, per mile, when round trip exceeds 14 miles |
| 1063M | Attending provider review of IME/IMHE report. |
| | |
| Consultation codes | |
| | |
| 0128C | Limited Consultation - A limited consultation is conducted without the client present. Service is limited to the review of records and consultation with the treating therapist for the purpose of evaluation of a diagnostic or therapeutic challenge, and treatment recommendations. A report is required from the consulting therapist. |
| 0129C | Extensive Consultation - An extensive consultation includes a review of records and the examination of the client for the purpose of evaluation of a diagnostic or therapeutic challenge, and treatment recommendations. A report is required from the consulting therapist. |
| | |
| Reporting codes | |
| | |
| 0116C | Treatment report, monitoring treatment only - <i>payable only when treatment costs are not being paid by Crime Victims Compensation Program.</i> |
| 0122C | Initial Response and Assessment: Form I |
| 0123C | Initial Response and Assessment: Form II |
| 0124C | Progress Note: Form III |
| 0125C | Treatment Report: Form IV |
| | |

PROVIDER PROTESTS

Protest – A timely request to the Crime Victims Compensation Program to reconsider any order, decision or award (includes remittance advices). A protest is considered less formal than an appeal and the reconsideration is done at the Program level.

How do I protest?

Send a letter to the CVCP, PO Box 44520 Olympia, WA 98504-4520, with the following information;

- the decision you disagree with and why,
- the claim number, your name, the victim's name, remittance advice (RA) number and date.
- The more clearly you explain why you think our decision is wrong and the more documentation you provide to substantiate your position the better.
- All protests must be in writing and received by the Program within the appropriate timeframe.

What is the timeframe for filing a protest?

- 90 days for initial payments/increased adjustments,
- 20 days for adjustments resulting in a decreased payment.
- The 90/20 days start from the date you receive the order, decision, award or RA.

What happens after I protest?

We will;

- determine if the protest is timely, within the 90/20 days,
- review the protest,
- gather any other applicable information,
- issue a further RA or order, which will either change or affirm the decision.

What if my protest is not timely?

We will issue an order informing you the decision is final and no adjustments can be made. (You can appeal this order to the Board of Industrial Insurance Appeals)

What if I still don't like your decision?

You can file a timely, written, appeal with the Board of Industrial Insurance Appeals.

PROVIDER APPEALS

Appeal – A timely request to the Board of Industrial Insurance Appeals (BIIA) to reconsider any order, decision or award (includes remittance advices). An appeal is more formal than a protest and generally is filed if a party does not agree with the outcome of a protest. An Industrial Appeals Judge will hold a hearing and issue a decision.

How do I appeal? What is the timeframe for filing an appeal?

The requirements are the same as filing a protest. Send the appeal to BIIA, PO Box 42401, Olympia, WA 98504-2401. Or on and electronic for found at: <http://www.biia.wa.gov/>

What happens after I appeal?

The BIIA will;

- assign a docket number to your case and,
- send a copy of the appeal to the Program.
- The Program will review the appeal to determine if it is timely and, decide to either reassume jurisdiction of the claim or send the claim file to the BIIA for further action. You will be notified if we reassume. The Program would then have 90 days to take action and issue a further order.
- If the claim is sent to the BIIA a judge will hold a settlement conference to attempt to resolve the issue. The Attorney Generals Office will represent the Program.
- If we are unable to settle, the case will then proceed to a hearing.
- After the hearing an Industrial Appeals Judge will issue a proposed decision and order. Either party can then choose to petition the three member Board to review the judge's decision. They will then issue a decision and order. If no appeal is taken the proposed decision will become final.
- Further appeals to the Board's decision will be heard in Superior Court.

Please Note:

Providers may have the right to protest/appeal other claim related decisions such as, claim closure or PPD awards.

This information is a general guide. For specific legal requirements relating to protests and appeals please review RCW 7.68.110, RCW 51.52 and WAC 263-12.

FREQUENTLY ASKED QUESTIONS

Q: Will bills get paid by Crime Victims Compensation Program before an authorization form is submitted by the practitioner?

A: No. The quickest way to get paid for mental health services is to keep up with the forms I-VI.

Q: Can we collect any co-pays or fees from the patient at the time of service?

A: No. Per state law, a crime victim with an allowed claim should have no out-of-pocket expenses.

Q: What if we, the practitioner, KNOW the primary insurance won't pay – do we still have to bill them?

A: Yes. Each bill must have the appropriate primary insurance EOB attached when you bill Crime Victims Compensation Program.

Q: We are a group of mental health providers. Does each individual provider need a Crime Victims Compensation Program provider number, or can we all just bill under our group number?

A: Each individual provider must have their own provider number.

Q: How long does it take Crime Victims Compensation Program to process a bill—when can I expect to receive a written payment/denial?

A: Within sixty days after we receive your bill, if the bill is submitted properly.

Q: I have a provider account with L&I. Do I need a separate one for Crime Victims Compensation Program?

A: Yes.

Q: Is the patient's other insurance always primary to Crime Victims Compensation Program? What about DSHS and Medicare?

A: Yes, including all state and federal programs.

Q: How many sessions do I have with the patient before I need to request authorization for more?

A: The initial six sessions with Crime Victims Compensation Program claimants require no prior authorization. Before the seventh session, refer to page four "Mental Health Reporting Forms".

HIPAA'S PRIVACY RULE AND THE CVCP

The Crime Victims' Compensation Program (CVCP), administered through Labor & Industries, is not legally required to follow the **Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule**. However, we recognize that as a mental health care provider, you may be subject to the provisions of HIPAA's Privacy Rule. This can be confusing for providers who want to protect the privacy of their clients' mental health information, cooperate with the department, and minimize their own liability risk. The information below is intended to reassure providers that all of these are possible despite the ambiguities surrounding the implementation of the HIPAA Privacy Rule.

RCW 7.68.142 requires health care providers to send health information to the department for crime victim claims. HIPAA's Privacy Rule (45 CFR §164.512(a)) also permits this disclosure of health information because it is required by law. In addition, HIPAA's Privacy Rule (45 CFR § 164.508(2)(ii)) permits you to disclose psychotherapy notes without an authorization from the patient because it is required by law. The department may request psychotherapy notes under the following circumstances:

- To determine if there are conditions unrelated to the effects of the crime
- To determine if an unrelated condition is retarding a crime victim's recovery
- To determine if there are pre-existing conditions that may have been aggravated by the crime
- To determine if crime related treatment is still necessary and/or effective and leading to recovery
- To obtain other information that may be necessary for the department to make decisions on the crime victim's claim

For more information, visit L&I's HIPAA website at:

<http://www.lni.wa.gov/ClaimsIns/Providers/Manage/HIPAA/default.asp>

MENTAL HEALTH REPORTING FORMS

Submit this document to:
 Crime Victims Compensation Program
 Department of Labor & Industries
 Post Office Box 44520
 Olympia, Washington 98504-4520

CVCP INITIAL RESPONSE AND ASSESSMENT: FORM I

This form must be submitted if you are seeing the victim for **six sessions or less**. If you will provide more than six sessions, please complete Form II. *Payment is contingent on the detail provided in this form and upon the processing and approval of the CVCP application for benefits.*

Bill Procedure Code 0122C For This Report.

| | | |
|--|--|-----------------------------------|
| Victim's Name | | CVCP Claim Number |
| Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim) | | Date Treatment Began |
| Time Period this Report Covers (<i>from month/day/year to month/day/year</i>) | | Date Form Completed |
| Clinician's Name | Clinician's Provider Number (if known) | Number of sessions to date |
| Clinician's Address | | Clinician's Phone Number () |
| Street | City | State Zip+4 |

Does your patient have insurance other than CVCP? If so what insurance is available _____

It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed.

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

- 1) What is the victim's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment at this time.

Turn page to continue

2) What are the victim's presenting symptoms/issues (by your observation and client report)?

Handwriting practice area for question 2, featuring a large rounded rectangle with horizontal dashed lines.

3) Has the victim experienced time loss from work as a result of this victimization?

No

Yes; Please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why the time loss has occurred, the extent of impairment and the prognosis for future occupational functioning.

Dates:

Explanation:

Turn page to continue

4) What type of intervention(s) did you provide?



Submit this document to:
 Crime Victims Compensation Program
 Department of Labor & Industries
 Post Office Box 44520
 Olympia, Washington 98504-4520

CVCP INITIAL RESPONSE AND ASSESSMENT: FORM II

This form *must* be submitted by the sixth session, if you are seeking authorization to provide more than six sessions. *Preauthorization for payment of additional sessions, is contingent on the detail provided in this form.* The CVCP application for benefits must also have been processed and approved.

Bill Procedure Code 0123C For This Report.

| | | |
|--|--|-----------------------------------|
| Victim's Name | | CVCP Claim Number |
| Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim) | | Date Treatment Began |
| Time Period this Report Covers (<i>from</i> month/day/year <i>to</i> month/day/year) | | Date Form Completed |
| Clinician's Name | Clinician's Provider Number (if known) | Number of sessions to date |
| Clinician's Address | | Clinician's Phone Number () |
| Street | City | State Zip+4 |

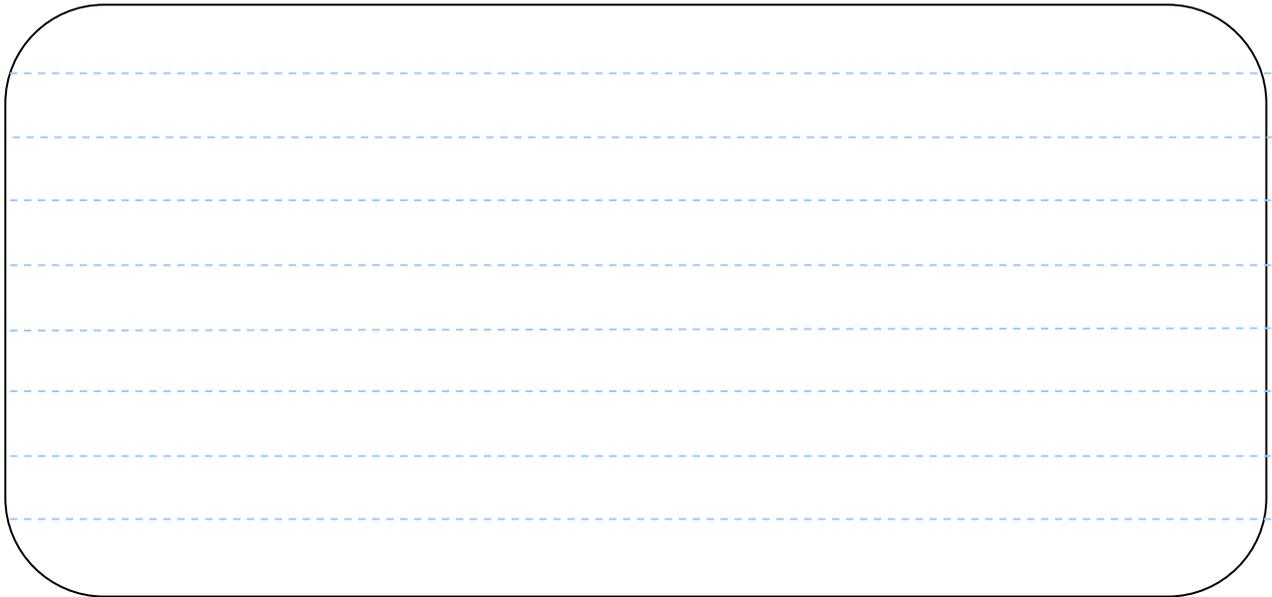
Does your patient have insurance other than CVCP? If so what insurance is available _____
It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed.

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

- 1) What is the client's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment at this time.

Turn page to continue

- 2) Briefly summarize the essential features of the victim's symptoms, related to the crime impact, beliefs/attributions, vulnerabilities, defenses and/or resources that led to your clinical impression (refer to the DSM IV and CVCP guideline on Initial Response, Assessment and Documentation Procedures):



- 3) Please describe pre-existing or co-existing emotional/behavioral or health conditions relevant to the crime impact if present, and explain how they were exacerbated by the crime victimization (e.g. depression, anxiety, vulnerabilities in personality structure, etc.).



Turn page to continue

4) List diagnoses on all 5 Axes (*be certain all diagnostic criteria are met*).

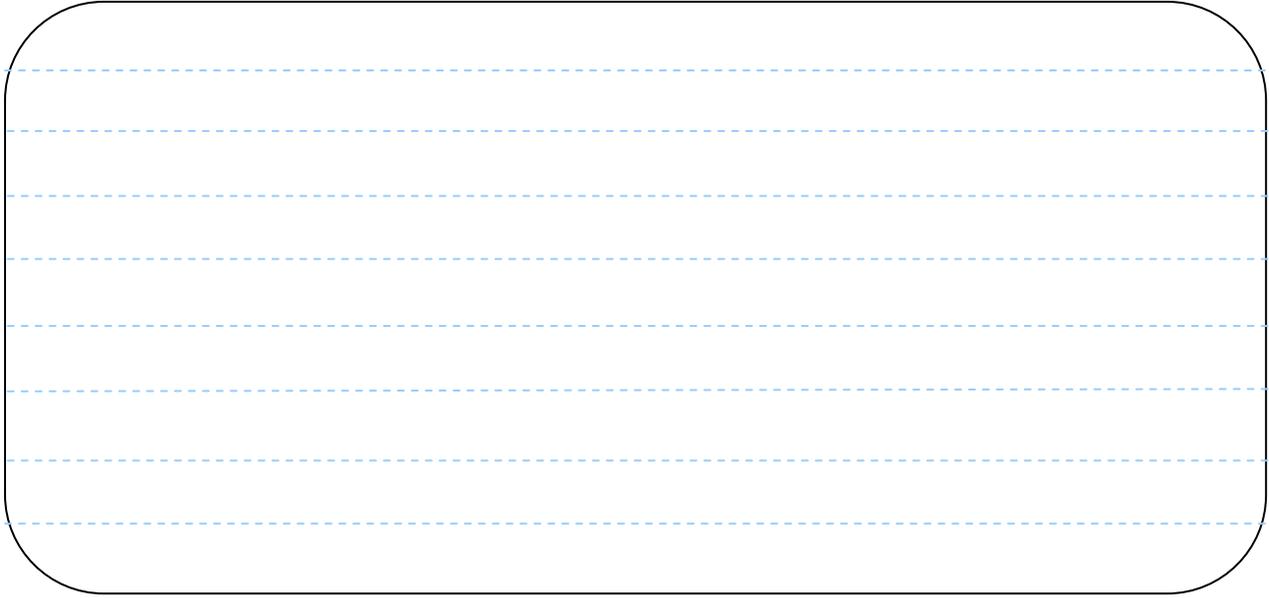
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V/Current GAF:
Highest GAF past year:

5) Treatment Plan (based on diagnosis and related symptoms, see the CVCP guideline on Initial Response, Assessment and Documentation Procedures)

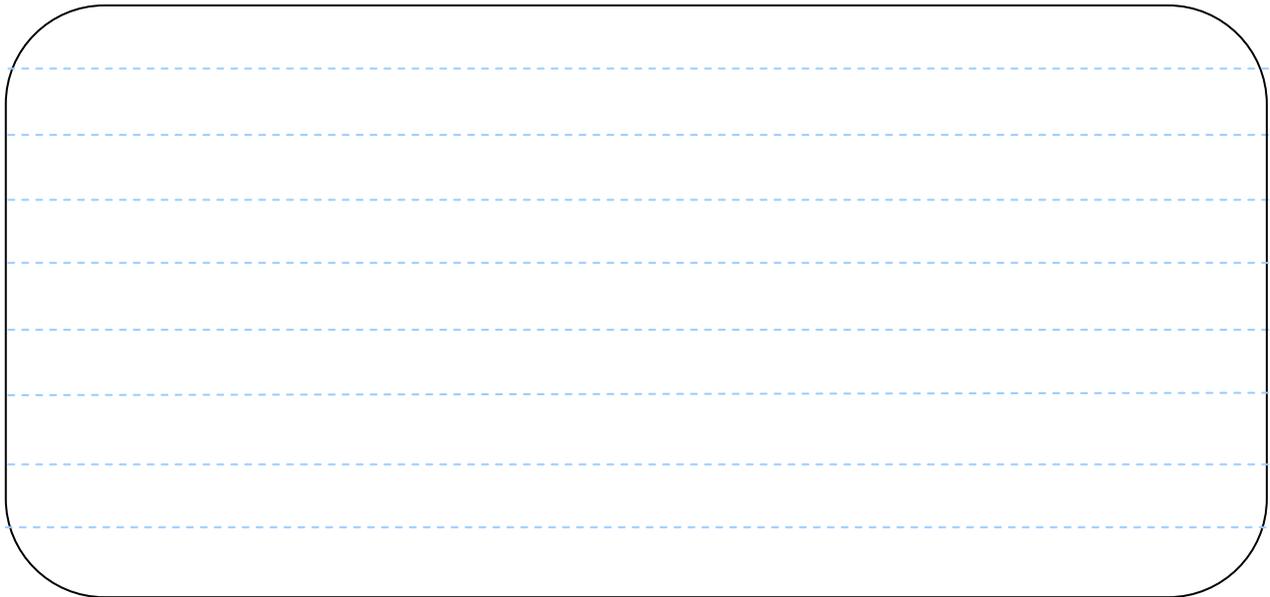
A. What are the specific treatment goals that you and the victim have set? Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant other.

Turn page to continue

B. What are the treatment strategies to achieve these goals? How many sessions are you requesting?

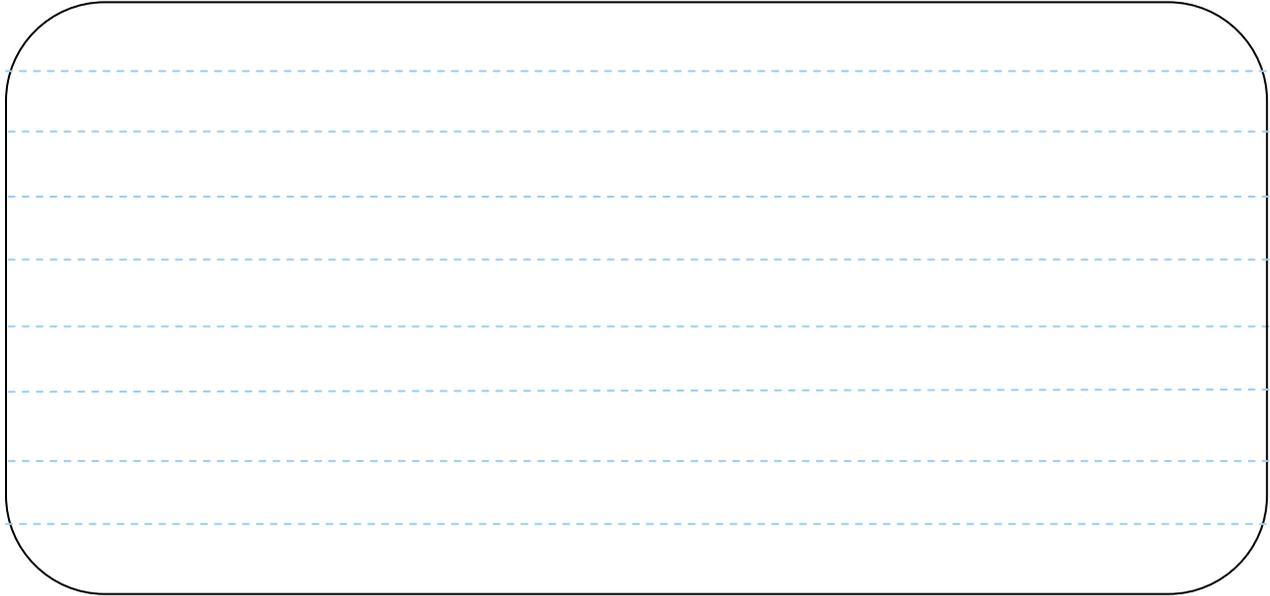


C. How will you measure progress toward these goals?

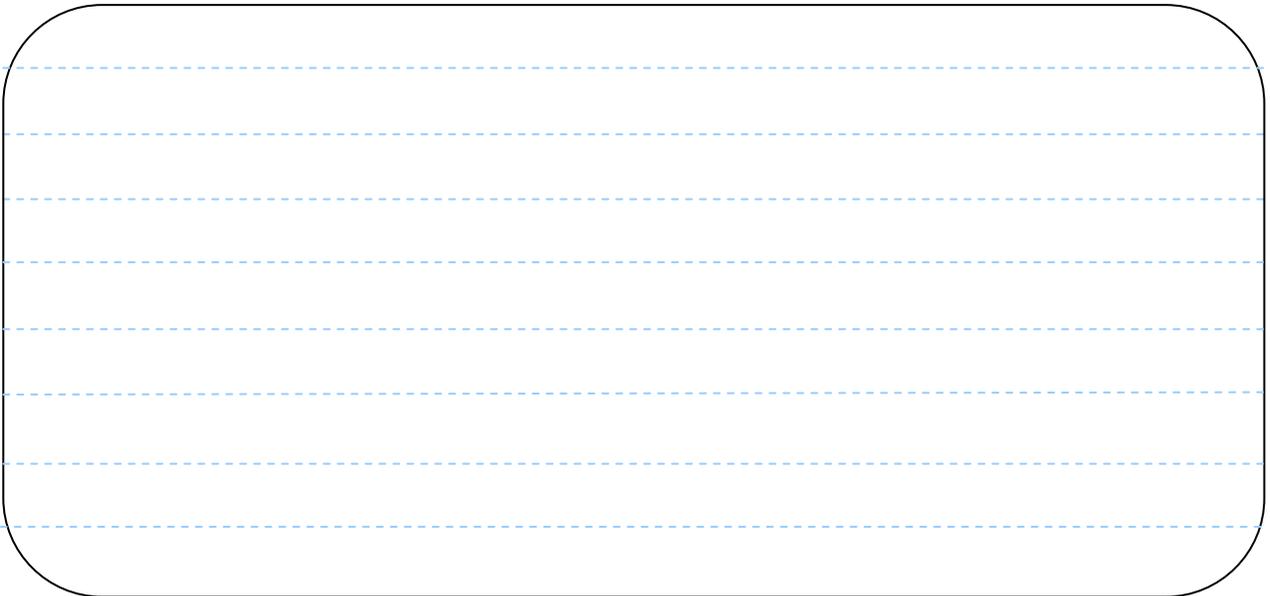


Turn page to continue

- D. Describe auxiliary care that will be incorporated (e.g. psychiatric evaluation, medication management, spiritual healers, community services, other services).



- 6) Please describe your assessment of the victim's treatment prognosis, as well as any extenuating circumstances and/or barriers that might affect treatment progress (e.g., previous trauma history, preexisting emotional/behavioral or medical conditions, family and social support system response and dynamics, religious/spiritual beliefs, cultural practices, involvement in criminal justice system or proceedings involvement with Child Protective Services, etc.).



Turn page to continue

7) Has the victim experienced time loss from work as a result of this victimization?

No

Yes; Please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why the time loss has occurred, the extent of impairment and the prognosis for future occupational functioning.

Dates:

Explanation:

Form area with dashed lines for writing.

Submit this document to:
 Crime Victims Compensation Program
 Department of Labor & Industries
 Post Office Box 44520
 Olympia, Washington 98504-4520

CVCP TREATMENT REPORT: FORM IV

This form must be submitted to request preauthorization for payment of additional sessions. Preauthorization is contingent on the detail provided.

Bill Procedure Code 0125C For This Report.

| | | |
|--|--|---------------------------------|
| Victim's Name | | CVCP Claim Number |
| Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim) | | Date Treatment Began |
| Time Period this Report Covers (<i>from</i> month/day/year <i>to</i> month/day/year) | | Date Form Completed |
| Clinician's Name | Clinician's Provider Number (if known) | Number of sessions to date |
| Clinician's Address | | Clinician's Phone Number () |
| Street | City | State Zip+4 |

Does your patient have insurance other than CVCP? If so what insurance is available _____

It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed.

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What were the diagnoses at treatment onset?

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V/Current GAF:

Highest GAF past Year:

Turn page to continue

2) What are the current diagnoses (*if different from those listed above*)?

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V/ Current GAF:

Highest GAF past year:

3) Request for extended sessions (*Complete either A, B or C, whichever is applicable*)

A. Substantial progress toward treatment goals has been made.
Explain:

Please explain the proposed plan for treatment and number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Turn page to continue

B. Partial progress toward treatment goals has been made.

Explain:

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Please explain the proposed plan for treatment and number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

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Turn page to continue

C. Little/no progress toward treatment goals has been made.

Explain:

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Please explain the proposed plan for treatment and number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Handwriting practice area with a solid top line, a dashed midline, and a solid bottom line. The area is currently blank.

Submit this document to:
 Crime Victims Compensation Program
 Department of Labor & Industries
 Post Office Box 44520
 Olympia, Washington 98504-4520

CVCP TREATMENT REPORT: FORM V

This form must be submitted for preauthorization for payment of additional sessions. Preauthorization is contingent on the detail provided. NOTE: Use this form for additional sessions.

Bill Procedure Code 0126C For This Report.

| | | |
|--|--|---------------------------------|
| Victim's Name | | CVCP Claim Number |
| Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim) | | Date Treatment Began |
| Time Period this Report Covers (<i>from month/day/year to month/day/year</i>) | | Date Form Completed |
| Clinician's Name | Clinician's Provider Number (if known) | Number of sessions to date |
| Clinician's Address | | Clinician's Phone Number () |
| Street | City | State Zip+4 |

Does your patient have insurance other than CVCP? If so what insurance is available _____
It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed.

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What were the diagnoses at treatment onset?

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V/Current GAF: _____

Highest GAF past Year: _____

Turn page to continue

2) What are the current diagnoses (*if different from those listed above*)?

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V/ Current GAF:

Highest GAF past year:

3) Request for extended sessions (*Complete either A, B or C, whichever is applicable*)

A. Substantial progress toward treatment goals has been made.
Explain:

Please explain the proposed plan for treatment and number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Turn page to continue

B. Partial progress toward treatment goals has been made.

Explain:

Handwriting practice area with horizontal dashed lines.

Please explain the proposed plan for treatment and number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Handwriting practice area with horizontal dashed lines.

Turn page to continue

C. Little/no progress toward treatment goals has been made.

Explain:

Handwriting practice area with horizontal dashed lines.

Please explain the proposed plan for treatment and number of sessions you are requesting. Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant others.

Handwriting practice area with horizontal dashed lines.

Submit this document to:
 Crime Victims Compensation Program
 Department of Labor & Industries
 Post Office Box 44520
 Olympia, Washington 98504-4520

CVCP TERMINATION REPORT: FORM VI

This form *must* be submitted within 60 days of the client's last session and you are no longer conducting treatment. Include a *complete description* of the client's diagnosis at the time of termination. This information will assist the CVCP should the client submit a reopening application at a later date.

Bill Procedure Code 0127C For This Report.

| | | |
|---|--|------------------------------------|
| Victim's Name | | CVCP Claim Number |
| Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim) | | Date Treatment Began |
| Time Period this Report Covers (<i>from</i> month/day/year <i>to</i> month/day/year) | | Date Form Completed |
| Clinician's Name | Clinician's Provider Number (if known) | Number of sessions to date |
| Clinician's Address | | Clinician's Phone Number () |
| Street | City | State Zip+4 |
| Does your patient have insurance other than CVCP? If so what insurance is available _____ | | |
| It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed. | | |

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

- 1) Date of last session: _____
- 2) Diagnosis at the time client stopped treatment:

Turn page to continue

3) Reason for termination (*check all that apply*):

- Current goals achieved
- Client choice to terminate treatment
- Therapist choice to terminate treatment
- Parent/guardian choice to terminate treatment
- Client relocated
- Client unavailable
- Client referred to other services
- Other

4) At this point in time, do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, please describe symptoms based on diagnostic criteria for a DSM diagnosis.

BILLING FORMS



STATEMENT FOR CRIME VICTIM MENTAL HEALTH SERVICES

**DO NOT
 WRITE IN
 SPACE** >

| |
|-------------------------|
| Claim Number V - |
|-------------------------|

| | | | | |
|---|-------|--------|--|----------------|
| Claimant's full name Last | First | Middle | Social Security Number (for ID only) | Date of Injury |
| Address | | | Date of Birth | |
| City | State | ZIP | BE SURE TO INCLUDE YOUR PROVIDER NUMBER AND YOUR PATIENT'S CLAIM NUMBER OR YOUR BILL MAY BE DENIED. | |
| DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM, DSM III or DSM IV). Designate left or right when applicable. | | | | |

- 1.
- 2.
- 3.
- 4.
- 5.

| ENTER ONLY ONE ITEM PER LINE Date of Service | POS | Procedure Code | Mod Code | Describe services provided | If mental health patient is not victim, give name and the relationship to victim. | Charges \$ | Unit | To Date of Service |
|---|-----|-------------------|-------------|----------------------------|--|------------|------|-----------------------|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |

| | | | |
|--|---|--|-------------------------------|
| The submission of this bill certifies that the material furnished, service(s) provided, expense incurred, or any other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due. | Provider of Service Name | Individual Provider No./NPI | Total Charge |
| | Group, Clinic, Center or Facility Name | Group Provider No./NPI | Phone Number |
| | Address | | Your Patient's Account Number |
| | City | State ZIP+4 | |
| Signature: | Federal Tax ID Number | | |
| Bill date: | <input type="checkbox"/> EIN <input type="checkbox"/> SSN | | |
| Amount Paid by Primary Insurance \$ | Name of Primary Insurance Company | PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS OR YOUR BILL MAY BE DENIED | |

INSTRUCTIONS FOR COMPLETING CRIME VICTIMS MENTAL HEALTH SERVICES BILLING FORM

*Crime Victims is a secondary insurer. Submit bills to public or private insurance first. You **must** attach Primary EOB to your bill.*

1. **CLAIM NUMBER:** Enter claimant's crime victim claim number.
2. **CLAIMANT'S NAME:** Enter claimant's last name, first name and middle name.
3. **SOCIAL SECURITY NUMBER:** Enter claimant's social security number.
4. **DATE OF INJURY:** The date of injury/illness positively identifies each claim.
5. **ADDRESS:** Enter claimant's current address.
6. **DATE OF BIRTH:** Enter claimant's date of birth.
7. **DIAGNOSIS:** Enter ICD-9-CM, DSM III or DSM IV code number and the narrative diagnosis for all conditions treated. Designate left or right side of body when applicable.
8. **ITEMIZATION OF SERVICES AND CHARGES:**
 - A. **DATE OF SERVICE:** Enter the month, day and year of service. (e.g., January 04, 2002 = 010402). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.
 - B. **PLACE OF SERVICE:** Place of Service codes are printed below. Enter appropriate code in space provided.
 - C. **PROCEDURE CODE:** Identify the procedure (CPT[®]/HCPCS/Local Code) performed or item provided. Enter only one code per line.
 - D. **CODE MODIFIER:** A modifier provides the means by which the provider can indicate a performed service or procedure has been altered by some specific circumstance, but has not changed in the definition or code.
 - E. **DESCRIBE SERVICES PROVIDED:** Enter brief description of services furnished.
 - F. **RELATIONSHIP TO VICTIM:** Enter patient's name and relationship to claimant.
 - G. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line. Do **NOT** bill negative charges
 - H. **UNIT:** Enter the total number of times a procedure is provided per line.
 - I. **TOTAL CHARGES:** Total of all charges.
9. **PROVIDER OF SERVICE NAME:** Enter name of provider providing service.
10. **PROVIDER NUMBER:** Enter the provider of service Crime Victims Compensation Program provider account number.
11. **NPI:** Enter the provider's National Provider Identifier (optional for Crime Victims Compensation Program)
12. **PROVIDER'S ADDRESS AND PHONE NUMBER:** Enter provider's billing address as recorded with Crime Victims Compensation Program.
13. **TOTAL CHARGE:** Total of all charges.
14. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. If the bill is prepared by computer, the signature may be left blank.
15. **BILL DATE:** The date your billing was prepared.
16. **FEDERAL TAX I.D. NUMBER:** Required. If the provider account number is incorrect this information helps identify the correct provider.
17. **PATIENT'S ACCOUNT NO.:** The number you use to identify your patient's account. This is for your convenience only.
18. **AMOUNT PAID BY PRIMARY INSURANCE:** The Crime Victims Compensation Program is a secondary insurer, public and private insurance must be billed first. Enter amount paid by public or private insurance.
19. **NAME OF PRIMARY INSURANCE:** Enter the name of the public or private insurance making payments on behalf of the claimant.

Place of Service (POS)

| | | | |
|----|--|--------|--|
| 05 | Indian Health Service Free-standing Facility | 35 | Adult Living Care Facility |
| 06 | Indian Health Services Provider-based Facility | 50 | Federally Qualified Health Center |
| 07 | Tribal 638 Free-standing Facility | 51 | Inpatient Psychiatric Facility |
| 08 | Tribal 638 Provider-based Facility | 52 | Psychiatric Facility Partial Hospitalization |
| 11 | Office | 53 | Community Mental Health Center |
| 21 | Inpatient Hospital | 54 | Immediate Care Facility/Mental Retarded |
| 22 | Outpatient Hospital | 55 | Residential Substance Abuse Treatment Center |
| 23 | Emergency Room – Hospital | 56 | Psychiatric Residential Treatment Center |
| 26 | Military Treatment Facility | 61 | Comprehensive Inpatient Rehabilitation Facility |
| 31 | Skilled Nursing Facility | 62 | Comprehensive Outpatient Rehabilitation Facility |
| 32 | Nursing Facility | 71 | State or Local Public Health Clinic |
| 33 | Custodial Care Facility | 72 | Rural Health Clinic |
| | | 99 | Other Unlisted Facility |
| | | (none) | (Place of Service Code not supplied) |

CPT* codes and descriptions only are copyright 2001 American Medical Association

Remember to attach Primary EOB to your bill.

STATEMENT FOR CRIME VICTIM MISCELLANEOUS SERVICES



Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

- | | |
|--|---|
| <input type="checkbox"/> Dental Services | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Medical Equipment/ Prosthetics-Orthotics | <input type="checkbox"/> Vocational / Retraining |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Home Health/ Nursing Home Services | |

**DO NOT
WRITE IN
SPACE** ➤

| | | | | |
|---|-------|--------|--|-------------------|
| Claimant's full name, Last | First | Middle | SSN (ID only) | Claim Number |
| Mailing address | | | Date of Birth | Date of Injury |
| City | State | ZIP | Reimburse claimant <input type="checkbox"/> Yes <input type="checkbox"/> No | Amount paid \$ |
| Name of referring physician or other source | | | Referring physician provider number / NPI | |

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM, DSM III, or DSM IV) Designate left or right when applicable

For glasses, advise if old Rx was available
 Yes No

Give hospitalization date for inpatient services

Admitted _____

Discharged _____

REFUND CERTIFICATION

I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE: _____

| FROM DATE OF SERVICE | * POS | PROC CODE | MOD CODE | Describe procedures, medical services or supplies furnished. Attach lab reports, X-ray findings and any special services | Dental tooth number | Home Nursing | | GLASSES | | | | CHARGES \$ C | Unit | T O DATE OF SERVICE |
|----------------------|-------|-----------|----------|--|---------------------|----------------|-----------------|-----------|-----------|----|----|--------------|------|---------------------|
| | | | | | | No. of hrs/day | Hourly/Day rate | OLD RX OD | NEW RX OS | OD | OS | | | |
| 1. | | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | |
| 5. | | | | | | | | | | | | | | |
| 6. | | | | | | | | | | | | | | |
| 7. | | | | | | | | | | | | | | |

| | | | | | |
|--|-----------------------------------|---|-------|-------------------------------|--------------|
| Submission of this bill certifies the material furnished, service provided, expense incurred or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid. Signature: _____ Bill date: _____ | Provider or Supplier name | Provider Number | NPI | Taxonomy | |
| | Address | | | | Total Charge |
| | City | State | ZIP+4 | | Phone Number |
| | Federal tax ID number | <input type="checkbox"/> EIN <input type="checkbox"/> SSN | | Your Patient's Account Number | |
| Amount paid by Primary Insurance \$ | Name of Primary Insurance Company | | | | |

PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS OR YOUR BILL MAY BE DENIED.

INSTRUCTIONS FOR COMPLETING CRIME VICTIMS MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
2. **CLAIMANT'S NAME:** Claimant's full name, last name first.
3. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the claimant's name is common.
4. **CLAIM NUMBER:** For the claimant receiving services. Billings cannot be processed without the claim number. Crime Victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK or VL".

Send bills for Crime Victims claims to:

Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

5. **ADDRESS:** The claimant's most current address.
6. **DATE OF BIRTH:** Enter the claimant's date of birth.
7. **DATE OF INJURY:** This is important and must be included. One claimant may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
8. **REIMBURSE CLAIMANT:** Place an "X" in the applicable box. If payment should be made to the claimant, indicate the amount paid.
9. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
10. **REFERRING PHYSICIAN PROVIDER NUMBER / NPI:** The Crime Victims Compensation Program provider account number or NPI of the referring physician.. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
11. **DIAGNOSIS:** Indicate both the ICD-9-CM, DSM III or DSM IV number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services billing.)
12. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
13. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
14. **REFUND CERTIFICATION - FOR CLAIMANT REIMBURSEMENT:** Signature of the claimant who received the care.
15. **ITEMIZATION OF SERVICES AND CHARGES:**
 - A. **DATE(S) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
 - B. **PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
 - C. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
 - D. **CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
 - E. **DENTAL:** To be used for dental services only.
Tooth Number: Identify dental services provided by placing the specific tooth number in the appropriate box.
 - F. **HOME NURSING:** To be used for home care only
Number of Hours or Days: Identify the number of hours or the number of days that the home care services were provided.
Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home care services provided.
 - G. **GLASSES:** To be used for glasses repair or replacement only.
Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.
New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
 - H. **CHARGES:** Charges for services provided.
 - I. **UNIT:** The sum total of services provided for days, units, or miles, etc.
16. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.)
17. **PROVIDER NUMBER:** Enter Crime Victims Compensation Program provider account number.
18. **NPI:** Enter the national provider identifier.
19. **TAXONOMY:** Enter the ten-digit taxonomy code.
20. **TOTAL CHARGE:** Total of **all** charges for services provided.
21. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
22. **FEDERAL TAX IDENTIFICATION NUMBER:** Enter provider's IRS (Internal Revenue Service) federal tax identification number. Indicate by marking box whether federal tax ID number is EIN or SSN.
23. **AMOUNT PAID BY PRIMARY INSURANCE :** As Crime Victims Compensation is a secondary insurer, private or public insurance must be billed first. Enter amount paid by private or public insurance. Attach a copy of the explanation of benefits for payments and denials.
24. **NAME OF PRIMARY INSURANCE COMPANY:** Enter name of private or public insurance company making payment on behalf of the claimant.

REQUIRED ATTACHMENTS:

The following attachments **must be** submitted with billings for appropriate services:

- | | | | |
|-------------------|----------------------|-----------------------------|---------------------------------------|
| 1. X-ray findings | 3. Office Notes | 5. Emergency Room reports | 7. Cost invoice of supplies furnished |
| 2. Lab reports | 4. Operative reports | 6. Diagnostic Study reports | 8. Consultation reports |

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

DUE TO THE FACT THAT CRIME VICTIMS' BILL RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.

The following attachment **is not** acceptable: Office Visit Slips

REBILLS: If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate **"Rebill"** on the bill. Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

| | | | |
|--|--|---|---|
| PLACE OF SERVICE (POS) 03. School 04. Homeless Shelter 05. Indian Health Service Free-standing Facility 06. Indian Health Service Provider-based Facility 08. Tribal 638 Provider-based Facility 09. Correctional Facility | 11. Office 12. Patient's Home 15. Mobile Unit 20. Urgent Care Facility 21. Inpatient Hospital 22. Outpatient Hospital 23. Emergency Rm - Hospital 24. Ambulatory Surgical Ctr 25. Birthing Ctr 26. Military Trmt Facility | 31. Skilled Nursing Facility 32. Nursing Facility 33. Custodial Care Facility 34. Hospice 41. Ambulance - Land 42. Ambulance - Air or Water 50. Federally Qualified Hlth Ctr 51. Inpatient Psychiatric Facility 52. Psychiatric Facility Partial Hospitalization 53. Community Mental Health Ctr | 54. Intermediate Care Facility/Mentally Retarded 55. Residential Substance Abuse Trmt Facility 56. Psychiatric Residential Trmt Ctr 60. Mass Immunization Ctr 61. Comprehensive Inpatient Rehabilitation Facility 65. End Stage Renal Disease Trmt Facility 71. State or Local Public Health Clinic 72. Rural Hlth Clinic 81. Independent Laboratory 99. Other Unlisted Facility |
|--|--|---|---|



CARRIER

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|--|--------|---|---|--|--|--|---|--|---------------|--|------------------|---|----------------------|--|--------------|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|
| PICA | | | | | | | | | | PICA | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID) | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY | | | | | SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | | | | | | | | | | |
| CITY | | | | | STATE | | | | | 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | | CITY | | | | | STATE | | | | | | | | | |
| ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | | | | | | | | | | ZIP CODE | | | | | TELEPHONE (Include Area Code) () | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | a. INSURED'S DATE OF BIRTH MM DD YY | | | | | | | | | | SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY | | | | | | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i> | | | | | | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____ | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT: MM DD YY | | | | | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 17a. _____ | | | | | 17b. NPI _____ | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____ | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____ 4. _____ | | | | | | | | | | 23. PRIOR AUTHORIZATION NUMBER _____ | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | | B. PLACE OF SERVICE | | C. EMG | | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | | | | E. DIAGNOSIS POINTER | | F. \$ CHARGES | | G. DAYS OR UNITS | | H. EPSDT Family Plan | | I. ID. QUAL. | | J. RENDERING PROVIDER ID. # | | | | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | SSN EIN <input type="checkbox"/> <input type="checkbox"/> | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | 28. TOTAL CHARGE \$ _____ | | | | | 29. AMOUNT PAID \$ _____ | | | | | 30. BALANCE DUE \$ _____ | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____ | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____ | | | | | | | | | | 33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____ | | | | | | | | | | | | | | |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

COMPLETING THE HEALTH INSURANCE CLAIM FORM – CMS-1500

You **must** attach Primary EOB to your bill.

The CMS-1500 is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Crime Victims Compensation Program.

The numbered boxes on the claim form are referred to as fields. Only those fields which pertain to billing Crime Victims Compensation Program are addressed below.

| <u>FIELD</u> | <u>DESCRIPTION/INSTRUCTIONS FOR COMPLETION</u> |
|---------------------|--|
| 1a. | INSURED'S I.D. NUMBER.; Enter the claimant's social security number. |
| 2. | PATIENT'S NAME: Enter claimant's last name, first name, and middle initial. |
| 3. | PATIENT'S BIRTH DATE: Enter the birth date of the claimant. |
| 5. | PATIENT'S ADDRESS: Enter claimant's current address. |
| 9. | OTHER INSURED'S NAME: Enter other insured's name. The Crime Victims Compensation Program pays bills for services secondary to other insurance resources. If the claimant has other insurance coverage, enter insurance information in 9 and 9a-d. |
| 9a. | OTHER INSURED'S POLICY OR GROUP NUMBER: Enter other insured's policy or group number. |
| 9b. | OTHER INSURED'S DATE OF BIRTH: Enter other insured's date of birth. |
| 9c. | EMPLOYER'S NAME OR SCHOOL NAME: Enter employer's name or school name. |
| 9d. | INSURANCE PLAN NAME OR PROGRAM NAME: Enter insurance plan or program name. |
| 11. | INSURED'S POLICY GROUP OR FECA NUMBER: Enter claimant's Crime Victims claim number. Omission of this number will result in billing being denied. Claim numbers are alpha-numeric, consisting of seven characters. They are either six digits preceded by a "V", or five digits preceded by a "VA thru VZ". |
| 11d. | IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN: Indicate "Yes" or "No". If "Yes", complete fields 9 and 9a-d. |
| 14. | DATE OF CURRENT INJURY/ILLNESS: The date of injury/illness positively identifies each claim. This is important and must be included. A claimant may have several claims; therefore, it is vital the proper claim is identified and charged for services provided. |
| 21. | DIAGNOSIS OR NATURE OF INJURY OR ILLNESS: You may use this space to describe in more detail ICD-9-CM, DSM III or DSM IV code number and the narrative diagnosis for all conditions treated. You must fill in specific diagnosis on line 24E for each line item. Designate left or right side of body when applicable. |

24a. **DATE(S) OF SERVICE:** Enter the month, day and year of service (e.g., January 04, 2002 = 010402). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.

24b. **PLACE OF SERVICE:** The following is a list of Place of Service codes and descriptions for billing our department.

| | | | |
|----|--|--------|--|
| 05 | Indian Health Service Free-standing Facility | 50 | Federally Qualified Health Center |
| 06 | Indian Health Services Provider-based Facility | 51 | Inpatient Psychiatric Facility |
| 07 | Tribal 638 Free-standing Facility | 52 | Psychiatric Facility Partial Hospitalization |
| 08 | Tribal 638 Provider-based Facility | 53 | Community Mental Health Center |
| 11 | Office | 54 | Immediate Care Facility/Mental Retard |
| 21 | Inpatient Hospital | 55 | Residential Substance Abuse Treatment Center |
| 22 | Outpatient Hospital | 56 | Psychiatric Residential Treatment Center |
| 23 | Emergency Room – Hospital | 61 | Comprehensive Inpatient Rehabilitation Facility |
| 26 | Military Treatment Facility | 62 | Comprehensive Outpatient Rehabilitation Facility |
| 31 | Skilled Nursing Facility | 71 | State or Local Public Health Clinic |
| 32 | Nursing Facility | 72 | Rural Health Clinic |
| 33 | Custodial Care Facility | 99 | Other Unlisted Facility |
| | | (none) | (Place of Service Code not supplied) |

24d. **PROCEDURE CODE:** Identify the procedure (CPT[®]/HCPCS/Local Code) performed or item provided. Enter only one code per line. Procedure codes for mental health services are found at: <http://www.lni.wa.gov/ClaimsIns/CrimeVictims/MentalHealthFees/Default.asp>.

If patient is not the claimant enter patient's name and relationship to claimant.

24d. **CODE MODIFIER:** A modifier indicates a performed service or procedure has been altered by a specific circumstance, but has not changed in the definition or code.

24e. **DIAGNOSIS POINTER:** Enter the diagnosis number from box 21 for this procedure.

24f. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line. Do **NOT** bill negative charges.

24g. **DAYS OR UNITS:** Enter the total number of units, minutes, or days for the services billed on a line.

24j. **RENDERING PROVIDER I.D. #:** Enter the provider of service Crime Victims Compensation Program provider account number. Due to system limitations, only one rendering provider number can be billed per paper bill form.

25. **FEDERAL TAX I.D. NUMBER:** Required. If the provider account number is incorrect this information helps to identify the correct provider.

26. **PATIENT'S ACCOUNT NO.:** The number you use to identify your patient's account. This is for your convenience only.

28. **TOTAL CHARGES:** Total of all charges.

29. **AMOUNT PAID:** Crime Victims Compensation Program is a secondary insurer. Public or private insurance must be billed first. Enter amount paid by public or private insurance and attach a copy of the insurance explanation of benefits.

30. **BALANCE DUE:** Total of all charges, minus any amount you entered in field 29.
31. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. For computer generated bills, the signature may be left blank. The “DATE” is the date the bill is prepared and sent to the department.
32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED:**
Physical location where services were rendered.
- 32a. **NPI:** Enter the facility’s NPI.
33. **BILLING PROVIDER INFO & PH #:** Enter the name of the provider providing the services (enter last name first), current address, area code and telephone number. If there are any changes in the provider’s address or status, immediately notify Provider Accounts, in writing at the following address:

CVCP Provider Accounts
PO Box 44520
Olympia WA 98504-4520

Indicating a new address on the bill will not change the department’s record of your address and could delay payment.

- 33a. **NPI:** Enter the rendering provider’s group NPI
- 33b. **Group Provider Number:** Enter the Crime Victims provider account number assigned by Crime Victims for the group.

Remember to attach Primary EOB to your bill.

ADJUSTMENT REQUEST FORM

IF YOUR ORIGINAL BILL WAS DENIED IN FULL, **DO NOT USE THIS FORM**. PLEASE SUBMIT A NEW BILL.

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ----- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover the money from your future payment(s); OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the Internal Control Number (ICN) overpaid. Submit refunds to:

**Cashiers Office
Department of Labor and Industries (L&I)
PO Box 44835
Olympia WA 98504-4835**

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information for the procedures/items paid incorrectly.

UNDERPAYMENT ----- A portion of the bill was underpaid. Complete adjustment request form with correct information for the procedures/items paid incorrectly. Corrections or justification and/or reports must be included.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

1. **CLAIMANT'S NAME:** Clearly print claimant's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **PROVIDER NAME:** Enter the name of the provider who performed these services.
4. **ICN NUMBER:** Enter the 17-digit number found in the ICN column on the remittance advice, to identify the ICN needing correction.
5. **CVC PROVIDER NUMBER / NPI:** Enter the CVC provider account number or NPI.
6. **SERVICE ITEMIZATION:** Enter the line item number(s) that corresponds to the line item number on your original bill. Enter **ONLY** the information you want to correct, as it should have appeared on your original bill. *Example: 2 units of service billed on line 3 and should have billed 4 units. Enter line item number 3 in column 6 and 4 in column i.* If insurance wasn't considered, attach EOB and explain in "Reason for Adjustment" that insurance has paid.
 - a. **From/to Date of Service or Covered Dates:** Date of service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
 - b. **Place of Service:** (POS) Two digit code identifying the place service was performed.
 - c. **Type of Service:** (TOS) One digit code identifying the type of service performed.
 - d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
 - e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
 - f. **ICD-9-CM Diagnosis/Side of Body:** ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
 - g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
 - h. **Charge:** Total of charges for services provided this line.
 - i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
 - j. **Days Supply:** Total number of days a prescription is intended to cover.
 - k. **Description:** Describe procedure or service.

If you have questions completing this form, please call 1-800-762-3716.

**Crime Victims Compensation Program
Mental Health Fee Schedule
July 1, 2008**

| CPT® Code | MD Non Facility | MD Facility | Psychologist Non Facility | Psychologist Facility | ARNP Non Facility | ARNP Facility | Master Level Non Facility | Master Level Facility |
|------------------|------------------------|--------------------|----------------------------------|------------------------------|--------------------------|----------------------|----------------------------------|------------------------------|
| 90801 | \$257.20 | \$221.51 | \$257.20 | \$221.51 | \$231.48 | \$199.35 | \$167.18 | \$143.98 |
| 90802 | \$256.72 | \$233.91 | \$256.72 | \$233.91 | \$231.04 | \$210.51 | \$166.87 | \$152.04 |
| 90804 | \$107.68 | \$94.14 | \$107.68 | \$94.14 | \$96.91 | \$84.72 | \$69.99 | \$61.19 |
| 90805 | \$119.37 | \$105.83 | \$119.37 | \$105.83 | \$107.43 | \$95.24 | N/A | N/A |
| 90806 | \$153.83 | \$144.60 | \$153.83 | \$144.60 | \$138.44 | \$130.14 | \$99.99 | \$93.99 |
| 90807 | \$169.82 | \$156.90 | \$169.82 | \$156.90 | \$152.83 | \$141.21 | N/A | N/A |
| 90808 | \$227.05 | \$217.20 | \$227.05 | \$217.20 | \$204.34 | \$195.48 | \$147.58 | \$141.18 |
| 90809 | \$241.81 | \$228.89 | \$241.81 | \$228.89 | \$217.62 | \$206.00 | N/A | N/A |
| 90810 | \$109.93 | \$102.34 | \$109.93 | \$102.34 | \$98.93 | \$92.10 | \$71.45 | \$66.52 |
| 90811 | \$125.14 | \$113.45 | \$125.14 | \$113.45 | \$112.62 | \$102.10 | N/A | N/A |
| 90812 | \$162.57 | \$151.45 | \$162.57 | \$151.45 | \$146.31 | \$136.30 | \$105.67 | \$98.44 |
| 90813 | \$174.85 | \$163.15 | \$174.85 | \$163.15 | \$157.36 | \$146.83 | N/A | N/A |
| 90814 | \$234.49 | \$225.13 | \$234.49 | \$225.13 | \$211.04 | \$202.61 | \$152.42 | \$146.33 |
| 90815 | \$245.61 | \$233.91 | \$245.61 | \$233.91 | \$221.04 | \$210.51 | N/A | N/A |
| 90816 | \$102.14 | \$102.14 | \$102.14 | \$102.14 | \$91.92 | \$91.92 | \$66.39 | \$66.39 |
| 90817 | \$112.60 | \$112.60 | \$112.60 | \$112.60 | \$101.34 | \$101.34 | N/A | N/A |
| 90818 | \$152.59 | \$152.59 | \$152.59 | \$152.59 | \$137.33 | \$137.33 | \$99.18 | \$99.18 |
| 90819 | \$163.05 | \$163.05 | \$163.05 | \$163.05 | \$146.74 | \$146.74 | N/A | N/A |
| 90821 | \$225.82 | \$225.82 | \$225.82 | \$225.82 | \$203.23 | \$203.23 | \$146.78 | \$146.78 |
| 90822 | \$236.28 | \$236.28 | \$236.28 | \$236.28 | \$212.65 | \$212.65 | N/A | N/A |
| 90823 | \$108.18 | \$108.18 | \$108.18 | \$108.18 | \$97.36 | \$97.36 | \$70.32 | \$70.32 |
| 90824 | \$118.71 | \$118.71 | \$118.71 | \$118.71 | \$106.83 | \$106.83 | N/A | N/A |
| 90826 | \$160.23 | \$160.23 | \$160.23 | \$160.23 | \$144.20 | \$144.20 | \$104.15 | \$104.15 |
| 90827 | \$167.25 | \$167.25 | \$167.25 | \$167.25 | \$150.52 | \$150.52 | N/A | N/A |
| 90828 | \$232.16 | \$232.16 | \$232.16 | \$232.16 | \$208.94 | \$208.94 | \$150.90 | \$150.90 |
| 90829 | \$239.17 | \$239.17 | \$239.17 | \$239.17 | \$215.25 | \$215.25 | N/A | N/A |

Fees are updated annually. Please check the CVC website for current fees after 07/01/09.

| LOCAL CODES | Description | MD/Psychologist | | ARNP | | Master Level | |
|-----------------------------|--|-----------------|----------|--------------|----------|--------------|----------|
| | | Non Facility | Facility | Non Facility | Facility | Non Facility | Facility |
| Administrative codes | | | | | | | |
| 0101C | Telephone conference with or about claimant for therapeutic or diagnostic purposes. Requires written justification, identification of parties involved, report of conference, and department authorization (excludes other reporting required by law, i.e., child protective services). | \$59.06 | \$42.10 | \$53.15 | \$37.89 | \$38.39 | \$27.37 |
| 1039M | Time loss notification form | \$18.93 | \$18.93 | \$17.03 | \$17.03 | \$12.30 | \$12.30 |
| 1040M | Completion of application for benefits form. | \$37.84 | \$37.84 | \$34.05 | \$34.05 | \$24.60 | \$24.60 |
| 1041M | Completion of reopening application form. Diagnostic studies associated with the reopening exam will be allowed in addition to this fee. | \$49.18 | \$49.18 | \$44.26 | \$44.26 | \$31.97 | \$31.97 |
| 1046M | Provider mileage, per mile, when round trip exceeds 14 miles | \$4.86 | \$4.86 | \$4.37 | \$4.37 | \$3.16 | \$3.16 |
| 1063M | Attending provider review of IME/IMHE report. | \$37.84 | \$37.84 | \$34.05 | \$34.05 | \$24.60 | \$24.60 |
| Consultation codes | | | | | | | |
| 0128C | Limited Consultation - A limited consultation is conducted without the client present. Service is limited to the review of records and consultation with the treating therapist for the purpose of evaluation of a diagnostic or therapeutic challenge, and treatment recommendations. A report is required from the consulting therapist. | \$201.16 | \$154.97 | \$181.04 | \$139.47 | \$130.75 | \$100.73 |
| 0129C | Extensive Consultation - An extensive consultation includes a review of records and the examination of the client for the purpose of evaluation of a diagnostic or therapeutic challenge, and treatment recommendations. A report is required from the consulting therapist. | \$367.82 | \$307.59 | \$331.03 | \$276.83 | \$239.08 | \$199.93 |

Fees are updated annually. Please check the CVC website for current fees after 07/01/09.

| LOCAL CODES | Description | MD/Psychologist | | ARNP | | Master Level | |
|--|---|-----------------|---------|---------|---------|--------------|---------|
| Reporting codes | | | | | | | |
| 0116C | Treatment report, monitoring treatment only - <i>payable only when treatment costs are not being paid by Crime Victims Compensation Program.</i> | \$24.59 | \$24.59 | \$22.13 | \$22.13 | \$15.98 | \$15.98 |
| 0122C | Initial Response and Assessment: Form I | \$43.51 | \$43.51 | \$39.15 | \$39.15 | \$28.28 | \$28.28 |
| 0123C | Initial Response and Assessment: Form II | \$87.02 | \$87.02 | \$78.31 | \$78.31 | \$56.56 | \$56.56 |
| 0124C | Progress Note: Form III | \$43.51 | \$43.51 | \$39.15 | \$39.15 | \$28.28 | \$28.28 |
| 0125C | Treatment Report: Form IV | \$59.75 | \$59.75 | \$53.77 | \$53.77 | \$38.84 | \$38.84 |
| 0126C | Treatment Report: Form V | \$59.75 | \$59.75 | \$53.77 | \$53.77 | \$38.84 | \$38.84 |
| 0127C | Termination Report: Form VI | \$43.51 | \$43.51 | \$39.15 | \$39.15 | \$28.28 | \$28.28 |
| Special Programs | | | | | | | |
| Non routine services requiring prior agreement with the Department. Approved special programs require prior authorization for each case. | | | | | | | |
| 0112C | Adult self defense | BR | BR | BR | BR | BR | BR |
| 0113C | Child self defense | BR | BR | BR | BR | BR | BR |
| 0114C | Child/adolescent day treatment – Approved program intended to provide a range and mix of planned and structured services for seriously ill persons under the age of 18. | BR | BR | BR | BR | BR | BR |
| HCPCS CPT® Codes | | | | | | | |
| S9982 | Med record copying per page | \$0.48 | \$0.48 | 0.48 | 0.48 | \$0.48 | \$0.48 |
| BR - By Report | | | | | | | |

Fees are updated annually. Please check the CVC website for current fees after 07/01/09.

REMITTANCE ADVICE DETAIL AND SAMPLE

REMITTANCE ADVICE DETAIL

The remittance advice provides a detailed report of all bill activity. If you are due fees per the remittance advice, you will also receive a warrant (payment).

Page one of the provider's remittance advice is the "Newsletter." Its free-form text relays information about the payment cycle, future warrants, billing instructions, rule changes, fee schedule changes, future workshops, etc.

The middle page(s) inform the provider or claimant which bills are being paid in the warrant, which bills denied and which bills are pending. At the very end of this section, it will list all explanation of benefit codes used in the remittance.

The last page of the remittance advice is the Notice that informs you of your right to request reconsideration or appeal any payment determination in the remittance advice.

| | |
|---|---|
| PAYEE PROVIDER NUMBER | Provider's Crime Victims Compensation Program payee account number. |
| REMITTANCE ADVICE NUMBER | Sequence number in this warrant register. |
| WARRANT REGISTER NUMBER | Number assigned to this payment cycle. |
| DATE | Date of this payment cycle. |
| CLAIM NUMBER | Crime Victims claim number. |
| NAME | Crime Victims last name and first initial. |
| PATIENT ACCOUNT/ PRESCRIPTION NUMBER | Account number or prescription number assigned by the provider or pharmacy to identify the injured worker, bill, or prescription. |
| ICN | Internal Control Number Crime Victims Compensation Program assigned to permanently identify this bill. |
| SERVICE DATES FROM | The date of service or the beginning date of a service period. |
| SERVICE DATE TO | The date of service or the ending date of the period. |
| UNIT OF SERVICE | The number of days/visits/time units/miles. |

| | |
|---|---|
| PROCEDURE / REVENUE / NDC | The CPT [®] /L&I procedure code/revenue code/NDC. |
| ALLOWED | The amount payable. |
| BILLED CHARGES | Amount the provider billed. |
| TAX OR NON COVERED CHARGES | The amount of sales tax payable or the amount of hospital charges not payable. |
| PAYABLE | The total amount Crime Victims Compensation Program is paying. |
| EXPLANATION OF BENEFIT (EOB) CODES | The explanation of benefit reason code for the amount being paid or not paid. These codes can be applicable to the total bill or to specific line charges. |
| PAID BILL | The bill by type of bill being paid in this warrant in line-item detail. |
| DENIED BILLS | The bills and types of bill forms that are being denied in this remittance. |
| BILLS-IN-PROCESS | The bills that have been received and entered into MIPC, but have not cleared all adjudication edits in time for this payment cycle's cutoff date. |
| CREDIT BALANCE BILLS (CRE) | The bills that are being held in abeyance until a credit satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. This is money owed to the department. |
| BILLS RETURNED | Resubmit original returned bill with the information requested. |
| PAID BILLS - GROSS ADJUSTMENT | The bills and types of bills being paid in this warrant in summary detail only. |
| DENIED BILLS - GROSS ADJUSTMENT | The bills and types of bills being denied in this remittance in summary detail only. |
| BILLS PAID MTD | The total number of bills paid this month to date. |
| AMOUNT PAID MTD | The total dollar amount paid this month to date. |

BILLS PAID YTD

The total number of bills paid this year to date.

AMOUNT PAID YTD

The total dollar amount paid this year to date.

**BILLS DENIED/
RETURNED MTD**

The total number of bills denied and/or returned this month to date.

BILLS DENIED/ RETURNED YTD

The total number of bills denied and/or returned this year to date.

EOB EXPLANATIONS

The narrative explanation of the EOB codes appearing on this remittance advice.

After you have reviewed your remittance advice and if you disagree with the amount paid, please submit a ***“Providers Request for Adjustment”*** form referencing the ORIGINAL ICN number within 90 days.

If you disagree with the action taken, please submit a request for reconsideration. See the protest language on the remittance advice sample.

SAMPLE PAGE

BCMC8000-R001
AS OF 01/06/2002

**WASHINGTON DEPARTMENT OF LABOR AND INDUSTRIES
CRIME VICTIMS COMPENSATION PROGRAM**

007589

REMITTANCE ADVICE

INSTRUCTIONS:

- 1. REFER TO LAST PAGE FOR LEGAL NOTICES
- 2. FOR INFORMATION ON BILLS: CALL 1-800-762-3716

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **XXXXX** DATE **01/08/2002** PAGE X

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE, ZIP

- NEWSLETTER UPDATE -

WASHINGTON DEPARTMENT OF LABOR AND INDUSTRIES
CRIME VICTIMS COMPENSATION PROGRAM

REMITTANCE ADVICE

INSTRUCTIONS:

1. REFER TO LAST PAGE FOR LEGAL NOTICES
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PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **60048** DATE **01/08/2002** PAGE **X**

| CLAIM NUMBER | NAME | I | PATIENT ACCT/RX NUMBER | SERVICE FROM | DATES TO | UNIT OF SVC | PRICE IND | REV | PROC DRG/MDC | M1 NDC | M2 | APC | BILLED CHARGES | ALLOWED | TAX OR NON-COVD CHARGES | PAYABLE | EOB CODES |
|---|---------|---|-------------------------------|--------------|----------|-----------------------|---------------------|-----|---------------------|--------------------|----|---------|----------------|---------|----------------------------|---------|-----------|
| X000000 | XXXXXXX | X | XXXXXXXXXX | 010101 | 010101 | 1 | | | XXXXX | | | | XX.XX | XX.XX | 0.00 | XX.XX | |
| X000000 | XXXXXXX | X | XXXXXXXXXX | 010201 | 010201 | 1 | | | XXXXX | | | | XXX.XX | XXX.XX | 0.00 | XXX.XX | |
| X000000 | XXXXXXX | X | XXXXXXXXXX | 010301 | 010301 | 1 | | | XXXXX | | | | XXX.XX | 0.00 | 0.00 | 0.00 | 149 |
| X000000 | XXXXXXX | X | XXXXXXXXXX | 010301 | 010301 | 1 | | | XXXXX | | | | X.XX | 0.00 | 0.00 | 0.00 | |
| ***PAID BILLS TOTAL - PRACTITIONER BILLS | | | | | | | ***BILL TOTAL ***** | | | **NUMBER OF BILLS- | | 4 | XXX.XX | XXX.XX | 0.00 | XXX.XX | |
| P000000 | XXXXXXX | X | XXXXXXXXXX | 122500 | 122500 | 1 | | | XXXXX | | | | XX.XX | 0.00 | 0.00 | 0.00 | |
| Y000000 | XXXXXXX | X | XXXXXXXXXX | 010501 | 010501 | 1 | | | XXXXX | | | | XX.XX | 0.00 | 0.00 | 0.00 | |
| ***BILLS PENDING TOTAL - PRACTITIONER BILLS | | | | | | | ***BILL TOTAL ***** | | | **NUMBER OF BILLS- | | 2 | XX.XX | 0.00 | 0.00 | 0.00 | 0.00 |
| | | | | | | | | | | | | | | | ***TOTAL WARRANT AMOUNT*** | | XXX.XX |
| *** BILLS PAID MTD 6 | | | *** AMOUNT PAID MTD XXXX.XX | | | *** BILLS PAID YTD 12 | | | *** AMOUNT PAID YTD | | | XXXX.XX | | | | | |
| *** BILLS DENIED/RETURNED MTD 1 | | | *** BILLS DENIED/RETURNED YTD | | | 1 | | | | | | | | | | | |

***** THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION CODES UTILIZED ABOVE:*****

149 USE OF THIS PROCEDURE CODE FOR THIS DATE OF SERVICE IS INVALID.

TOTAL WARRANT AMOUNT*** XXX.XX

0 **01002** **25** **045** **000300**
Media Julian Date Film Roll Number Batch Number Bill Number

REMITTANCE ADVICE

INSTRUCTIONS:

1. REFER TO LAST PAGE FOR LEGAL NOTICES
2. FOR INFORMATION ON BILLS: CALL 1-800-762-3716

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **XXXXX** DATE **01/08/2002** PAGE **X**

******* REMITTANCE ADVICE LEGAL NOTICE *******

INITIAL PAYMENTS OR ADJUSTMENTS RESULTING IN INCREASED PAYMENTS MADE ON THIS REMITTANCE ADVICE WILL BECOME FINAL NINETY (90) DAYS AFTER RECEIPT UNLESS 1) A WRITTEN REQUEST FOR RECONSIDERATION IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 3) AN APPEAL IS FILED WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA, WITHIN THAT TIME.

ADJUSTMENTS MADE TO PREVIOUS PAYMENTS ON THIS REMITTANCE ADVICE RESULTING IN DECREASED PAYMENTS WILL BECOME FINAL TWENTY (20) DAYS AFTER RECEIPT UNLESS: 1) A WRITTEN REQUEST FOR RECONSIDERATION IS FILED WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 2) A PROVIDER'S REQUEST FOR ADJUSTMENT FORM WITH THE DEPARTMENT OF LABOR AND INDUSTRIES, OLYMPIA, OR 3) AN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS, OLYMPIA WITHIN THAT TIME.

ADJUSTMENT AND/OR RECONSIDERATION REQUESTS MUST BE SENT TO THE DEPARTMENT OF LABOR AND INDUSTRIES, PO BOX 44520, OLYMPIA, WA 98504-4520

APPEALS MUST BE SENT TO THE BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, OLYMPIA, WA 98504-2401.

WAC 296-31

Chapter 296-31 WAC

CRIME VICTIMS COMPENSATION MENTAL HEALTH TREATMENT RULES AND FEES

Last Update: 4/3/07

Chapter 296-31 WAC

Crime victims compensation mental health treatment rules and fees

[Chapter Listing](#)

WAC Sections

- [296-31-010](#) What mental health treatment and services are available?
- [296-31-012](#) What mental health treatment and services are not authorized?
- [296-31-016](#) What treatment or services require authorization from the crime victims compensation program?
- [296-31-030](#) What are the eligibility requirements of a mental health treatment provider under the Crime Victims Act?
- [296-31-035](#) How do I register to become an authorized provider with the crime victims compensation program?
- [296-31-040](#) Can the department purchase or authorize a special service or treatment that does not appear in its fee schedule?
- [296-31-045](#) Can the department deny, revoke, suspend or impose conditions on a provider's authorization to treat crime victim claimants?
- [296-31-055](#) What type of corrective action can be taken against providers?
- [296-31-056](#) Can providers be charged interest on incorrect or inappropriate payments?
- [296-31-057](#) Can the department penalize a provider?
- [296-31-058](#) What protest and appeal rights are available?
- [296-31-060](#) What reports are required from mental health providers?
- [296-31-065](#) Can my client be referred for a consultation?
- [296-31-067](#) When is concurrent treatment allowed?
- [296-31-068](#) When can a client transfer providers?
- [296-31-069](#) For what reasons may the department require independent mental health or independent medical evaluations be obtained?
- [296-31-06901](#) What is required in an independent mental health evaluation report?
- [296-31-06903](#) Who may perform independent mental health evaluations for the crime victims compensation program?
- [296-31-06905](#) How does a provider become an approved examiner to perform independent mental health evaluations for the crime victims compensation program?
- [296-31-06907](#) What factors does the crime victims compensation program consider in approving or removing examiners from the approved examiners list?

- [296-31-06909](#) Is there a fee schedule for independent mental health evaluations?
- [296-31-070](#) What are my general obligations as an approved mental health provider?
- [296-31-071](#) What records must providers maintain?
- [296-31-072](#) Are provider records subject to a health care services review or an audit?
- [296-31-073](#) Can the department enlist utilization review or management programs?
- [296-31-074](#) What if my patient has an unrelated condition?
- [296-31-075](#) What is excess recovery?
- [296-31-080](#) How do providers bill for services?
- [296-31-085](#) Can out-of-state providers bill the department?

DISPOSITIONS OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 296-31-020 Definitions. [Statutory Authority: RCW 51.36.010, 7.68.030, 51.04.020 (1) and (4), 51.04.030, 7.68.080 and 7.68.120 . 97-02-090, § 296-31-020, filed 12/31/96, effective 1/31/97. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-020, filed 7/5/95, effective 8/5/95. Statutory Authority: Chapter 7.68 RCW. 94-02-015, § 296-31-020, filed 12/23/93, effective 1/24/94. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-020, filed 11/13/92, effective 12/14/92.] Repealed by 00-10-003, filed 4/20/00, effective 5/22/00.
- 296-31-050 Initial treatment and application for benefits. [Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-050, filed 7/5/95, effective 8/5/95. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-050, filed 11/13/92, effective 12/14/92.] Repealed by 00-03-056, filed 1/14/00, effective 2/14/00.
- 296-31-090 Mental health fees. [Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-090, filed 7/5/95, effective 8/5/95. Statutory Authority: Chapter 7.68 RCW. 94-02-015, § 296-31-090, filed 12/23/93, effective 1/24/94. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-090, filed 11/13/92, effective 12/14/92.] Repealed by 00-03-056, filed 1/14/00, effective 2/14/00.
- 296-31-095 Consultation fees. [Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-095, filed 11/13/92, effective 12/14/92.] Repealed by 94-02-015, filed 12/23/93, effective 1/24/94. Statutory Authority: Chapter 7.68 RCW.
- 296-31-100 Severability. [Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-100, filed 11/13/92, effective 12/14/92.] Repealed by 99-07-004, filed 3/4/99, effective 4/4/99.

296-31-010

What mental health treatment and services are available?

(1) The crime victims compensation program provides payment for mental health treatment and services to victims of crime who are eligible for compensation under chapter 7.68 RCW, the Crime Victims' Act.

EXCEPTION: Benefits under the crime victims compensation program are secondary to services available from any other public or private insurance.

- (2) Services and treatment are limited to procedures that are:
 - (a) Proper and necessary for the diagnoses of an accepted condition;
 - (b) Available at the least cost;
 - (c) Consistent with accepted standards of mental health care; and
 - (d) Will enable the client to reach maximum recovery.

[Statutory Authority: 7.68.030, 7.68.130, 51.04.030 and 51.36.010 . 99-20-031, § 296-31-010, filed 9/29/99, effective 11/1/99. Statutory Authority: RCW 51.36.010, 7.68.030, 51.04.020 (1) and (4), 51.04.030, 7.68.080 and 7.68.120. 97-02-090, § 296-31-010, filed 12/31/96, effective 1/31/97. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-010, filed 7/5/95, effective 8/5/95. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-010, filed 11/13/92, effective 12/14/92.]

296-31-012

What mental health treatment and services are not authorized?

(1) The crime victims compensation program will not authorize services and treatment:

(a) Beyond the point that the accepted condition becomes fixed and stable (i.e., maintenance care);

(b) After the date a permanent partial disability award is made;

(c) After a client is placed on a permanent pension roll, except as allowed in RCW 51.36.010;

(d) When services are not considered proper and necessary. Services that are inappropriate to the accepted condition, which present hazards in excess of the expected benefit, are controversial, obsolete, or experimental are presumed not to be proper and necessary, and shall only be authorized on an individual case basis with written authorization for the service from the department; or

(e) For any therapies which focus on the recovery of repressed memory or recovery of memory which focuses on memories of physically impossible acts, highly improbable acts for which verification should be available, but is not, or unverified memories of acts occurring prior to the age of two.

(2) We will not pay for services or treatment, including medications:

(a) On rejected claims;

EXCEPTION: We will pay for assessments or diagnostic services used as a basis for the department's decision.

(b) After the date a claim is closed.

EXCEPTION: Therapy for eligible survivors of victims of homicide can be provided on closed claims.

[Statutory Authority: RCW 7.68.030, 51.04.030, 51.36.010. 00-10-003, § 296-31-012, filed 4/20/00, effective 5/22/00; 99-20-031, § 296-31-012, filed 9/29/99, effective 11/1/99.]

296-31-016

What treatment or services require authorization from the crime victims compensation program?

(1) The program must authorize the following mental health services and/or treatment:

(a) Treatment beyond thirty sessions for adults or forty sessions for children;

(b) Treatment beyond fifty sessions for adults or sixty sessions for children;

(c) Consultations beyond what are allowed in WAC [296-31-065](#);

(d) Inpatient hospitalization;

(e) Concurrent treatment with more than one provider;

- (f) Electroconvulsive therapy;
 - (g) Neuropsychological evaluation (testing);
 - (h) Day treatment for seriously ill children under eighteen years old;
 - (i) Referrals for services or treatment not in our fee schedule (see WAC [296-31-040](#)).
- (2) Your request for authorization must be in writing and include:
- (a) A statement of the condition(s) diagnosed;
 - (b) Current DSM or ICD codes;
 - (c) The relationship of the condition(s) diagnosed to the criminal act; and
 - (d) An outline of the proposed treatment program that includes its length, components, procedure codes and expected prognosis.

[Statutory Authority: RCW 7.68.030 and 51.04.030. 99-20-031, § 296-31-016, filed 9/29/99, effective 11/1/99.]

296-31-030

What are the eligibility requirements of a mental health treatment provider under the Crime Victims Act?

(1) Mental health providers must qualify as an approved provider and register with the crime victims compensation program before they are authorized to provide treatment and receive payment in accordance with these rules.

(2) The following providers who are permanently licensed or registered in Washington are eligible to register with this program:

- (a) Psychiatrists;
- (b) Psychologists;
- (c) Advanced registered nurse practitioners with a specialty in psychiatric and mental health nursing;
- (d) Ph.D.s not licensed as psychologists and master level counselors whose degree is in a field of study related to mental health services including, but not limited to, social work, marriage and family therapy or mental health counseling.

(3) Out-of-state providers must be currently licensed, registered and/or certified within the state in which they practice. Washington requires mental health counselors to have a masters degree to treat Washington crime victim clients.

EXCEPTION: In areas where the department has determined licensed, registered and/or certified providers are not available, the department may consider registration exceptions on an individual basis.

[Statutory Authority: RCW 7.68.030. 01-22-105, § 296-31-030, filed 11/7/01, effective 12/8/01. Statutory Authority: RCW

7.68.030, 7.68.080. 00-03-056, § 296-31-030, filed 1/14/00, effective 2/14/00. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-030, filed 7/5/95, effective 8/5/95. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-030, filed 11/13/92, effective 12/14/92.]

296-31-035

How do I register to become an authorized provider with the crime victims compensation program?

You must send us:

- (1) A completed provider application and Form W-9;
- (2) A legible copy of your license, certification and/or registration;
- (3) Ph.D.s not licensed as psychologists and master level counselors must provide a legible copy of their degree.

[Statutory Authority: RCW 7.68.030, 7.68.080. 00-03-056, § 296-31-035, filed 1/14/00, effective 2/14/00.]

296-31-040

Can the department purchase or authorize a special service or treatment that does not appear in its fee schedule?

- (1) We may purchase **and/or** authorize agreements for service or treatment not covered in the fee schedule.
- (2) The service or treatment must be provided by registered providers authorized to bill the department.
- (3) We must establish payment rates for special agreements for service or treatment that we purchase or authorize.
- (4) We may establish criteria to ensure each claimant receives quality and effective service or treatment that is provided at the least cost and is consistent with necessary services. Examples include, but are not limited to, outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, and special reporting requirements.
- (5) We may terminate a special agreement by giving the provider thirty days **written** notice.
- (6) Any request for a special agreement must be made in writing to the crime victims' compensation program.

[Statutory Authority: RCW 7.68.030. 99-07-004, § 296-31-040, filed 3/4/99, effective 4/4/99. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-040, filed 11/13/92, effective 12/14/92.]

296-31-045

Can the department deny, revoke, suspend or impose conditions on a provider's authorization to treat crime victim claimants?

The department has a duty to supervise the provisions of proper and necessary mental health care that is delivered promptly, efficiently and economically. We may deny, revoke, suspend or impose

conditions on your authorization to treat crime victim claimants for reasons that include, but are not limited to:

(1) Incompetence or negligence that results in injury to a client or that exposes the client to harm.

(2) The possession, use, prescription for use, or distribution of controlled substances, legend drugs, or addictive, habituating or dependency-inducing substances except for therapeutic purposes.

(3) Limits placed on your license, certification and/or registration by any court, board or administrative agency. The limits may be temporary or permanent and may involve probation, suspension or revocation.

(4) The commission of any act involving moral turpitude, dishonesty, or corruption that relates to the practice of your profession. The act does not need to be a crime. If a court or other tribunal issues a conviction or finding regarding the act, a certified copy of the conviction or finding is conclusive evidence of the violation.

(5) Failure to comply with our rules, orders or policies.

(6) Failure, neglect or refusal to:

(a) Provide us with copies of your license, certification and/or registration and degree;

(b) Provide records requested by the department pursuant to a health care service review or an audit;

(c) Provide us with complete and timely reports that we require, or additional reports or records that we request.

(7) The submission or collusion in the submission of false or misleading reports or bills to any government agency.

(8) Billing a claimant for:

(a) Treatment of a condition for which the department has accepted responsibility; or

(b) The difference between the amount paid by the department and/or public or private insurance under the maximum allowable fee set forth in these rules and any other charge.

(9) Repeated failure to notify the department immediately and prior to burial in any death, where cause of death is not definitely known and possibly related to a crime victim injury.

(10) Repeated failure to recognize emotional and social factors that impede a client's recovery.

(11) Repeated unreasonable refusal to comply with the recommendations of a board certified or qualified specialist who examines or reviews a claim for us.

(12) Repeated use of treatment that is:

(a) Controversial or experimental;

(b) Contraindicated or hazardous;

(c) Performed after the condition stabilizes; or

(d) Performed after maximum mental health improvement is reached.

(13) Mental incompetence declared by a court or other tribunal.

(14) Failure to comply with the applicable code of professional conduct or ethics.

(15) Failure to inform us of disciplinary action against your license, certification or registration to practice, issued by order or formal letter.

(16) The finding of reason(s) to take action against your privileges to practice by any peer group review body.

(17) Misrepresentation or omission of any material information in your application for authorization to treat crime victims.

(18) Repeated billing of the department for services that are available to clients from public or private insurance sources. You must bill us only after all public or private insurance benefits are exhausted.

[Statutory Authority: RCW 7.68.030, 7.68.080, 7.68.100. 00-03-056, § 296-31-045, filed 1/14/00, effective 2/14/00.]

296-31-055

What type of corrective action can be taken against providers?

(1) If the department finds reason to take corrective action, we may also order one or more of the following:

(a) Recoup our payments to you with interest.

(b) Deny or reduce payment.

(c) Assessment of penalties for each action that falls within the scope of WAC [296-31-045](#) (1) through (18).

(d) Place you on a prepayment review status that requires you to submit supporting documents prior to payment.

(e) Require you to satisfactorily complete education courses and/or programs.

(f) Impose other appropriate restrictions or conditions, including revoking your privilege to be reimbursed for treating clients under the Crime Victims Act.

(2) Cases involving questions of ethics or quality of care will be referred to the department of health.

(3) We will forward a copy of any corrective action taken against you to the applicable disciplinary authority.

[Statutory Authority: RCW 7.68.030, 7.68.080, 7.68.100, 51.48.080, 51.48.250, 51.48.260, 51.48.280, 51.48.290. 00-03-056, § 296-31-055, filed 1/14/00, effective 2/14/00.]

296-31-056

Can providers be charged interest on incorrect or inappropriate payments?

(1) When you receive a payment to which you are not entitled, you must repay the excess payment, plus accrued interest, without regard to whether the excess payment occurred due to your error or department error or oversight.

EXCEPTION: If you accept in good faith a determination by the department that a crime victim client is eligible for benefits under the Crime Victims Act and we later determine the client was ineligible for services, interest will not begin to accrue until notification is received by you that the client was ineligible.

(2) Interest will accrue on excess payments at the rate of one percent per month or portion of a month beginning on the thirty-first day after payment was made. When partial payment of an excess payment is made, interest accrues on the remaining balance.

(3) The department has the option of requesting you to remit the amount of the excess payment and accrued interest or offsetting excess payments and accrued interest against future payments due to you.

[Statutory Authority: RCW 7.68.030, 7.68.080, 51.48.250, 51.48.260. 00-03-056, § 296-31-056, filed 1/14/00, effective 2/14/00.]

296-31-057

Can the department penalize a provider?

The penalty provisions for physicians contained in chapter 51.48 RCW are the same for mental health providers under these rules.

[Statutory Authority: RCW 7.68.030, 7.68.080, 7.68.100, 51.48.060, 51.48.080, 51.48.090, 51.48.250, 51.48.260, 51.48.270, 51.48.280, 51.48.290. 00-03-056, § 296-31-057, filed 1/14/00, effective 2/14/00.]

296-31-058

What protest and appeal rights are available?

If you or the client do not agree with our order, decision or award a written protest may be sent to the crime victims compensation program or appeal to the board of industrial insurance appeals. A protest or appeal to our order or decision requiring repayment by a provider must be received within twenty days from receipt of the order or decision. A protest or appeal regarding other issues must be received within ninety days of receipt of the order or decision.

Note: Protest and appeal rights are governed under chapter 51.52 RCW and RCW 7.68.110.

[Statutory Authority: RCW 7.68.030, 7.68.110, 51.52.050, 51.52.060(1). 00-03-056, § 296-31-058, filed 1/14/00, effective 2/14/00.]

296-31-060

What reports are required from mental health providers?

The crime victims compensation program requires the following reports from mental health providers:

(1) **Initial response and assessment: Form I:** This report is required if you are seeing the client for **six sessions or less**, and must contain:

- (a) The client's initial description of the criminal act for which they have filed a crime victims compensation claim;
- (b) The client's presenting symptoms/issues by your observations and the client's report;
- (c) An estimate of time loss from work as a result of the crime injury, if any. Provide an estimate of when the individual will return to work, why they are unable to work, the extent of impairment and the prognosis for future occupational functioning; and
- (d) What type of intervention(s) you provided.

EXCEPTION: If you will be providing more than six sessions it is not necessary to complete Form I, instead complete Form II.

(2) Initial response and assessment: Form II: This report is required if **more than six sessions** are anticipated. Form II must be submitted no later than the sixth session, and must contain:

- (a) The client's initial description of the criminal act for which they have filed a crime victims compensation claim;
- (b) A summary of the essential features of the client's symptoms related to the criminal act, beliefs/attributions, vulnerabilities, defenses and/or resources that lead to your clinical impression (refer to current DSM and crime victims compensation program guidelines);
- (c) Any preexisting or coexisting emotional/behavioral or health conditions relevant to the crime impact if present, and how they may have been exacerbated by the crime victimization;
- (d) Specific diagnoses with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year;
- (e) Treatment plan based on diagnoses and related symptoms, to include:
 - (i) Specific treatment goals you and the client have set;
 - (ii) Treatment strategies to achieve the goals;
 - (iii) How you will measure progress toward the goals; and
 - (iv) Any auxiliary care that will be incorporated.
- (f) A description of your assessment of the client's treatment prognosis, as well as any extenuating circumstances and/or barriers that might affect treatment progress; and
- (g) An estimate of time loss from work as a result of the crime injury, if any. Provide an estimate of when the individual will return to work, why they are unable to work, the extent of impairment and the prognosis for future occupational functioning.

(3) Progress note: Form III: This report must be completed **after session fifteen has been conducted**, and must contain:

- (a) Whether there has been substantial progress towards recovery for the crime related condition(s);
- (b) If you expect treatment will be completed within thirty visits (for adults) or forty visits (for children); and
- (c) What complicating or confounding issues are hindering recovery.

(4) **Treatment report: Form IV:** This report must be completed for authorization for **treatment beyond thirty sessions for adults or forty sessions for children**, and must contain:

(a) The diagnoses at treatment onset with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year;

(b) The current diagnoses, if different now, with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year; and

(c) Proposed plan for treatment and number of sessions requested, and an explanation of:

(i) Substantial progress toward treatment goals;

(ii) Partial progress toward treatment goals; or

(iii) Little or no progress toward treatment goals.

(5) **Treatment report: Form V:** This report must be completed for authorization for **treatment beyond fifty sessions for adults or sixty sessions for children**, and must contain:

(a) The diagnoses at treatment onset with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year;

(b) The current diagnoses, if different now, with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year;

(c) Proposed plan for treatment and number of sessions requested, and an explanation of:

(i) Substantial progress toward treatment goals;

(ii) Partial progress toward treatment goals; or

(iii) Little or no progress toward treatment goals.

(6) **Termination report: Form VI:** If you **discontinue treatment of a client** for any reason, a termination report should be completed within sixty days of the client's last visit, and must contain:

(a) Date of last session;

(b) Diagnosis at the time client stopped treatment;

(c) Reason for termination (e.g., goals achieved, client terminated treatment, client relocated, referred to other services, etc.); and

(d) At this point in time do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, describe symptoms based on diagnostic criteria for a DSM diagnosis.

(7) **Reopening application:** This application is **required to reopen a claim** that has been closed more than ninety days, to demonstrate a worsening of the client's condition and a need for treatment. We will reimburse you for filing the application, for an office visit, and diagnostic studies needed to complete the application. No other benefits will be paid until a decision is made on the reopening. If the claim is reopened, we will pay benefits for a maximum of sixty days prior to the date we received the reopening application.

[Statutory Authority: RCW 7.68.030, 51.04.030 and 51.36.060. 99-20-031, § 296-31-060, filed 9/29/99, effective 11/1/99. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030 . 95-15-004, § 296-31-060, filed 7/5/95, effective 8/5/95. Statutory Authority: Chapter 7.68 RCW. 94-02-015, § 296-31-060, filed 12/23/93, effective 1/24/94. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-060, filed 11/13/92, effective 12/14/92.]

296-31-065

Can my client be referred for a consultation?

(1) There may be instances when the client's accepted mental health condition presents a diagnostic or therapeutic challenge. In such cases, you or the department may refer the client for a consultation or you may ask the department for an independent mental health examination.

(2) There are two levels of consultations that can be performed: Limited and extensive. Descriptions and procedure codes are included in the *Crime Victims Compensation Program Mental Health Treatment Rules and Fees*.

(3) The consultant will be required to submit a report to the department that contains the following elements:

(a) The reason(s) for the consultation referral; and

(b) Consultants related recommendations.

(4) Authorization from the department is required for:

(a) More than two consultations before the thirtieth session for adults or fortieth session for children; and

(b) More than one consultation between thirty and fifty sessions for adults or between forty and sixty sessions for children.

(5) You may **not** make a referral for a consultation if:

(a) An independent mental health examination has been scheduled;

(b) Claim reopening is pending; or

(c) The claim is closed.

Note: The consultant must meet provider registration requirements per WAC [296-31-030](#).

[Statutory Authority: RCW 7.68.030 and 51.04.030. 99-20-031, § 296-31-065, filed 9/29/99, effective 11/1/99. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-065, filed 7/5/95, effective 8/5/95. Statutory Authority: Chapter 7.68 RCW. 94-02-015, § 296-31-065, filed 12/23/93, effective 1/24/94. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-065, filed 11/13/92, effective 12/14/92.]

296-31-067

When is concurrent treatment allowed?

(1) In some cases, treatment by more than one provider may be allowed by the crime victims compensation program. We may authorize concurrent treatment on an individual basis:

(a) If the accepted condition requires specialty or multidisciplinary care.

Note: Individual and group counseling sessions given by more than one provider is not concurrent treatment.

(b) If we receive and approve your written request that contains:

(i) The name, address, discipline, and specialty of each provider requested to assist in treating the client;

(ii) An outline of each provider's responsibility in the case; and

(iii) An estimated length for the period of concurrent treatment.

(2) If we approve concurrent treatment, we will recognize one primary attending mental health treatment provider. That provider will be responsible for:

(a) Directing the overall treatment program for the client;

(b) Providing us with copies of all reports received from involved providers; and

(c) In time loss cases, providing us with adequate evidence certifying the claimant's inability to work.

[Statutory Authority: RCW 7.68.030 and 51.04.030. 99-20-031, § 296-31-067, filed 9/29/99, effective 11/1/99.]

296-31-068

When can a client transfer providers?

(1) RCW 51.36.010 provides that clients are entitled to a free choice of attending providers, subject to the limits of RCW 7.68.130 and the requirements of the claimant's public or private insurance. The provider must meet registration requirements of WAC [296-31-030](#).

(2) The department must be notified if a client changes providers.

(3) We may require a client to select another provider for treatment under the following conditions:

(a) When a provider, qualified and available to provide treatment, is more conveniently located;

(b) When the attending provider fails to comply with our rules;

(c) Subject to the limits of RCW 7.68.130 outlined in subsection (1) of this section.

[Statutory Authority: RCW 7.68.030, 7.68.130 and 51.36.010. 99-20-031, § 296-31-068, filed 9/29/99, effective 11/1/99.]

296-31-069

For what reasons may the department require independent mental health or independent medical evaluations be obtained?

Independent medical and mental health evaluations may be required by the department for the following reasons:

(1) To rate permanent impairment when treatment has been concluded; or

(2) To evaluate an application to reopen a claim; or

(3) To determine if there are conditions related to the effects of the crime or preexisting conditions aggravated by the crime for which the claim was filed; or

(4) To determine if crime-related treatment is still necessary and if present treatment is effective; or

(5) To determine if treatment is still leading to recovery; or

(6) To obtain other information that may be necessary for the department to make decisions on the victim's claim.

[Statutory Authority: RCW 7.68.030, 51.04.030, 51.32.112, 51.32.114. 00-24-065, § 296-31-069, filed 12/1/00, effective 1/1/01. Statutory Authority: RCW 7.68.030, 7.68.070, 51.32.110, 51.04.020(1) and 51.04.030. 98-24-095, § 296-31-069, filed 12/1/98, effective 1/1/99. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-069, filed 7/5/95, effective 8/5/95. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-069, filed 11/13/92, effective 12/14/92.]

296-31-06901

What is required in an independent mental health evaluation report?

Practitioners participating in an independent mental health evaluation ordered by the department must provide the crime victims compensation program with a report within thirty days following the evaluation date. The report must meet the guidelines published in the *Independent Mental Health Evaluators' Handbook*.

[Statutory Authority: RCW 7.68.030, 51.04.030, 51.32.112, 51.32.114. 00-24-065, § 296-31-06901, filed 12/1/00, effective 1/1/01.]

296-31-06903

Who may perform independent mental health evaluations for the crime victims compensation program?

Providers who wish to perform independent mental health evaluations for the crime victims compensation program must be approved examiners and meet the following minimum qualifications:

| | | |
|---|---|---|
| Counselors | ▪ | Masters or doctorate degree in a field of study related to mental health; and |
| | ▪ | Licensed by the Washington department of health as a social worker, mental health counselor or marriage and family therapist. |
| Advanced registered nurse practitioners | ▪ | Licensed with the Washington department of health; and |
| | ▪ | Have a specialty in psychiatric and mental |

| | | |
|-------------------------|---|---|
| | | health nursing. |
| Psychologists | ▪ | Licensed with the Washington department of health; or |
| | ▪ | Licensed within Oregon or Idaho by that state's health care licensing authority. |
| Psychiatrists | ▪ | Board certified; and |
| | ▪ | Licensed with the Washington department of health; or |
| | ▪ | Licensed within Oregon or Idaho by that state's health care licensing authority. |
| All examiners must have | ▪ | An active practice; or |
| | ▪ | Be a clinical supervisor in an active practice; |
| | ▪ | Five years post licensure clinical experience treating crime victims; or |
| | ▪ | Three years clinical experience treating crime victims and two years supervising clinical work. |

Note: Geographic need of the program may substitute for some of the above experience requirements.

[Statutory Authority: RCW 7.68.030, 01-22-105, § 296-31-06903, filed 11/7/01, effective 12/8/01. Statutory Authority: RCW 7.68.030, 51.04.030, 51.32.112, 51.32.114, 00-24-065, § 296-31-06903, filed 12/1/00, effective 1/1/01.]

296-31-06905

How does a provider become an approved examiner to perform independent mental health evaluations for the crime victims compensation program?

Providers must submit a completed independent mental health evaluator application to the crime victims compensation program. Applications and standards for independent mental health evaluations are published in the *Independent Mental Health Evaluators' Handbook*. Approved examiners will be included on the program's approved examiners list.

[Statutory Authority: RCW 7.68.030, 51.04.030, 51.32.112, 51.32.114, 00-24-065, § 296-31-06905, filed 12/1/00, effective 1/1/01.]

296-31-06907

What factors does the crime victims compensation program consider in approving or removing examiners from the approved examiners list?

(1) The program may consider the following in approving examiners. The list is not inclusive.

- (a) Minimum qualifications established in WAC [296-31-06903](#);
- (b) Disciplinary proceeding or actions;
- (c) Experience in direct patient care and the area of specialty;
- (d) Geographic need of the program.

(2) The program may consider the following in removing examiners. The list is not inclusive.

- (a) Complaints about the conduct of the examiner;
- (b) Disciplinary proceeding or actions;
- (c) Ability to effectively convey and substantiate opinions and conclusions concerning victims;
- (d) Quality and timeliness of reports;
- (e) Availability and willingness to testify at the board of industrial insurance appeals if required;
- (f) Acceptance of the program's fee schedule rates.

[Statutory Authority: RCW 7.68.030, 51.04.030, 51.32.112, 51.32.114. 00-24-065, § 296-31-06907, filed 12/1/00, effective 1/1/01.]

296-31-06909

Is there a fee schedule for independent mental health evaluations?

The maximum fee schedule for performing independent mental health evaluations is published in the *Independent Mental Health Evaluators' Handbook* available from the crime victims compensation program.

[Statutory Authority: RCW 7.68.030, 51.04.030, 51.32.112, 51.32.114. 00-24-065, § 296-31-06909, filed 12/1/00, effective 1/1/01.]

296-31-070

What are my general obligations as an approved mental health provider?

(1) When treating a crime victim who comes under our jurisdiction, you agree to accept and comply with this chapter, the department's rules, and the *Crime Victims Compensation Program's Mental Health Treatment Rules and Fee Schedule*.

(2) You must inform the client they may be entitled to benefits under the Crime Victims Act and provide whatever assistance is necessary for the client to apply for benefits. There is no charge for these services.

(3) It is the responsibility of the client to notify the provider if they believe their condition is related to a criminal act. If you discover a condition that you believe is crime related, you must notify the client. It is your responsibility to determine if you are the first treating provider.

(4) If you are the first treating provider, you must:

(a) Provide crisis intervention as necessary;

(b) Provide instructions or help the client complete their portion of the application for benefits; and

(c) Continue necessary treatment according to our mental health rules if the client remains in your care.

(5) If you are not the first treating provider, you should ask the client if an application for benefits has been filed for the condition.

(a) If an application for benefits has been filed, and you and the client agree that a change of provider is desirable, the department should be notified of the transfer according to WAC [296-31-068](#).

(b) If an application for benefits has not been filed:

(i) Provide instructions or help the client complete their portion of the application for benefits; and

(ii) Include the name and address of the original provider, if known.

Note: Providers must determine if the client has public or private insurance benefits available. If there is, the provider should make sure they would be able to continue treating under the client's primary insurance. Crime victims compensation is secondary to other benefits according to RCW 7.68.130.

(6) You must notify us and the client of the date they are released to regular work. Time-loss compensation terminates on the release date. We may allow further treatment if:

(a) You request it;

(b) Treatment is needed; and

(c) The accepted condition is not fixed and stable.

(7) You must notify us if permanent functional impairment or loss (permanent partial disability) is indicated after maximum recovery of the accepted condition is achieved. We will arrange to have impairments rated according to WAC 296-20-200 et al.

(8) A client must not be billed for treatment, except under the following condition:

A provider may require the client to pay for treatment if the client's eligibility is in question (e.g., when an investigation or claim determination is pending). If the claim is subsequently allowed, the provider must refund the client **in full** and bill us at their usual and customary fees if such rates are in excess of the public and private insurance entitlements.

(9) No fee is payable by the department for missed appointments unless the appointment is for an examination arranged by the department. Clients may be billed directly for missed or no show appointments.

[Statutory Authority: RCW 7.68.030. 04-14-069, § 296-31-070, filed 7/2/04, effective 8/2/04. Statutory Authority: RCW 7.68.030, 7.68.060, 7.68.080. 00-03-056, § 296-31-070, filed 1/14/00, effective 2/14/00. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-070, filed 7/5/95, effective 8/5/95. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-070, filed 11/13/92, effective 12/14/92.]

296-31-071

What records must providers maintain?

If providers request payment from us for service, they must:

(1) Maintain all patient and billing records needed to:

(a) Determine the extent of services provided to claimants or to their family members. Each record must, at a minimum:

(i) Document the level and type of service provided; and

(ii) Where applicable, indicate the name of our representative who authorized equipment or treatment.

(b) Comply with our audit of services, if an audit is authorized.

(2) Maintain records for audit purposes for at least five years from the claimant's last treatment date.

(3) Provide records to us, if requested.

Note: The confidentiality (safeguarding and release) of a claimant's records is governed by RCW 7.68.140 and 7.68.145 of the Crime Victims Act.

[Statutory Authority: RCW 7.68.030, 51.04.020(4) and 51.04.030. 99-07-004, § 296-31-071, filed 3/4/99, effective 4/4/99. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-071, filed 11/13/92, effective 12/14/92.]

296-31-072

Are provider records subject to a health care services review or an audit?

(1) We may review or audit patient and related billing records to ensure:

(a) Claimants are receiving proper and necessary care; and

(b) You are complying with our mental health rules, fee schedules, and policies.

A records review can become the basis of corrective action against you.

(2) We may review your records:

(a) Before, during or after delivery of services;

(b) For cause or at random;

(c) Using statistical sampling methods and projections based on sample findings; and

(d) At or away from your place(s) of business.

(3) We must provide you with ten working days written notice that our auditors intend to review your patient and related billing records at your place(s) of business.

(4) We will not remove original records from your place of business, but we may request copies of your records. If copies are requested, they must be legible and provided to us within thirty calendar days of receiving our request.

[Statutory Authority: RCW 7.68.030, 51.04.020(4) and 51.04.030. 99-07-004, § 296-31-072, filed 3/4/99, effective 4/4/99.
Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-072, filed 11/13/92, effective 12/14/92.]

296-31-073

Can the department enlist utilization review or management programs?

As a trustee of funds appropriated by the legislature, we have a duty to supervise the provisions of proper and necessary mental health care. We may enlist utilization review or management programs to monitor and control the delivery, use, and cost of necessary mental health care services. Examples include, but are not limited to, managed care contracting, prior authorization of services, and alternative reimbursement systems.

[Statutory Authority: RCW 7.68.030, 51.04.020(4) and 51.04.030. 99-07-004, § 296-31-073, filed 3/4/99, effective 4/4/99.
Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-073, filed 11/13/92, effective 12/14/92.]

296-31-074

What if my patient has an unrelated condition?

(1) You must immediately notify us when you are treating an unrelated condition concurrently with an accepted condition and provide us with the following information:

- (a) Diagnosis and/or nature of unrelated condition;
- (b) Treatment being provided; and
- (c) The effect, if any, on the accepted condition.

(2) Temporary treatment of an unrelated condition may be allowed and payment for service authorized if:

- (a) We approve your request for authorization prior to treatment;
- (b) You give us a thorough explanation of how the unrelated condition is affecting the accepted condition;
- (c) Treatment of the unrelated condition is retarding recovery of the accepted condition; and
- (d) We receive monthly reports from you, outlining treatment and its effect on both the unrelated and accepted conditions.

(3) We will not approve or pay for treatment of:

- (a) An unrelated condition that has no influence or no longer influences the existing condition.
- (b) A preexisting unrelated condition that was treated prior to acceptance of the crime victim's claim, unless it is retarding recovery of the accepted condition.

[Statutory Authority: RCW 7.68.030. 00-03-056, § 296-31-074, filed 1/14/00, effective 2/14/00.]

296-31-075

What is excess recovery?

The remaining balance of a recovery, which is paid to the victim but must be used to offset future payment of benefits.

How does excess effect the bill payment process?

- (1) When an excess recovery exists, the department is not responsible for payment of bills.
- (2) The provider must bill the department in accordance with the department's medical aid rules and maximum fee schedules.
- (3) The department will:
 - (a) Determine the amount payable according to the fee schedule;
 - (b) Credit the excess recovery with the amount payable; and
 - (c) Send the provider a remittance advice showing the amount due from the victim.
- (4) The victim must pay the provider in accordance with the remittance advice.
- (5) When the excess is reduced to zero the department will resume responsibility for payment of bills.

[Statutory Authority: RCW 7.68.030, 7.68.050 and 7.68.130. 99-07-004, § 296-31-075, filed 3/4/99, effective 4/4/99.
Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-075, filed 7/5/95, effective 8/5/95.
Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-075, filed 11/13/92, effective 12/14/92.]

296-31-080

How do providers bill for services?

(1) Neither the department nor the claimant is required to pay for provider services which violate the mental health treatment rules, fee schedule or department policy.

(2) All fees listed are the maximum fees allowable. Providers must bill their usual and customary fee for each service. If this is less than our fee schedule rate, you must bill us at the lesser rate. The department will pay the lesser of the billed charge or the fee schedule's maximum allowable.

The provider is prohibited from charging the claimant for any difference between the provider's charge and our allowable amount.

(3) Regardless of who completes the bill form, you are responsible for the completeness and accuracy of the description of services and of the charges billed.

(4) All bills submitted to the department must:

- (a) Be itemized on forms approved by us.

For example: Physicians, psychologists, advanced registered nurse practitioners and master level mental health counselors may use our form or the current Health Insurance Claim Form (as defined by the National Uniform Claim Committee). Hospitals use the current National Uniform Billing Form (as defined by the National Uniform Billing Committee) for institution services and the current Health Insurance Claim Form (as defined by the National Uniform Claim Committee) for professional services.

(b) Refer to the crime victims compensation program mental health billing instructions for detailed billing information. Billings must be submitted in accordance with these instructions. Procedure codes and fees are available on the crime victims compensation web site or by contacting the crime victims program.

(5) The following supporting documentation must be maintained and, if applicable, submitted when billing for services:

- (a) Intake evaluation;
- (b) Progress reports;
- (c) Consultation reports;
- (d) Special or diagnostic study reports;
- (e) Independent assessment or closing exam reports;

(f) BR (by report) describing why a service or procedure is too unusual, variable, or complex to be assigned a value unit;

(g) The claimant's or patient's (if patient is other than claimant) private or public insurance information;

For example: When services provided are for survivors of homicide victims.

(6) The claim number must appear in the appropriate field on each bill form. Reports and other correspondence must have the claim number in the upper right hand corner of each page.

(7) You may rebill us if your bill is not reported on your remittance advice within sixty days. Unless the information on the original bill was incorrect, a rebill should be identical. Rebills must be submitted for services denied if a claim is closed or rejected and subsequently reopened or allowed.

(8) We will adjust charges when appropriate. We must provide you with a written explanation as to why a billing was adjusted. A written explanation is not required if the adjustment was made solely to conform to our maximum allowable fees. Any inquiries regarding adjustment of charges must be received in the required format within ninety days from the date of payment.

[Statutory Authority: RCW 51.04.020, 51.36.080, 7.68.030, 7.68.080, 07-08-088, § 296-31-080, filed 4/3/07, effective 5/23/07. Statutory Authority: RCW 7.68.030, 7.68.080, 7.68.120, 51.36.010, 51.04.020 (1) and (4) and 51.04.030. 99-07-004, § 296-31-080, filed 3/4/99, effective 4/4/99; 97-02-090, § 296-31-080, filed 12/31/96, effective 1/31/97. Statutory Authority: RCW 7.68.030, 51.04.020(1) and 51.04.030. 95-15-004, § 296-31-080, filed 7/5/95, effective 8/5/95. Statutory Authority: Chapter 7.68 RCW. 94-02-015, § 296-31-080, filed 12/23/93, effective 1/24/94. Statutory Authority: RCW 43.22.050. 92-23-033, § 296-31-080, filed 11/13/92, effective 12/14/92.]

296-31-085

Can out-of-state providers bill the department?

(1) Providers of mental health diagnostic and treatment services located outside the state of Washington:

(a) May bill us for services that we allow and are authorized by the crime victims compensation program mental health treatment rules;

(b) Must bill us according to the provisions of this chapter;

(c) Must bill their usual and customary fees; and

(d) Will be paid according to the Washington state crime victims compensation program mental health treatment rules and fees.

Exception: Hospitals located outside the state of Washington are paid according to WAC 296-30-081.

(2) Independent medical or mental health examinations must be billed and will be paid according to the examiner's usual and customary fee.

(3) We will not reimburse a charge for service(s) allowed under any out-of-state crime victims compensation program unless it is allowed in chapters 296-30 and 296-31 WAC. When in doubt, the provider should contact us to verify coverage.

[Statutory Authority: RCW 7.68.030, 7.68.080, 7.68.120, 51.36.010, 51.04.020 (1) and (4) and 51.04.030 . 99-07-004, § 296-31-085, filed 3/4/99, effective 4/4/99.]

*Other formats for persons with disabilities are available on request.
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