

Medical Treatment

Self-Insurance Claim Adjudication Guidelines

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Ambulance Services [RCW 51.36.020](#)

Emergency Transport

Ambulance services are paid when a worker's injury is so serious that the use of any other method of transportation is contraindicated.

The insurer pays for ambulance services to the nearest place of proper treatment:

- The facility must be generally equipped to provide the needed medical care.
- A facility is not considered a place of proper treatment if no bed is available when inpatient medical services are required.

Air ambulance services, either by helicopter or fixed wing aircraft, are paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that could not have been provided by ground ambulance, or
- The point of pickup is inaccessible by ground vehicle, or
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

Nonemergency Transport

Only medical providers may arrange for non-emergency ambulance transportation. Workers may not arrange nonemergency ambulance transportation.

Nonemergency transport by ambulance is appropriate if:

- The worker is bed-confined, and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated.

Bed-confined means the worker is unable to:

- Get up from bed without assistance, and
 - Ambulate, and
 - Sit in a chair or wheelchair
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

An ambulance can also be used to transport workers to:

- Another facility for treatment.
- Their own city if injured and treated in another city.
- Scheduled, regularly provided diagnostics or treatment.
- An independent medical examination or a consultation.

Payment is made in accordance with the appropriate fee schedule.

Amputation and Prosthetics [RCW 51.36.020](#), [WAC 296-20-1102](#)

The insurer will authorize and pay for amputation, prosthetics, and orthotics when needed by the worker and substantiated by the attending provider. The provider must obtain prior authorization, and the amputation, prosthetics, and orthotics must be appropriate and medically necessary to treat the worker's accepted condition.

There are three types of claims involving amputation and prosthetics;

- A traumatic amputation, where a catastrophic incident either caused or necessitated the amputation of a limb or appendage.
- An amputation as a result of complications of the injury or occupational disease itself or from complications caused by preexisting or unrelated illness.
- An injury that caused damage to an artificial limb. (Once the repair/replacement is completed and certified by the attending provider as acceptable, no additional prosthetic services should be allowed under the claim.)

Prosthetics

With any amputation, there will be post-operative casting applied to the remaining portion of the limb (stump). The initial prosthesis is a temporary one and will last from three to nine months. Each replacement will last about twice as long as the previous replacement, up to a long-term replacement every three to five years. Although stump shrinkage may occur at any time, the majority of shrinking will occur during the first three to nine months.

Stump Socks and Sleeves

Reasonable quantities of stump socks and sleeves should be authorized. For example, a moderately active amputee may need seven pairs of prosthetic socks and/or two sleeves approximately every six months. More socks and/or sleeves will be needed to prevent skin breakdown for extremely active amputees and during warmer weather.

Additional or Backup Prosthetics

The purchase of an original prosthetic and a backup prosthetic can be allowed if both are medically necessary. Normally, a worker can get by with just one prosthesis by using an old prosthesis for backup when the good one needs to be repaired.

Depending on the worker's job and medical documentation, there may also be situations when a work prosthesis and a second one, for home or social use, should be allowed. Authorizations for additional or backup prostheses must be based on medical need.

Repair and Replacement

The insurer is responsible for repairing or replacing prosthetics for the lifetime of the worker who lost a limb as a result of an industrial injury, as long as the damage is not caused by negligence.

- The insurer will repair or replace damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices which were originally furnished by the insurer.
- The insurer will repair or replace prosthetics when needed due to normal wear and tear or anatomical changes and medically necessary.

The insurer is not responsible for replacing lost or stolen insurer-provided prosthetics or special equipment. There are no provisions for lost or stolen prosthetics in [WAC 296-20-1102](#).

Permanent prostheses should last from three to five years, depending on the activity level, including the job of the worker. Most manufacturers recommend that prosthetists replace the components in a limb at three-year intervals to prevent fractures and part failure. Prosthetists try to repair limbs to keep them functional, but there are times when they must be replaced. If parts are worn out and dangerous, a new limb will be requested. Most parts carry a manufacturer's warranty of three months to one year. Satisfaction and workmanship warranties vary with each facility.

When receiving a request for prosthetic replacement, there are several factors to consider:

- Very active amputees usually need replacements or major modifications every two to three years. Therefore, the length of time since the previous replacement should be checked.
- The use of multiple prosthetic socks or those of extra thick ply would indicate excessive stump shrinkage. This may require relining the socket, a new socket, or replacing the prosthesis.
- Only two check sockets are allowed per prosthetic construction. A check socket is a temporary trial socket to check the fit. In some cases, x-rays may be required to determine where bone is located to avoid pressure points, which can lead to skin ulcers.

Repairing or Replacing Prosthetics on Closed Claims

It is not necessary to reopen a closed claim to repair or replace a prosthesis or authorize socks or sleeves which were originally supplied under the claim. (See [WAC 296-20-124\(4\)](#).)

Autologous Blood Transfusions

Authorization is not required for the collection and storage of a worker's blood prior to a planned surgery.

The Washington State Blood Bank requires a physician's prescription.

Prior authorization is required for the oral iron and/or vitamin C products prescribed by an attending provider to prevent anemia as a result of the blood being drawn. The use of these dietary supplements should begin one month before the first donation and continue for at least six months after the first donation.

Biofeedback [WAC 296-20-03001\(10\)](#), [WAC 296-20-280](#)

Biofeedback treatment requires an attending provider's prescription and must be prior authorized. Biofeedback is not a cure-all and does not work equally well for all workers. Whether or not biofeedback is an appropriate treatment technique is determined by an initial evaluation.

Biofeedback treatment uses concentration and relaxation techniques, as well as electronic equipment, to teach workers how to control voluntary physiologic responses. A physiological response, such as muscle tension or skin temperature, is measured, and information about the response is immediately provided to the worker. In this way, the worker can learn how his or her body is reacting, and in many cases, how to control different physiological systems to better control pain and other symptoms.

Biofeedback may be very helpful in the treatment of stress-related disorders, such as tension headaches, migraine headaches, hypertension, pain management, circulatory problems, and general anxiety.

A typical session lasts 40 to 50 minutes, during which the worker may try different strategies to learn to control the specific body system. Biofeedback usually takes one or two sessions per week. The overall length of treatment depends on the medical problem and the worker's progress.

Chiropractic Treatment

Introduction

[RCW 51.36.015](#) permits workers to seek chiropractic care and evaluation. Chiropractic doctors must be licensed under RCW 18.25. Chiropractic is defined by [RCW 18.25.005](#):

“Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.”

Chiropractic Scope of Practice

In June 2002, [RCW 18.25.005](#) expanded the chiropractic scope of practice. Before the law change, a spinal condition needed to be part of the accepted injury or occupational disease in order for a chiropractor (DC) to be an attending provider (AP). Otherwise, a provider with a broader scope of practice needed to be the AP. In some cases, chiropractors could be concurrent care providers. Since this linkage is no longer required, chiropractors may be attending providers on claims for extremity conditions. Chiropractors may:

- Diagnose all joint dysfunction and musculoskeletal disorders, including those originating in the extremities.
- Treat back injuries with spinal adjustments and therapies. Extremity joint manipulations can be done along with the spinal adjustment. There is no separate charge allowed for it.

Chiropractic X-rays [WAC 296-20-121](#)

X-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization when medically necessary.

- No payment will be made for excessive or unnecessary x-rays.
- Repeat or serial x-rays may be performed only upon receipt of adequate clinical justification to confirm changes in the worker's condition.

Chiropractic Treatment

Chiropractic treatment is conservative care and usually consists of spinal adjustments and extremity joint manipulations. Chiropractors may bill only one chiropractic care visit per day. Chiropractic treatment may not include the application of sound, diathermy, or electricity, but may include:

- The use of heat, cold, water, exercise, massage, trigger point therapy, traction, and light.
- Certain types of supportive devices, such as cervical collars, lumbosacral supports, heel lifts, and under certain conditions, orthotics, such as arch supports, or spinal pelvic stabilizers.
- Patient education in daily living, exercise, and return to work; counseling on diet, hygiene, sanitation, and preventative measures.
- Referral to physical therapy, licensed massage therapy, or other medical specialists.

Chiropractic Diagnoses and Billing

Chiropractors may diagnose and bill for any musculoskeletal conditions and are no longer limited to diagnosing only specific International Classification of Diseases (ICD-9) codes.

The chiropractor must provide the reports required by [WAC 296-20-01002](#) and [WAC 296-20-06101](#), including documentation that the:

- Objective findings support the subjective complaints.
- Diagnosis being treated is related to the injury on a more probable than not basis.
- Treatment recommended has a clear goal and is time-limited.
- Progress reports indicate that the treatment plan has been effective and supports continued and curative and/or rehabilitative treatment.

Chronic Pain Management Program [WAC 296-20-12055 through WAC 296-20-12095](#)

Injured workers eligible for benefits under Title 51 RCW may be evaluated for and enrolled in a comprehensive treatment program for chronic noncancer pain if it meets the definition of a structured, intensive, multidisciplinary program (SIMP).

Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain ([WAC 296-20-12055](#)).

All SIMP services require:

- Prior authorization by the insurer; and
- A referral from the worker's attending provider.

An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider. Refer to [WAC 296-20-12095](#) for referral and prior authorization requirements.

Special conditions and requirements apply to workers who are considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease. Lumbar surgery candidates **must** successfully complete a SIMP to obtain authorization for a lumbar fusion or a lumbar intervertebral artificial disc replacement ([WAC 296-20-12060](#)).

SIMP

SIMP is defined in [WAC 296-20-12065](#) as a chronic pain management program with the following four components:

S—Structured means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed health care practitioners. Workers follow a treatment plan designed specifically to meet their needs.

I—Intensive means the treatment phase is delivered on a daily basis, 6-8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs.

M—Multidisciplinary (interdisciplinary) means that structured care is delivered and directed by licensed health care professionals with expertise in pain management in **at least** the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits.

P—Program means an interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

An Approved SIMP Consists of Three Phases

- Evaluation Phase – [WAC 296-20-12070](#)
- Treatment Phase – [WAC 296-20-12075](#)
- Follow up Phase – [WAC 296-20-12080](#)

Requirements the SIMP Provider Must Meet [WAC 296-20-12085](#)

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all the requirements listed in this section. They must:

- Meet the definition of a Structured Intensive Multidisciplinary Program.
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF). Providers must maintain CARF accreditation and provide the L&I with documentation of satisfactory recertification. A

provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed.

- Provide the services described in each phase.
- Communicate with providers who are involved with the worker's care.
- Ensure care is coordinated with the worker's attending provider.
- Inform the claim manager whether the worker stops services prematurely, has unexpected adverse occurrences, or does not meet the worker requirements.
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment.
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed.
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Requirements the Worker Must Meet

An injured worker must make a good faith effort to comply with the treatment plan prescribed for them by the SIMP provider. To successfully complete a SIMP, the worker must meet all the requirements in [WAC 296-20-12090](#).

Vocational Services and SIMP

Vocational Referrals

The insurer will determine, based on the facts of each case, whether to request a vocational referral prior to authorizing participation in a SIMP. The insurer may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable ([WAC 296-19A-020](#)). The insurer will not make a vocational referral when the worker:

- Is working.
- Is scheduled to return to work.
- Has been found employable or not likely to benefit from vocational services.

Return to Work Action Plan

A return to work action plan is required when vocational services are needed in conjunction with SIMP treatment and the insurer assigns a vocational counselor ([WAC 296-20-12075\(8\)](#)).

The return to work action plan provides the focus for vocational services during a worker's participation in a chronic pain management program. The return to work action plan may be modified or adjusted during the treatment or follow up phase as needed.

At the end of the program, the outcomes listed in the return to work action plan must be included with the treatment phase summary report. The insurer assigned vocational counselor will work with the SIMP vocational counselor to agree upon a return to work action plan with a return to work goal.

Return to Work Action Plan Roles and Responsibilities

In the development and implementation of the return to work action plan, the insurer assigned vocational counselor, the SIMP vocational counselor, the attending provider, and the worker are involved. Their specific roles and responsibilities are listed below.

- The SIMP Vocational Counselor:
 - Co-develops the return to work action plan with the insurer assigned vocational counselor.
 - Presents the return to work action plan to the claim manager at the completion of the evaluation phase if the SIMP recommends the worker move on to the treatment phase and needs assistance with a return to work goal.
 - Communicates with the insurer assigned vocational counselor during the treatment and follow up phases to resolve any problems in implementing the return to work action plan.

- The insurer assigned vocational counselor:
 - Co-develops the return to work action plan with the SIMP vocational counselor.
 - Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone.
 - Negotiates with the attending provider when the initial return to work action plan is not approved in order to resolve the attending provider's concerns.
 - Obtains the worker's signature on the return to work action plan.
 - Communicates with the SIMP vocational counselor during the treatment and follow up phases to resolve any problems in implementing the return to work action plan.
 - Implements the return to work action plan following the conclusion of the treatment phase.

- The attending provider:
 - Reviews and approves/disapproves the initial return to work action plan within 15 days of receipt;
 - Reviews and signs the final return to work action plan at the conclusion of the treatment phase within 15 days of receipt;
 - Communicates with the insurer assigned vocational counselor during the treatment and follow up phases to resolve any issues affecting the return to work goal.

- The worker:
 - Will participate in the selection of a return to work goal;
 - Will review and sign the final return to work action plan;
 - Will cooperate with all reasonable requests in developing and implementing the return to work action plan. Should the worker fail to be cooperative, the sanctions as set out in [RCW 51.32.110](#) shall be applied.

Concurrent Treatment [WAC 296-20-071](#)

It is preferable that an injured worker be under the care of one provider who can treat all areas of injury. However, in some cases, treatment by more than one provider may be allowed.

The insurer can consider allowing concurrent treatment when the accepted conditions resulting from the injury involve more than one body area or system, and/or require specialty or multidisciplinary care.

When requesting consideration for concurrent treatment, the attending provider (AP) must provide the insurer with:

- The name, address, discipline, and specialty of all other practitioners assisting in treatment,
- An outline of their responsibilities, and
- An estimate of the length of the period of concurrent care.

Each request for concurrent treatment must be considered on an individual basis. Consideration should be given to all factors in the case, including:

- The availability of providers in the worker's geographic location.
- The AP's willingness to treat all conditions.

Concurrent treatment should be goal-oriented and time-limited. It should rarely be long-term, except in claims with multiple areas of injury, for example:

- Accepted lumbar and psychiatric conditions.

- Spinal cord injuries.
- Multiple fractures, etc.

When concurrent treatment is allowed, the insurer will recognize one primary AP. The primary AP will be responsible for directing the over-all treatment program, including:

- Monitoring or prescribing medications, when appropriate,
- Directing the overall treatment program,
- Providing copies of all reports and other data received from the involved practitioners, and
- Providing adequate certification of the injured worker's inability to work in time-loss cases.

Concurrent care providers may prescribe medications, if appropriate. Prescribing concurrent care providers are required to send the primary AP, and the insurer, all required reports, including a report of the medications prescribed.

Consultations

Medical consultations can be used in claims for a variety of reasons.

- The attending provider (AP) may identify a need for a consultation to evaluate a worker's condition to assist with a diagnosis or treatment plan ([WAC 296-20-051](#)).
- A complete examination is required to determine the need for continued treatment beyond 60 days ([WAC 296-20-035](#)).
- A consultation may be used to determine the appropriateness of drugs a worker is receiving ([WAC 296-20-03015](#)).
- To resolve controversy, disputes, for nonemergent major surgery, treatment aspects of a claim, conservative care beyond 120 days, or when requested by the insurer ([WAC 296-20-045](#)).

Consultations do not require authorization ([WAC 296-20-030](#)) within the guidelines of [WAC 296-20-051](#).

Medical consultants must submit the required reports ([WAC 296-20-01002](#) and [WAC 296-20-06101](#)). Any recommendations from the consultant should be sent to the AP to determine if they concur with the recommendations. In some cases the consultant may recommend treatment which is not within the scope of the AP. If the AP concurs they should assist the worker in selecting a provider who can carry out the recommended treatment. If the AP does not concur with the recommendations, a transfer should not be required.

Coverage Decisions on Medical Devices & Procedures

For coverage decisions made by L&I's Office of the Medical Director, access the [Condition and Treatment Index](#). Select the treatment or condition for additional information about billing and related rules. You will find:

- A list of policies relating to medical devices and procedures.
- Health technology assessments, study reports, and systematic reviews completed or commissioned by L&I.

If you need the department to evaluate a medical device not yet addressed, fill out and submit a [Medical Device Review Request](#) form.

Dental Treatment [WAC 296-20-110](#)

The insurer is only responsible for repair or replacement of teeth injured or dentures broken as a result of an industrial injury. Dental work needed because of underlying conditions unrelated to the industrial injury, such as decay, is the responsibility of the worker.

Dental repair or replacement may be done by general practitioners or specialists. About 80 percent of all dentists are general practitioners. The following are specialists:

- Endodontists deal with the diagnosis and treatment of diseases of the tooth pulp, and injuries involving the pulp and supporting tissues.
- Oral and maxillofacial surgeons treat diseases, injuries, and defects of the jaw, mouth, and face using surgery. They also perform extractions.
- Orthodontists guide and correct growing or mature dentofacial structure. They also treat conditions that require moving teeth, or correcting malformations or poor relationships of teeth and jaws.
- Periodontists treat diseases of the tissues supporting and surrounding the teeth.
- Prosthodontists design and fit dentures, bridges, and other replacements for missing teeth.

The dentist must outline the extent of the dental injury and the treatment program necessary to repair damage due to the injury. The insurer must know exactly what teeth were injured.

Dental injuries and their treatment may include:

- Tooth Fractures – classified and treated as:
 - Class I: Fracture of only the enamel cap of the tooth. Treatment frequently requires only the smoothing of irregularities along the fracture line.
 - Class II: Extensive injury to the crown with a pulp exposure. Treatment generally requires a full crown after cleaning and filling the affected pulp canal.
 - Class III: Extensive injury to the crown with a pulp exposure. Treatment generally requires a full crown after cleaning and filling the affected pulp canal.
 - Class IV: Fracture at or below the cemento enamel junction of the tooth. Generally, if the tooth root is fractured apical to the level of cemento enamel junction, the tooth should be extracted.
- Luxation – Simple loosening of a tooth. Treatment may range from simple observation to the need for stabilization or splinting by bonding to adjacent teeth or wiring to existing bridgework or crowns. Direct impact may result in its intrusion (impaction) further into the bone surrounding the socket.
- Avulsion – The tooth and root are completely torn away. If brought to the dentist within four to six hours and kept clean and moist, endodontic therapy can be performed extraorally and the tooth replanted and stabilized by bonding to adjacent teeth.

For PPD on dental claims see the [Permanent Partial Disability](#) chapter in the Claim Adjudication Guidelines.

Authorization

All dental work requires preauthorization. Dental work, such as extractions, x-rays, caps, crowns, and bridges are payable if needed as a result of the injury. If a bridge or partial denture must be replaced and the abutment or anchor teeth cannot be used, the insurer should authorize extension of the bridge or partial as far as necessary to adequately secure it. When it is necessary to include restoration of previously missing or decayed teeth in order to carry out restorative work needed due to the injury, this can be allowed if the dentist explains and documents the need for the additional work. When it is inadvisable to use any restoration and a full denture is needed due to injury-related loss of teeth, the insurer will pay for the extractions and denture.

Relining of dentures is not authorized in advance or as part of the denture fee. If relining or replacement is needed on a closed claim for dentures provided by the insurer, this can be authorized without reopening the claim. The insurer is unable to authorize further dental work unless the claim is reopened.

Although dental implants are no longer considered experimental or controversial, they are more expensive than alternate treatments, such as bridges or partial dentures. If dental implants are requested, the insurer should find out why implants are considered the appropriate treatment and obtain justification on why other dental procedures would not be acceptable. If the reason for implants over other alternatives is cosmetic, or the worker prefers them to another medically acceptable alternative, the request will likely be denied. If the reason for implants is that they are the best treatment alternative, they should be covered. For example, if a worker has healthy teeth and gums but has lost front teeth, implants may be the appropriate treatment.

General Drug Guidelines

General Principles Used to Determine Coverage [WAC 296-20-03010](#)

- The insurer will pay for drugs deemed proper and necessary. See [WAC 296-20-01002](#) for the definition of proper and necessary.
- The insurer pays for drugs when they are used as recommended by the FDA, or within current medical standards.

General Limitations [WAC 296-20-03011](#)

- Payment is made for a 30-day supply at a time, including opioids and other scheduled drugs.
- Payment is made for over-the-counter items when prescribed by the provider.
- Prescriptions must be filled with generic drugs unless the provider indicates a substitution isn't permitted.
- Payment isn't made for scheduled drugs for continuing pain on pension claims.
- Payment is made for unrelated drugs only when hindering recovery. Prior authorization is required.

Outpatient Drug and Medication Decisions [WAC 296-20-03012](#)

- See <http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/PDL.asp> for the department's complete formulary.
- The drug formulary is also found in Appendix F of the [Medical Aid Rules and Fee Schedules](#) (MARFS).
- The formulary lists drugs in the following categories:

- Allowed: Drugs routinely used for treatment of accepted industrial injuries and occupational diseases.
- Prior authorization required: Some drugs require prior authorization usually because they are for conditions not normally considered work related.
Example: drugs to treat for hypertension.
- Denied: Drugs not normally used for treating industrial injuries or not normally dispensed by outpatient pharmacies.
Examples: hormones and most nutritional supplements.

Drugs with Limitations [WAC 296-20-03014](#)

- Injectable drugs are covered for inpatients:
 - During emergency treatment, and
 - In cases of severe injuries when needed for dressing or cast changes.
- In general, injectable drugs aren't covered for outpatients. For post-operative care, injectable drugs may be covered for 48 hours from the time of discharge.
- Insulin, heparin, anti-migraine medications, or drugs for impotency treatment, are covered only when proper and necessary.
- Sedatives or hypnotics aren't covered for chronic conditions.
- Benzodiazepines (**Examples:** Valium, Ativan, Serax, Klonopin, Dalmane.) are covered only for:
 - Inpatients,
 - Workers with accepted psychiatric disorders,
 - A psychiatric disorder retarding recovery,
 - Workers with spinal cord injuries, or
 - Cancer.
(**Hint:** Look also for drugs ending in "zepam.")
- Stadol, a nasally administered pain reliever, is not covered.

Special Drug Situations

- See [WAC 296-20-03013](#) for special circumstances for payment of denied outpatient drugs.
- See [WAC 296-20-03015](#) for the steps to take if there are concerns with medications prescribed for the worker.

- See [WAC 296-20-03016](#) for rules regarding payment for detoxification or chemical dependency treatment.
- See [WAC 296-20-03017](#) for reporting requirements for prescribing providers.
- See [WAC 296-20-03018](#) for payment of inpatient drugs.
- [WAC 296-20-03019](#) states the insurer will pay for oral opioids for chronic **noncancer** pain when deemed proper and necessary.
- For rules regarding payment for opioid medications for treatment of chronic pain, see the department's [Opioid Rules](#).

Home and Vehicle Modifications

[WAC 296-23-180](#) requires approval from the assistant director for industrial insurance for home and vehicle modifications. However exceptions have been made in Policies 11.10 and 11.20 that allow a self-insured employer to pay without department approval. Denial of these benefits must be approved by the department.

Home Modifications [RCW 51.36.020\(7\)](#), Policy 11.10

A home modification is a permanent structural change to a worker's residence. These may include, but are not limited to changes such as ramps, change in height of counters, widened doorways, and modifications to a primary bathroom.

Medical equipment such as doorknobs and grab bars may be appropriate as part of a home modification. However, the worker does not need a modification to the home to receive medical equipment such as a shower transfer bench.

In order for a worker to qualify for a home modification under [RCW 51.36.020\(7\)](#):

- They must have sustained a catastrophic injury;
- The modification must be proper and necessary; and
- The claim must be open or in a pension status for consideration.

Modifications must be appropriate for the worker's actual functional disability, style of home and level of self-care. Recommendations must meet accessibility standards.

The law entitles a worker up to 100 percent of the state's average annual wage at the time of modification. It should be noted that only **one** residence may be modified or constructed under [RCW 51.36.020\(7\)](#). Later modifications can be considered for the same residence.

Vehicle Modifications [RCW 51.36.020](#)(8), Policy 11.20

A vehicle modification is a change made to a worker's vehicle to facilitate a return to work or to help make the worker as independent and safe as possible. These include, but are not limited to changes such as adapted foot and hand controls, electric lifts, and specialized seats. The worker **must** show proof of ownership of the vehicle to be modified.

Injured workers who have experienced catastrophic injuries in which permanent paralysis or amputation has occurred may be eligible for vehicle modification under [RCW 51.36.020](#)(8). In order for a worker to qualify for a vehicle modification:

- The paralysis or amputation must interfere with the worker's ability to operate or be transported in a motor vehicle;
- The modification must be reasonable and necessary; and
- The claim must be open or in a pension status for consideration.

The insurer should obtain a vehicle modification consultation to determine need. A vehicle modification consultation should be conducted by an occupational therapist, physical therapist or licensed medical professional with experience or training in rehabilitation and vehicle modification for people with permanent paralysis or amputation.

A vehicle modification is considered reasonable and necessary when all of the following are true:

- The modification is necessary to meet the worker's needs for safe transportation; and
- The proposed modification will satisfy the necessary transportation needs; and
- The vehicle is mechanically sound (is expected to be operational for at least five more years).

Each vehicle modification cannot exceed 50 percent of the state's average annual wage at the time of modification. An additional \$4,000 may be provided over the 50 percent limit for vehicle modification.

Regardless of the number of vehicles owned by the worker, vehicle modifications are limited to one vehicle. At such time as the modified vehicle becomes mechanically unsound, further consideration can be given to modification of another vehicle.

The worker may be entitled to multiple modifications of the same vehicle. Where the insurer has already given a worker payment for a vehicle modification, the insurer will consider an additional modification reasonable and necessary only in one of the following situations:

- The worker's functional ability has changed or a new medical condition is allowed, resulting in the need for additional modifications, or
- The original modification needs repair unless it is covered by manufacturer warranty. If the claim is closed, repair or replacement of the original modification may be made without reopening the claim. ([WAC 296-20-124](#))

Home Health and Nursing Home Services

Introduction

Home health care providers, such as registered nurses (RNs), physical therapists (PTs), occupational therapists (OTs), speech therapists (STs), attendants, nursing homes, hospices, and other residential care services require prior authorization. The insurer will only pay for proper and necessary care, and the supplies needed because of the physical restrictions caused by the industrial injury or occupational disease. The insurer will not pay for services that are not specifically authorized.

Home Health Care and Attendant Services [RCW 51.32.060\(3\)](#), [RCW 51.32.072](#), [WAC 296-20-091](#), [WAC 296-23-245](#), [WAC 296-23-246](#)

In order to receive home health care or attendant services, the worker must be physically unable to care for his or her personal needs. In addition, the attending provider (AP) must advise that these services are necessary due to the industrial injury or occupational disease.

Home health care and attendant services will be provided in the worker's residence. These services allow the worker to stay at home, instead of in a hospital or skilled nursing facility.

Home Health Care Definitions [WAC 296-20-01002](#)

The following terms are commonly associated with home health care and attendant services:

Agency - One of three types: home health, home care, or hospice. The Department of Health licensing law describes the types of services each can provide. L&I requires that agencies be licensed.

- Home Health Care Agency - Provides personal care services, and supplies multiple services in the home, such as PT, OT, ST, and nursing care.

- Home Care Agency - Provides personal care services, such as feeding, dressing, and bathing, but not nursing care. This type of agency can be used for long-term maintenance attendant services.
- Hospice Agency - Provides care to workers with terminal illnesses where death is imminent.

Home Health Care - A professional service provided by RNs, PTs, OTs, or STs, or aide care supervised by health care professionals. Home health care includes hourly and intermittent nursing care that is medically necessary and coordinated by a nursing agency. It may be long- or short-term, depending on the needs of the worker. For example, a worker in a body cast may need temporary care, and a quadriplegic may need permanent care.

Approved hours will be based on a RN's home nursing evaluation of the worker's care needs. A written report must be submitted to the insurer within 15 days of the evaluation. Updated plans must be submitted every 30 days thereafter. Respite (interval of rest or relief) care must also be approved in advance. Some examples of home care services include:

- Home PT and OT for workers to be taught ambulation, transferring, or other activities of daily living in their home environment.
- Home professional nursing care for home IV antibiotic administration, sterile dressing changes, or oxygen administration.
- Home health aide care for bathing, dressing, toileting, feeding, and to follow some health care treatment plans, such as range of motion (ROM) exercises or skin inspection for pressure sores.

Attendant Services - Proper and necessary personal care services provided to maintain the worker in his or her residence. Workers who are temporarily or permanently totally disabled and unable to care for themselves because of their industrial injuries or occupational diseases may receive attendant services.

Attendant services must be requested by the AP and authorized by the insurer before the care begins. The insurer will determine the maximum hours of authorized attendant services, based on an RN's home nursing evaluation of the worker's care needs. If the worker's care needs change, the worker or provider may request a new evaluation.

All attendant services must be provided through a home health or home care agency. In order for spouses to provide attendant care they must be employed by an agency.

Exception: Only spouses who provided attendant care to injured workers prior to October 1, 2001, and who meet department criteria, may continue to provide attendant care. The insurer does not authorize *new* requests for spouses not employed by an agency to provide attendant care.

Spouses eligible to provide attendant care are limited to a maximum of 70 hours per week or to the maximum hours authorized for the worker, whichever is less. If more than 70 hours of care per week are medically necessary, a second provider may be approved. The second provider must be employed by an agency eligible to provide attendant services.

Respite care will be allowed when non-agency spouse caregivers are unable to provide care due to their own illnesses, injuries, etc. Respite care must be authorized by the insurer and must be provided by licensed agencies.

The following are examples of attendant services that may be covered:

- Bathing and personal hygiene.
- Dressing.
- Administration of medications.
- Specialized skin care, including changing or caring for dressings or ostomies.
- Tube feeding.
- Feeding assistance (not meal preparation).
- Mobility assistance, including walking, toileting, and other transfers.
- Turning and positioning.
- Bowel and incontinent care.
- Assistance with basic ROM exercises.

No additional compensation is made for travel, mileage, holidays and weekends, overtime, shift differentials or supervisory visits. These expenses are considered part of the fee paid to the home health or home care agency.

Homemaker or Chore Worker Services - Required to meet the worker's everyday environmental needs are considered unrelated to the medical care of the worker and are **not covered**. The following are examples of services that are not covered:

- Housecleaning.
- Laundry.
- Shopping.
- Meal planning and preparation.

- Transporting the worker.
- Errands.
- Recreational activities.
- Yard work.
- Child care.

However, the insurer may consider payment for chore services during hospice care.

Nursing Home, Residential, and Hospice Care Services

Workers should be discharged from the hospital at the earliest date possible, consistent with proper health care ([WAC 296-20-075\(2\)](#)).

When a worker continues to need help with care but no longer needs hospitalization, special nursing care, home nursing services, or attendant services, transfer to a nursing home or convalescent center can be authorized. This could apply to workers who are ambulatory in a restricted way and who no longer require acute care. If transfer to a nursing home or convalescent center is indicated, the AP should make prior arrangements with the insurer.

Residential care services require prior authorization. Services must be proper and necessary, required due to an industrial injury or occupational disease, and requested by the attending provider.

Residential care facilities include:

- Skilled Nursing Facilities.
- Nursing Homes.
- Transitional Care Units.
- Critical Access Hospitals.
- Adult Family Homes/Boarding Homes including:
 - Assisted Living Facilities.
 - Adult Residential Care.
 - Enhanced Adult Residential Care.
- Hospice care providers.

Services in adult day care centers are **not covered**.

Independent Medical Examinations

An independent medical examination (IME) is defined in [WAC 296-23-302](#) as “an objective medical-legal examination requested (by the department or self-insurer) to establish medical facts about a worker’s physical condition”.

IME’s are scheduled for many reasons including but not limited to:

- Assisting in making a determination regarding claim validity. (i.e. Could the condition diagnosed on the SIF-2 have been caused by the activity or exposure described, on or a more probable than not basis?)
- Determining if current treatment is appropriate or to determine whether further treatment if any is necessary. (i.e. Chiropractic treatment has been ongoing for over 4 months with no notable improvement. Is further chiropractic treatment curative or palliative?)
- Resolving issues in the claim. (i.e. A specialist believes the worker needs surgery, but the attending physician would like to try conservative treatment for longer. The worker would like a second surgical opinion.)
- Determining if there is any permanent partial disability (PPD) related to the industrial injury. (i.e. The attending physician has stated the claim is ready for closure and they are unwilling to rate any PPD that may be present.)
- Assisting in making decisions regarding reopening applications. (i.e. The worker has submitted a reopening application and it is unclear from the application whether there has been objective medical worsening of the condition since claim closure.)

Scheduling Independent Medical Examinations [RCW 51.32.114](#), [WAC 296-14-410](#)

IME’s must be scheduled with department approved examiners. In setting up the IME, the self-insurer or department must have complied with the following:

- Scheduled at a time and place reasonably convenient for the worker.
- Given the worker written notice, at least 14 days but not more than 60 days, prior to the exam. If the worker has had legal representation, sent one notice directly to the worker and one copy to their representative.

- Provided the date, time and directions to the location of the medical examination.

Compensation for Attending an Independent Medical Examination [RCW 51.32.110](#)

Workers must be paid their usual wages when they miss work to attend an independent medical exam (IME) at the request of the department or self-insurer. They should be compensated in one-hour increments for actual work hours missed to attend an examination.

This rule does not apply to workers who have not returned to work and are receiving time loss compensation; they would be paid time loss.

Workers are entitled to be compensated for mileage to and from the IME, regardless the distance traveled. They are also entitled to reimbursement for parking, meals and hotel/motel expenses.

No Show Fees

If a worker does not show up for an IME the insurer may request an order from the department directing the worker to pay a no-show fee. The request should include:

- Verification of the charge of the no-show fee.
- Documentation of the written notice of the IME appointment.
- A copy of the letter requesting good cause for missing the appointment, giving the worker 30 days to respond, along with the worker's response if received.

The department adjudicator will review the request to determine whether the worker had "good cause" for missing the IME. Good cause can include but is not limited to:

- The worker did not receive notice of the examination within the timeframes.
- The worker arrived within 30 minutes after the scheduled appointment time and could not be seen.
- The worker waited more than one hour for the medical examination and then left.
- An unforeseen event occurred prior to the examination that could not be avoided.
- Travel expenses were not paid in advance, if necessary.

If the department adjudicator determines that the worker had "good cause" for not attending the examination they will write the self-insurer a letter explaining the reasons for not issuing the no-

show fee. If the adjudicator determines that the worker did not have “good cause”, an order will be issued listing the amount of the fee.

Note: Only time loss benefits on the same claim are affected. The fee cannot be deducted from PPD or from time loss benefits on other claims.

Infectious Diseases [RCW 51.36.010](#), [WAC 296-20-03005](#)

When a disease can be readily transmitted from one individual to another it is called communicable or infectious. Examples of infectious diseases are hepatitis A, hepatitis B, influenza, rabies, tetanus, meningitis, tuberculosis, and acquired immunodeficiency syndrome (AIDS). Validity issues regarding infectious disease claims are discussed under Filing an Infectious Disease Claim in the [Claim Validity](#) chapter.

Preventative Treatment

Payment for testing, inoculation or immunological treatment may be authorized when a **work-related** activity has resulted in probable exposure to a potential infectious occupational disease. This should be authorized even if the disease has not been contracted and there is no allowable claim. Routine inoculations without a specific incident of exposure are not payable.

L&I guidelines for the management of possible exposures to Hepatitis B (HBV), Hepatitis C (HCV), and Human Immunodeficiency Virus (HIV) and be found on the department website under [Bloodborne Pathogens Guidelines](#).

Confidentiality of Infectious Disease Records

Claims for hepatitis A, B, and C, human immunodeficiency virus (HIV), AIDS and other diseases that may be sexually-transmitted (STDs) are confidential claims and must be handled with special care. Policy S1.42 defines STD as “a bacterial, viral, fungal, or parasitic disease or condition usually transmitted through sexual contact”. Examples include, but are not limited to, gonorrhea, nongonococcal urethritis, and syphilis. Whether the disease was transmitted sexually or by some other means does not affect its confidential status.

[RCW 70.24.105\(2\)\(j\)](#) specifies that disclosure of confidential information can be made to claim management personnel employed by a payer of health care claims only “for the prompt and accurate evaluation and payment of medical or related claims”. Therefore, as specified in Policy S1.42, individuals or groups not authorized to handle or determine medical claim payments must obtain a sexually-transmitted disease (STD) release from the worker to receive STD information. This means that some parties who can receive claim information on a claim without STD information cannot receive any STD information without the STD release signed by the worker. Examples include the worker’s attorney, chiropractors (even when they are workers attending doctors) and ancillary health care providers.

Injections (Therapeutic or Diagnostic)

Epidural Injection

An epidural injection is the injection of an anesthetic or steroid given on or outside the dura (the first layer of the meninges or spinal covering). It can be used therapeutically or diagnostically and is safely administered in an outpatient setting in most situations.

Epidural injections are used to treat the swelling, pain, and inflammation of radiculopathy (sciatica) where there are signs and symptoms that normally suggest entrapment of a specific spinal nerve root. Note: Low back pain alone isn't sufficient for authorization.

Prior authorization is required. A maximum of six injections per acute episode may be allowed, but no more than three injections in a 30-day treatment period. The treatment period must be followed by a 30-day evaluation period. An additional series of three injections will be allowed if there is significant relief from the first series of three injections. (See [WAC 296-20-03001\(7\)](#).)

Vertebral Facet Joint Injection

A facet injection is a guided injection of dye, anesthetic, or steroid into a facet joint. This technique can be used diagnostically and therapeutically. Injections must be performed under radiographic control (fluoroscopy) and are safely administered in outpatient settings.

Cervical, thoracic, and lumbar facet injections are covered. If neurotomies are requested after facet injection, cervical and lumbar neurotomies may be considered according to the Medical Treatment Guidelines. Thoracic neurotomies are not covered.

Vertebral facet joint injections are used to treat:

- Focal tenderness over facet joints.
- Low back pain, with or without sciatica, but with a normal radiographic workup.
- Postlaminectomy syndrome with no evidence of arachnoiditis or recurrent disk disease.
- Persistent pain after a stable spinal fusion.

Prior authorization is required. There is a limit of four injections for any claim. Because each new claim is a new event, and since the purpose of these injections is to decrease inflammation, a new series of injections may be appropriate for each new claim. (See [WAC 296-20-03001\(12\)](#).)

Trigger Point Injection

A trigger point injection is an injection of an anesthetic or steroid into a tender area of muscle, fascia, ligament, or tendon. It is used to treat localized pain in the area being injected. Trigger point injections are safely administered in an outpatient setting.

The first series of three injections does not require authorization. The second series of three injections requires justification and the procedure code from the attending provider. A maximum of six injections may be allowed for any claim. Because each new claim is a new event, and since the purpose of the injections is to decrease inflammation, a new series of injections may be appropriate for each new claim.

Note: If both trigger point and dry needling injections are provided, a maximum of six injections of both may be allowed under any claim.

Dry Needling Injection

Dry needling is considered a variant of trigger point injections only without medications. It is a technique where needles are inserted directly into trigger point locations, but no medications are injected. This is different than acupuncture; in acupuncture, needles are inserted in the distant points or meridians (pathways of energy, a term used in acupuncture). Acupuncture services are not covered, but dry needling is.

Dry needling follows the same rules as trigger point injections and is included in the maximum of six of any combination of trigger point and dry needling injections allowed per claim. (See [WAC 296-20-03001](#))

Hyaluronic Acid Injection

Hyaluronic acid, a complex sugar chain substance with viscous properties, has been approved as a device for the treatment of osteoarthritis of the knee by the Food and Drug Administration (FDA). The device is marketed under the trade names Hyalgan, Synvisc, and Supartz. (See [Hyaluronic acid](#) on L&I's website.)

Cartilage in the knee normally provides a cushion between the bones to allow the joint to move smoothly. Hyaluronic acid is naturally produced by the body and lubricates cartilage within the joint. However, osteoarthritis can cause the cartilage and other structures of the joint begin to break down. In some workers, a small amount of inflammation breaks down the hyaluronic acid so that lubrication is lost, joints become stiff and movement is painful. Hyaluronic acid injections replace or supplement the body's natural hyaluronic acid that is broken down by inflammation.

Hyaluronic acid is indicated for the treatment of knee pain caused by osteoarthritis for workers who have failed to respond adequately to conservative non-pharmacologic therapy or to simple analgesics, e.g., acetaminophen. Though pain relief for six to 12 months is the primary purpose of this therapy, a secondary goal is to delay or prevent a total knee replacement. Hyaluronic acid

injections are indicated only for osteoarthritis of the knee. Other uses are considered experimental, and therefore, are not payable. (See [WAC 296-20-03002\(6\)](#))

Hyaluronic acid is administered by intra-articular injection on an outpatient basis. The schedule of injections varies with the FDA-approved product used. One course of the currently approved products consists of one of the following:

- Hyalgan or Supartz, administered by intra-articular injection once a week (one week apart), for a total of five injections.
- Synvisc or Orthovisc, administered by intra-articular injections once a week (one week apart), for a total of three injections.

The use of hyaluronic acid is covered when osteoarthritis is:

- **An accepted condition.** One course of hyaluronic acid may be considered medically necessary when osteoarthritis of the knee is a diagnosed and accepted condition. The requesting provider must provide the insurer with documentation of the existence of osteoarthritis of the knee, and with documentation that the worker has failed to benefit from, or is unable to tolerate, all of the following therapies recommended by the American College of Rheumatology:
 - Non-pharmacological therapies, e.g., PT;
 - Non-opioid analgesics, e.g., acetaminophen; and
 - Treatment with non-steroidal anti-inflammatory drugs (NSAIDs). Intolerance, e.g., rash, gastropathy, etc., and therapeutic failure must be documented with at least a one week trial of two formulary products from different NSAIDs classes.
- **Unrelated but hindering recovery.** When osteoarthritis is unrelated to the injury but is hindering recovery of the accepted medical condition, temporary treatment may be authorized when all of the following apply:
 - The occupational disease or industrial injury is not stable;
 - Osteoarthritis is directly hindering recovery of the accepted occupational or industrial injury; and
 - The required documentation for treatment of osteoarthritis when it is an accepted condition is submitted.

Additional course of hyaluronic acid treatment. Under rare circumstances, an additional course of hyaluronic acid treatment may be considered. However, an additional course of treatment is payable only when osteoarthritis is the accepted medical condition, not when it is the condition hindering recovery. In order for additional courses of hyaluronic acid injections to be considered medically necessary:

- The provider must request prior authorization in writing; and

- The request must include documentation of the return of pain complaints and the evidence of functional improvement for a worker who has undergone a prior course of hyaluronic acid treatment.

Chymopapain Injection

Chymopapain injection is also known as chemonucleolysis. Chymopapain injections may be authorized for the treatment of lumbar disk disease under certain limitations and criteria according to [WAC 296-20-03004](#). This procedure involves the injection of chymopapain (an enzyme derivative of papaya) into the vertebral column to disintegrate ruptured disc material. Chymopapain is used to treat lumbar disk disease and disk herniation.

Botulinum Toxin-A Injection (Botox)

Botulinum toxin-A (BTA) injection, commonly known as botox, is a potent neuromuscular paralyzing agent that can relieve involuntary spasms of certain muscle groups without causing excessive weakness. The drug's effect is temporary, but it may be effective for three or more months.

BTA is injected into the muscle in an outpatient setting. Electromyographic (EMG) guidance for muscle injection may be necessary when injecting muscles that are difficult to identify. For example, extreme care must be taken when injecting the muscles of a quadriplegic that are near the auxiliary muscles assisting in respiration.

Generally, injections are repeated every three to 12 months, as needed. They are tailored to the worker's status at follow-up, as well as to the worker's response to any previous injections.

Injectables

Per [WAC 296-20-03002](#)(2), the insurer will not authorize or pay for injections of:

- Colchicine (a medication given for gout, a joint disease which is not work-related).
- Fibrosing or sclerosing agents, unless they are used for chemotherapy for an accepted condition or for a condition that is retarding recovery.
- Injections of substances other than anesthetic or contrast into the subarachnoid space (intrathecal injections).

In addition, prescriptions for home use of injectable drugs are generally not covered. (See [WAC 296-20-03014](#)) These include:

- Narcotics.

- Sedatives.
- Analgesics.
- Antihistamines.
- Tranquilizers.
- Psychotropics.
- Vitamins.
- Minerals.
- Food supplements.
- Hormones.

The insurer covers injectable medications under the following circumstances:

- For inpatients, except when the hospital admission is solely for the administration of drugs to relieve chronic pain.
- During emergency treatment of a life-threatening condition or injury.
- During outpatient treatment of burns or fractures, when needed for dressing or cast changes.
- During the preoperative and post-operative periods, not to exceed 48 hours from the time of discharge.
- For prescriptions of injectable insulin and heparin, and prescriptions for syringes and needles specifically for use with insulin and heparin. Normally, prescriptions for syringes and needles are prohibited.
- For injections of vitamins for specific therapeutic treatment of the accepted condition, when the provider can demonstrate that published clinical studies indicate vitamin therapy is the treatment of choice for the condition.

Medical Reports and Documentation

In order to make accurate and timely decisions when adjudicating a claim, the claim manager must have current, complete medical information on the worker's condition and treatment needs. The claim manager is not a medical expert and must rely on medical providers for that expertise.

The claim manager is responsible for ensuring that adequate medical reports are on file to adjudicate the claim and to support their authorization decisions on treatment, time loss compensation benefits, and other claim benefits. If these documents are not in the file or file documents are incomplete, the claim manager must obtain whatever information is needed to complete the claim file.

Reporting Requirements

Providers are required to submit reports at various times during the course of a claim. [WAC 296-20-06101](#) lists the following: required reports, the specific timeframes within which the provider must submit them, and the information that should be contained in them.

- **Providers Initial Report (PIR).** This is the first report required of the provider. The provider helps the worker fill out the PIR and is expected to submit it to the insurer within five days of the worker's visit.

Doctors licensed to practice medicine and surgery (MD), osteopathic medicine and surgery (OD), chiropractic (DC), naturopathic (ND), podiatry (DPM), dentistry (DDS or DMD), or optometry (OD), advanced registered nurse practitioners (ARNPs), and physician assistants (PAs), may sign and be paid for completion of this form.

- **60-day narrative report.** When conservative (non-surgical) treatment continues beyond 60 days, the Attending Provider (AP) must submit a narrative report every 60 days to support and document the need for continued care.

If the worker requires treatment beyond 60 days following the injury, the claim most likely involves a major industrial condition or a complication by another condition. In these situations, a complete examination is necessary to determine whether the claim manager needs to authorize continued treatment and pay time loss compensation benefits. This examination may either be done by the AP or by a consulting doctor. The examiner must submit a detailed examination report to the insurer. (See [WAC 296-20-01002](#) and [WAC 296-20-035](#) for more information.)

The only exception to this 60-day reporting requirement is for a claim for severe or extensive injuries, i.e., quadriplegia, paraplegia, multiple fractures. Due to the complexity of injuries such as these, there is usually an abundance of medical reports supporting treatment and time loss compensation benefits.

- **Office notes.** Office notes may also be referred to as chart notes or progress notes. They must be sent following each office visit. Doctors may submit legible comprehensive office/chart notes in lieu of 60-day narrative reports if the notes include all the information required in the 60-day narrative report. However, office notes are not acceptable in lieu of specifically requested reports (special reports), and the provider may not bill the special report fee for offices notes submitted in place of a requested special report.

- **Special report/follow-up report.** Special reports are used to respond to specific questions asked by the claim manager or vocational counselor (VRC), and are payable only when requested by the insurer.
- **Consultation examination report.** Following 120 days of conservative (non-surgical) care, a consultation with another doctor is required to obtain an objective evaluation of the need for ongoing conservative medical management. (See [WAC 296-20-01002](#) for the definition of consultation examination report, [WAC 296-20-045](#) for other times consultations are required, and [WAC 296-20-051](#).) If the worker has been seen by the consulting doctor within the past three years, the consultation will be considered a follow-up office visit. Therefore, instead of sending a consultation report, the doctor should submit a follow-up (SOAPER) report and bill accordingly. (See [WAC 296-20-06101](#).) A copy of the consultation or follow up report must be submitted to the AP, and must be received by the insurer within 15 days from the date of the consultation.
- **Attending provider review of IME report.** This review is to obtain the AP's opinion about the accuracy of the diagnoses and information provided in an IME. The AP should include his or her agreement or disagreement with IME findings and recommendations. If the AP disagrees with the IME, he or she should provide objective and subjective findings to support the opinion, along with his or her further treatment plans.
- **Reopening application.** On claims closed over 60 days, the insurer will pay for the completion of a [reopening application](#), an office visit, and diagnostic studies necessary to complete the application. No other medical benefits will be paid until the claim manager makes a decision on the reopening.
- **Ancillary provider reports.** While it is important to have current medical reports to support treatment provided by the worker's doctors, it is also important to have current medical reports from other types of providers, such as lab, radiology, and physical therapy. [WAC 296-20-06101](#) lists the provider type and whether chart notes, reports, or both are required. In addition to the requirements in [WAC 296-20-06101](#), [WAC 296-20-125](#) requires ancillary providers to submit supporting documentation when billing for services.

Insurer Activity Prescription Form (APF). If the office notes or other medical records do not provide the required information, the claim manager or VRC may ask the AP to complete an Insurer APF. Insurer APFs should be requested when adequate information is not available from the AP's reports already in the file. Providers are only authorized to initiate an Insurer APF when it is submitted along with a Providers Initial Report (PIR) and there are work restrictions. The PIR must show the worker has physical work-related restrictions that must be accommodated for light duty work. If the insurer requires additional Insurer APFs, a request letter with a blank Insurer APF should be sent to the provider. Find detailed information regarding the [Insurer Activity Prescription Form](#) (APF) online.

When the AP Does Not Cooperate [WAC 296-20-065](#)

If the AP does not respond to requests for medical information, the insurer should write to the provider regarding reporting requirements. The provider should be advised that authorization and payment of further treatment is contingent on receiving the required medical reports.

If the AP fails to cooperate, the self-insurer may require the worker to select another doctor or specialist for treatment.

Report Content—SOAPER

In addition to the requirements in [WAC 296-20-01002](#) and [WAC 296-20-06101](#), the department has asked providers to provide office/chart/progress notes and 60-day narrative reports using the “SOAPER” format. SOAPER contents include:

S—The worker's **subjective** complaints or symptoms about the injury or incident reported by the worker, employer, co-worker, family member, or friend. Subjective complaints are what the worker senses or feels; they cannot be measured or independently proven.

O—The provider's **objective** findings are independent of voluntary action and are all the findings the examiner can see, feel, or consistently measure. This includes factual information, such as physical exams, i.e., range of motion (ROM), muscle spasms, lab tests, x-rays, and psychological testing.

The objective findings should be consistent and logical. The provider should identify the significant objective basis that supports his or her medical opinion regarding a diagnosis, the need for treatment, or the worker's inability to work.

A—The provider's **assessment** of progress toward meeting goals is the conclusion the doctor makes after evaluating all the subjective complaints and objective findings. The conclusion may be:

- A definite diagnosis (dx.).
- A rule out (R/O) diagnosis—Suspected diagnosis.
- An etiology (ET)—The origin of the diagnosis.
- A prognosis—A prediction of the probable course of, or the likely recovery from, the disease or injury.
- Maximum medical improvement (MMI)—The point when no fundamental or marked change in an accepted condition can be expected, with or without further treatment. MMI is the term most often used by medical providers.

MMI is also referred to as "fixed and stable". However, fixed and stable is a department term and is generally not used by medical professionals. A condition is considered to be at MMI or fixed and stable when it is reasonably certain that further medical treatment will not predictably alter the course of the illness or medical condition. (See [RCW 51.36.010](#) and [WAC 296-20-01002](#) for the definition of proper and necessary.)

MMI may be present though there may be fluctuations in levels of pain and function, and though the condition might be expected to either improve or deteriorate with the passage of time. When a worker's condition reaches this point, treatment that results in only temporary or transient changes is not consider proper and necessary.

- Probability, if any, of **permanent partial disability** (PPD) resulting from the industrial condition.

P—The provider's treatment **plan**. What the provider recommends based on the assessment. The plan should include a goal (the expected outcome), the prescribed treatment (specific modalities and frequency), and the length of the treatment plan (expected completion date and anticipated outcome). The treatment plan should include information on the worker's functional improvement. Doctors are also requested to mention any risk factors for **chronic** disability in this area of their report.

E—**Employment** issues. The doctor should provide the following types of information about the worker's employment status:

- Whether the worker is currently working, and if so, at what job.
- Whether the worker been released for work, if not currently working.
- When the doctor anticipates releasing the worker for work.

R—**Restrictions** to recovery. The doctor should list any restrictions, barriers, or unrelated conditions preventing recovery or return to work. If the worker has not returned to work, the doctor should include an estimate of physical capacities and should:

- Describe the physical limitations, both temporary and permanent, that keep the worker from returning to work.
- Indicate whether the worker can perform modified work or different duties while recovering.
- Indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work, and if so, why.

Reviewing Medical Reports

When reviewing medical reports, the following questions should be asked:

- Does the provider clearly report subjective and objective information, assessment, and plan (SOAP)?
- Are there objective findings to substantiate the subjective complaints?
- If the worker has not returned to work, has the doctor addressed employment issues and restrictions to recovery?
- Does the provider state that the injury or illness is directly related to the worker's employment?
- Is there a stated, measurable treatment goal with a reasonable, expected completion date?
- Does the provider include a prognosis with the diagnosis?

Components of a Medical Chart

A medical "chart" or "record" is a comprehensive file kept by health care providers on the individuals they treat. It can be brief or lengthy depending on how much care the person has received. Some examples of what may be put in a medical chart are:

- **History and physical report.** (The initial part of a chart. The patient's personal and family medical history and the initial examination.)
- **Progress notes and reports.**
- **Operative reports.**
- **Consultation reports.**
- **Ancillary provider reports.** (Reports from other types of providers such as lab, radiology, and physical therapy.)

Employer Requests for Return to Work Information

Studies have shown that workers recover more quickly when they return to work as soon as possible following an injury. Employers are encouraged to offer light-duty, modified work, or transitional work to their injured workers.

If the AP's chart notes, reports, or Insurer APFs, do not contain the current medical information necessary to assist their workers in returning to work, the employer may request current physical capacity information from the AP.

Obtaining Prior Medical Records

Prior medical records may be needed at any point in a claim. For example, when:

- The worker had prior treatment to an area of the body affected by the accepted injury, i.e., the claim is for a back strain and the worker had a prior back injury.
- An unrelated condition is retarding recovery from the accepted condition, i.e., prior to the injury, the worker had been treated for depression and that is now impacting recovery.

The presence of a pre-existing condition does not disqualify a worker from receiving benefits, but it may affect the extent of benefits available under the current claim(s). Therefore, the insurer must establish as soundly as possible the existence of any prior condition.

The insurer should request copies of prior treatment records from the worker and the worker's doctors. The prior records will give a better understanding of what the worker's condition was at the time of the current injury.

When an injured worker signs the SIF-2/PIR, they are also signing a medical authorization permitting medical care providers to release, without liability, the worker's pertinent medical records to the insurer ([RCW 51.36.060](#)). To obtain medical records, the insurer may forward to the provider a copy of the signed SIF-2/PIR with a letter requesting needed medical records.

If a provider questions the release for records because of the federal Health Information Portability and Accountability Act (HIPAA), the insurer may send the provider a copy of the department's December 2009 [Release of Medical Records and Patient Privacy in Workers' Compensation](#) document.

Detailed information about HIPAA can be found at the web site for the [U.S. Department of Health and Human Services](#). You can also check L&I's web site for [HIPAA information](#).

Newly Contended or Unrelated Medical Conditions

Contention of a New Condition

When a new medical condition(s) arises in an existing allowed claim the worker or medical provider may believe the new condition is a result of the industrial injury and may request medical and/or disability benefits for the new condition under the existing claim.

Contention may be **obvious**: the worker or medical provider contacts the insurer and requests treatment for a new condition.

Contention may also be **less obvious**, a new condition showing up in:

- Progress or chart notes.

- Medical bills with unrelated diagnostic or procedure codes.
- Physical therapy notes.
- A new medical provider's reports and bills (i.e. a chiropractic bill listing back conditions on a claim for a knee condition).
- Diagnostic test results.

Conditions Resulting from Treatment for the Industrial Injury or Occupational Disease

A condition arising from treatment rendered for an industrial injury or occupational disease should be accepted on a claim, provided the condition is diagnosed and related to the claim by a medical provider. For example:

- A worker has a knee injury which requires the use of crutches. From using the crutches the worker sustains a shoulder strain. Since the use of the crutches for an allowed condition caused the shoulder strain (regardless of whether the worker used the crutches correctly, they were the wrong size, etc.) the shoulder strain should be accepted under the claim. The same would be true if an accepted knee condition caused a worker to fall injuring another part of the body such as an arm.
- A deep vein thrombosis (DVT), a blood clot that develops in a deep vein, may occur following a surgery, traumatic injury, or prolonged hospitalization. DVT may cause pain and can lead to complications if the clot breaks off and travels in the blood stream to the lungs.
- Surgical complications.
- Reactions to medication.

Segregation of an Unrelated Condition

If information is received regarding an obviously unrelated condition that is not affecting recovery, **and not** contended by anyone to be related to the industrial injury or occupational disease, the insurer may send a letter notifying all concerned that the condition is not covered under the claim.

If the worker or provider **is contending** that a new condition is related to the industrial injury or occupational disease, the insurer will need to decide whether they believe it should be accepted on the claim. Several factors to consider include:

- The description of the initial injury. Is it reasonable that at the time of the injury the worker also injured the newly contended body part?
- The length of time between the date of injury and the onset of symptoms related to the additional condition.
- Prior medical records for the new condition. Was there treatment for that condition prior to the injury?
- A medical opinion giving a causal relationship regarding whether a contended condition is related to the covered injury on a more probable than not basis.

If the insurer agrees that the new condition should be included in the claim they can inform the worker and medical provider and begin coverage of the additional condition.

If after their review, the insurer believes that the condition is unrelated to the industrial injury or occupational disease they should notify the worker and provider of their decision. If the insurer would like an order segregating out the condition they should send a written request to the department. The request should include:

- An explanation of why the segregation order is needed.
- The specific condition(s) to be segregated (segregating out “all other conditions” is not appropriate).
- All medical documentation not already sent to the department.

Once the department adjudicator reviews the request, an order will be issued either allowing or denying the condition or if the adjudicator does not believe there is enough information to issue an order, they may also request additional information.

Temporary Treatment of Conditions Delaying Recovery

[WAC 296-20-055](#), [WAC 296-20-081](#)

Conditions not related to the industrial injury or occupational disease are not the responsibility of the insurer.

When an unrelated condition is being treated concurrently with the injury, the attending provider must notify the insurer immediately and submit the following:

- Diagnosis and/or nature of unrelated condition.
- Treatment being rendered.

- The effect, if any, on the industrial condition.

Authorizing Temporary Treatment [WAC 296-20-055](#), [WAC 296-20-03013](#)

When an unrelated condition is delaying recovery of the accepted condition(s), temporary treatment can be covered with prior approval of the insurer. The request for approval should include a thorough explanation of how the unrelated condition is affecting the industrial condition.

Obesity Treatment Programs

Obesity does not meet the definition of an industrial injury or occupational disease. Weight loss services may be allowed on a temporary basis when an unrelated obesity condition impedes recovery from an accepted condition ([WAC 296-20-055](#)). Services for weight loss treatment **require prior authorization** ([WAC 296-20-03001](#)). The attending provider (AP) must submit medical justification including tests, consultations or diagnostic studies that support the request.

To be eligible for weight loss treatment, the worker must be severely obese. Severe obesity for the purposes of providing weight loss treatment is defined by the department as a Body Mass Index (BMI) of 35 or greater. For example, a person 5 feet 5 inches tall, weighing 210 or more pounds is considered severely obese.

The following table from [MedicineNet.com](#) has already calculated the BMI and converted the result to inches and pounds. To use the table, find the height in the left column and the weight in the same row. The number at the top of the column is the BMI for that height and weight.

BMI (kg/m²)	19	20	21	22	23	24	25	26	27	28	29	30	35	40
Height (in)	Weight (lb)													
58	91	96	100	105	110	115	119	124	129	134	138	143	167	191
59	94	99	104	109	114	119	124	128	133	138	143	148	173	198
60	97	102	107	112	118	123	128	133	138	143	148	153	179	204
61	100	106	111	116	122	127	132	137	143	148	153	158	185	211
62	104	109	115	120	126	131	136	142	147	153	158	164	191	218
63	107	113	118	124	130	135	141	146	152	158	163	169	197	225
64	110	116	122	128	134	140	145	151	157	163	169	174	204	232
65	114	120	126	132	138	144	150	156	162	168	174	180	210	240
66	118	124	130	136	142	148	155	161	167	173	179	186	216	247
67	121	127	134	140	146	153	159	166	172	178	185	191	223	255
68	125	131	138	144	151	158	164	171	177	184	190	197	230	262
69	128	135	142	149	155	162	169	176	182	189	196	203	236	270
70	132	139	146	153	160	167	174	181	188	195	202	207	243	278
71	136	143	150	157	165	172	179	186	193	200	208	215	250	286
72	140	147	154	162	169	177	184	191	199	206	213	221	258	294
73	144	151	159	166	174	182	189	197	204	212	219	227	265	302
74	148	155	163	171	179	186	194	202	210	218	225	233	272	311
75	152	160	168	176	184	192	200	208	216	224	232	240	279	319
76	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Obesity Treatment Requests

The AP must advise the insurer how obesity is delaying recovery. The AP’s medical justification must show:

- The worker is severely obese, and
- The worker’s weight and level of function prior to the injury and how it has changed since the injury, and
- Obesity is the primary condition impeding recovery from the accepted condition, and
- Weight loss is necessary to undergo required surgery, participate in physical rehabilitation, or return to work.

Prior to authorizing an obesity treatment program, the AP and worker are required to develop a treatment plan and sign an authorization letter. This authorization letter will serve as a

memorandum of understanding between the insurer, the worker and the attending doctor. The treatment plan must include:

- The amount of weight (average one to two pounds per week) the worker must lose.
- The estimated length of time needed for the worker to lose the weight.
- A diet and exercise plan, including a weight loss goal, approved by the AP as safe for the worker. The AP may request a consultation with a certified dietitian to determine if an obesity treatment program is appropriate for the worker.
- The specific program or other weight loss method requested.
- The AP's plan for monitoring weight loss.
- Documented weekly weigh-ins.
- Group support facilitated by trained staff.
- Counseling and education provided by trained staff.
- No requirements to buy supplements or special foods.

Obesity Treatment not Payable

The insurer does not pay for:

- Surgical treatments of obesity.
- Drugs or medications to assist in weight loss.
- Special foods (including liquid diets), supplements, or vitamins. (See [WAC 296-20-03002](#).)
- Educational material, such as food content guides or cookbooks.
- Food scales or bath scales.
- Exercise programs or exercise equipment.

Obesity Treatment Approved

Once the obesity treatment is authorized, the AP must monitor and document the weight loss every 30 days. The AP notifies the insurer when:

- The worker reaches the weight loss goal, or
- Obesity no longer interferes with recovery from the accepted condition, or
- The worker is no longer losing the weight needed to meet the weight loss goal in the treatment plan.

Treatment should be authorized in 90-day blocks, as long as the worker:

- Continues to lose **an average** of 1 to 2 pounds each week, and
- Pays the joining fee, continues to pay the weekly membership fee and obtains reimbursement by the insurer, and
- Regularly attends the treatment sessions (meetings and weigh-ins), and
- Sends the insurer the weekly weigh-in sheet signed by the specific program coordinator every week, and
- Is evaluated by the AP at least every 30 days, and
- Cooperates with the approved obesity treatment plan.

The insurer stops authorizing obesity treatment when **any** of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan.
- Obesity no longer interferes with recovery from the accepted condition. (See [WAC 296-20-055](#).)
- The worker is not losing weight at **an average** of 1 to 2 pounds each week.
- The worker is not cooperating with the approved obesity treatment plan.

Payment of Medical Bills

The insurer pays for proper and necessary services related to the diagnosis and treatment of an accepted condition(s) ([WAC 296-20-01002](#)).

The insurer must adjudicate bills in accordance with the Washington State Industrial Insurance Laws, Medical Aid Rules, Maximum Fee Schedules, Provider Bulletins, Coverage Decisions, and Payment Policy ([WAC 296-15-330\(1\)](#), [WAC 296-20-01002](#)).

Adjudication of Bills [WAC 296-20-010\(2\)](#), [WAC 296-20-125\(9\)](#), [WAC 296-15-330\(3\)](#)

Providers must bill their usual and customary fee for services rendered.

The insurer must:

- Pay the maximum allowable fee as set by the department if the provider's usual and customary fee is more than the maximum allowable fee.
- Pay the amount billed if the provider's usual and customary fee is less than the maximum allowable fee.
- Give the provider an explanation for nonpayment or for payment below the maximum allowable fee. An explanation is not required if payment is made according to the maximum allowable fee.

Out of State Providers [WAC 296-20-022](#)

All health care service providers, regardless of their geographic location, are paid according to the Washington State Industrial Insurance Laws, Medical Aid Rules, Fee Schedules, Provider Bulletins, Coverage Decisions, and Payment Policies.

Bills Paid by the Worker or Another Party [WAC 296-20-020](#)

In situations of questionable eligibility when the worker and/or their private insurance paid for medical services now covered under the claim, the insurer should:

- Request itemized billings and reports from the providers,
- Pay the maximum allowable fees, and
- Inform the providers of their obligation to refund the worker and/or private insurer in full.

Rejected and Closed Claims [WAC 296-20-124](#), [WAC 296-20-03005](#)

- No payment is allowed for treatment or medication on rejected claims except for:
 - Services specifically requested by the insurer.
 - Examination or diagnostic services used as a basis for the adjudication decision.
 - Testing protocols and immunological treatment for exposure claims without injury.
- Services rendered after the date of claim closure are not payable except for:
 - Repair/replacement of durable medical equipment purchased under the claim.
 - Examinations and diagnostic studies used for determination of claim reopening.

- Medical surveillance examinations for workers with closed claims for asbestos-related disease.
- Services specifically requested by the insurer.
- Testing protocols and immunological treatment for exposure claims with injury.

Physical Medicine

Massage Therapy [WAC 296-23-250](#)

Massage therapy (MT) is a therapeutic treatment in which the muscles are rubbed and manipulated to relieve local pain and for relaxation. It is used in restoring range of motion and in reducing pain and medication usage by stimulating muscles and tissues to promote better circulation and the healing process. MT is a covered physical medicine service when requested by the attending provider (AP), or their physician assistant, and provided by a licensed massage therapist or other provider whose scope of practice includes massage techniques.

A progress report must be sent to the AP and insurer following 6 treatments or one month, whichever comes first. MT beyond the initial 6 treatments will be authorized based on substantiation of improvement in the worker's functional capacities. Progress report must include the treatment plan, specific goals and length of treatment.

Physical Therapy [WAC 296-23-220](#)

Physical therapy (PT) uses physical agents such as water, heat, cold, massage, electricity, ultrasound, and exercise in the management of injuries. Physical therapists assess the current level of function and degree of dysfunction. They establish long and short-term goals and appropriate treatment plans. They conduct frequent evaluations of progress, and update the plans and goals, when indicated.

PT should always involve training and treatment so workers may reach their maximum potentials. It is the physical therapist's responsibility to provide care that results in a beneficial outcome, while not providing treatment more frequently or longer than medically necessary.

PT or physical medicine services may be provided on a claim only by the following providers ([WAC 296-21-290](#)):

- Medical or osteopathic physicians who are board certified or board qualified in physical medicine and rehab (physiatrist).
- Licensed physical therapists (LPT).
- PT assistants employed by and serving under the direction of a registered physical therapist (RPT), a physical medicine and rehabilitation physician, or attending provider.
- Attending providers, within the following limited situations:

- Attending provider's scope of practice includes physical medicine modalities and procedures.
- A maximum of 6 PT visits in the attending provider's office. If the worker requires treatment beyond 6 visits, they must be referred to a physiatrist or RPT for further PT services.
- In remote areas, when a physiatrist or RPT is not available within a reasonable distance.

Pool therapy and exercise classes supervised by an RPT can be allowed. However, membership at health spas or other similar facilities and home exercise equipment are not payable. In addition, the insurer will not pay for services provided by exercise physiologists, kinesiologists, athletic trainers, aides, or other unlicensed personnel.

Twelve PT treatments may be allowed without prior authorization ([WAC 296-20-030](#)). However, the therapy needs to be prescribed by the attending provider for the accepted condition, and the therapist must provide the initial evaluation and a treatment plan. Authorization for additional services is dependent on documentation of the attending provider's prescription for additional treatment and objective documentation showing that the worker's condition is improving.

PT providers must submit monthly PT progress reports to the AP and insurer following 12 treatments or one month, whichever comes first. PT beyond the initial 12 treatments will be authorized only upon substantiation of improvement in the worker's condition. Progress reports must include the treatment plan, expected restoration goals, and the length of treatment required ([WAC 296-23-220](#)).

Physical Capacities Evaluation

Physical capacities evaluations (PCE) are assessments of a worker's functional physical capacities. They should include return to work recommendations and assist with the clarification of physical abilities if the AP has not provided enough information. PCEs should take into consideration the effects of the injury and any pre-injury limitations which affect performance.

PCEs can be useful when:

- Information indicates there may be some capacity to return to work, but the limitations are not clear. Light duty work is available but the claim manager is not able to determine if the worker is able to perform the duties.
- A reasonable amount of time has passed to allow for recovery from a specific type of injury or condition.
- The AP indicates there are significant physical restrictions, which are not clearly documented in the medical information received.

Occupational Therapy

Occupational therapy (OT) is the use of purposeful activities for acquiring the knowledge, skills, and attitudes necessary for the performance of life tasks, such as eating, working, playing, and caring for oneself. OT helps workers who survive catastrophic physical injuries, i.e., head injuries, amputation, lead meaningful lives despite considerable limitations in their abilities.

The rules for OT are very similar to those for PT and are outlined in [WAC 296-23-230](#).

Work Hardening [WAC 296-20-12050](#), [WAC 296-23-235](#)

Work hardening is a highly structured goal oriented, individualized treatment program designed to return a person to work. Work hardening programs, which are interdisciplinary in nature, use real or simulated work activities designed to restore physical, behavioral, and vocational functions. Work hardening addresses the issues of productivity, safety, physical tolerance, and worker behaviors.

Work hardening programs require prior approval by the worker's AP and prior authorization by the insurer. Only L&I approved work hardening providers will be paid for work hardening services. More information about work hardening programs, including a list of approved providers, criteria for admission into a program, and program standards is available on [L&I's web site](#).

Work Conditioning

Work conditioning is a work related, intensive, goal oriented treatment program specifically designed to restore a worker's systemic, neuromusculoskeletal, and cardiopulmonary functions. Generally work conditioning is used to bridge a gap between acute outpatient therapy and a structured work hardening program or return to work. Work conditioning is not recognized by L&I as a special program, and is covered according to the rules for outpatient physical ([WAC 296-23-220](#)) and occupational therapy ([WAC 296-23-230](#)).

Psychiatric Treatment

There is a natural psychiatric impact in any worker who has been seriously injured and/or unable to work for a long period of time. Some workers have psychological or psychiatric problems of various degrees which may or may not be related to the industrial injury or occupational disease. Each person reacts differently to a situation.

Treatment may be authorized for psychiatric conditions caused or aggravated by an accepted condition.

Temporary treatment can be allowed if the psychiatric condition causes a delay or prevents recovery of an allowed industrial condition ([WAC 296-20-055](#)). However, unrelated conditions are NOT the responsibility of the insurer. The insurer stops payment for temporary treatment of unrelated conditions when:

- The allowed industrial condition is resolved, or
- The allowed industrial condition is no longer delayed from recovery by the unrelated psychiatric condition(s).

Psychiatric providers treating psychiatric conditions allowed on a claim need to submit progress reports to the insurer and to the attending provider every sixty days ([WAC 296-21-270](#)). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports need to be submitted to the insurer and attending provider every thirty days ([WAC 296-20-055](#)).

Who Can Treat

Workers' psychiatric services must be provided by a psychiatrist, a licensed clinical PhD psychologist, or a psychiatric advanced registered nurse practitioner (ARNP). Psychological testing can be administered by their staff. However, the supervising psychiatrist, licensed clinical psychologist, or psychiatric ARNP must interpret the testing and prepare the reports.

A psychiatrist or psychiatric ARNP may be the attending provider and certify time loss compensation if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychiatric ARNP may not rate permanent partial disability or perform an independent medical examination. A psychologist cannot be the attending provider and may not certify time loss compensation, sign the Report of Accident/Providers Initial Report, or rate permanent partial disability.

For psychiatrists and psychiatric ARNPs, the treatment plan may include prescribing medications. The psychiatrist or psychiatric ARNP may prescribe medication either as the attending provider or when providing concurrent care ([WAC 296-20-071](#) "Concurrent Treatment" and [WAC 296-21-270](#) "Psychiatric Services").

Authorizing a Psychiatric Evaluation

The authorizing of a psychiatric evaluation does not mean that the psychiatric condition has to be accepted under the claim. The evaluation is a one-time examination to see if a condition is present, if it is related to the injury, and if it needs treatment.

In addition to the reporting requirements listed in WAC 296-20, the initial psychiatric evaluation should contain the information required by [WAC 296-21-270](#) including:

- Testing results with scores, scales, and profiles.
- Raw data sufficient to allow reassessment by a panel or independent medical examiner.
- Use of the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) axis format and explanation of the numerical scales.

- Use of the SOAP (subjective complaints, objective findings, assessment of the worker's condition, and treatment plan) format.

American Psychiatric Association DSM-IV Axis Codes

The American Psychiatric Association has developed the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition), commonly referred to as the DSM-IV (Multiaxial Assessment). This manual includes diagnostic and etiological criteria used for each mental illness, along with a multiaxial approach to evaluation. This format allows the examiner to provide the data for the basis of the psychiatric diagnosis. The worker is evaluated on each of the five axes. When reporting on psychiatric conditions, the provider should spell out any psychiatric diagnoses in this format:

Axis I Clinical Disorders, Other Conditions That May Be a Focus on Clinical Attention
 Axis II Personality Disorders, Mental Retardation
 Axis III General Medical Conditions
 Axis IV Psychological and Environment Problems
 Axis V Global Assessment of Functioning

Axis I, Clinical Disorders and Conditions That May Need Clinical Attention. Generally represents the primary psychiatric diagnosis or disturbance, such as depression, anxiety or schizophrenia. More than one diagnosis may be listed under this axis. When an examiner identifies a diagnosis of a mental disorder using the DSM-IV, certain criteria must be identified. For example, to diagnose major depression, the DSM-IV lists that the patient must display a mood disturbance and three of the following: sleep disturbances, appetite disturbances, weight loss or weight gain, or decreased sexual desire.

Axis II, Personality Disorders and Mental Retardation. Identifies whether there are any personality disorders and/or developmental disorders displayed by poor communication skills, anger control problems, and/or manipulative behavior. More than one diagnosis may be listed under this axis. If the Axis II diagnosis is the primary diagnosis, the doctor should indicate this. A worker with a primary Axis II diagnosis is likely to have a criminal history, drug, and/or alcohol problems, an inability to maintain employment, and/or be experiencing marriage/family discord. Axis II may also indicate prominent maladaptive personality features that do not meet the criteria for the diagnosis of personality disorder. The habitual use of maladaptive defense mechanisms may also be indicated on Axis II. These types of disorders are long-standing and not post-injury phenomena, but could be exacerbated or increased by the injury.

Axis III, General Medical Conditions. Identifies any current, general medical condition. The industrial injury or occupational disease is usually listed here, although the psychiatric provider may defer this diagnosis to the AP.

Axis IV, Psychological and Environmental Problems. Identifies psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders. The psychosocial and environmental problems are grouped as: primary support group,

social environment, education, occupation, housing, economic, access to health care, interaction with the legal system or crime, and other psychosocial and environmental problems.

A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a family or other interpersonal stress, an inadequacy of social support or personal resources, or another problem related to the context in which the worker's difficulties have developed. Positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, such as when a worker has difficulty adapting to a new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may develop as a consequence of a worker's psychopathology, or may constitute problems that should be considered in the overall claim management plan.

Axis IV can be very critical in determining whether there is a causal relationship between the industrial injury or occupational disease and the psychiatric diagnosis, as Axis IV lists other factors, such as a death in the family, which may contribute to the worker's psychiatric problems. Axis IV identifies the level of stress the worker is experiencing and has experienced, generally during the past year. The doctor may choose to include older stressors which clearly contribute to the mental condition, such as previous combat experience leading to posttraumatic stress disorder (PTSD).

Axis V, Global Assessment of Functioning Scale (GAF). The GAF is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults, i.e., how well or adaptively one is meeting various problems-in-living. A one-time GAF displays how a worker is functioning at the time of the visit. Providers use the GAF to rate over a period of time. An example would be the worker who rates with a serious impairment (GAF 41-50) in occupational functioning before treatment then rates with some difficulty (GAF 61-70) after treatment.

Psychiatric Services

The following psychiatric services are **payable**:

- Medication.
- Individual psychotherapy.
- Group psychotherapy. This may be authorized on a case-by-case basis, but only as part of the worker's treatment plan, not as the primary component of the plan.
- Therapy sessions that include the worker's support system (family, significant other, etc.).
- Narcosynthesis and electroconvulsive therapy.
- Hypnotherapy.

- Biofeedback ([WAC 296-21-280](#)).
- A combination of these items.

The following psychiatric services are **not payable**:

- Interactive psychiatric interview/exam and interactive psychotherapy. Interactive psychotherapy is typically for children. It involves the use of physical aids, play equipment, language interpreter, or other mechanisms of nonverbal communication.
- Psychoanalysis. Psychoanalysis is the therapy technique originated by Sigmund Freud. The technique explores mental processes by using free association, dream interpretation, and analysis of resistance and transference.
- Family psychotherapy without the patient present.
- Multiple family group psychotherapy.

Specialized Equipment

Special equipment or devices can be authorized as a temporary treatment measure or may be purchased for use on a permanent basis. If a claim is closed it is not necessary to reopen the claim to repair or replace permanent equipment. If one or two office visits are needed for fitting, payment can be allowed without reopening the claim.

Travel required to repair, replace, or otherwise alter prosthetics, orthotics, or similar permanent mechanical appliances after closure of a claim is payable. This does not include travel for repair or replacement of hearing aids ([RCW 51.36.020\(5\)](#)).

Equipment not requiring prior authorization are items such as back braces, cervical collars, rib belts, crutches, canes, and other commonly used orthotics of minimal cost ([WAC 296-20-1102](#)).

The following references provide additional information:

- Closed claims – [WAC 296-20-124](#)
- [Condition and Treatment Index](#) – Select the treatment or condition for additional information about billing and related rules.
- Eye glasses – [WAC 296-20-100](#)
- Hearing Aids – [WAC 296-20-1101](#)
- Miscellaneous services and appliances – [WAC 296-23-165](#)

- Payment Policies on Durable Medical Equipment – found under the appropriate [Fee Schedule](#) for the year you need.
- Special equipment rental and purchase – [WAC 296-20-1102](#)
- Transportation – artificial substitutes and mechanical aids – [RCW 51.36.020](#)
- Treatment requiring authorization – [WAC 296-20-03001\(9\)](#)

Surgery

Surgery Authorization Requests

Requests for authorization must include a statement of:

- Condition(s) diagnosed,
- ICD-9 CM codes, including their relationship to the industrial injury/exposure,
- An outline of the proposed treatment program including its length and components,
- Procedure codes,
- Expected prognosis, and an estimate of when treatment would be concluded and condition stable.

Consultations for Second Opinions [WAC 296-20-045](#)

A consultation with a qualified doctor with experience and expertise on the subject is required prior to authorization of surgery in the following situations:

- Nonemergent major surgery on a patient with serious with serious medical, emotional or social problems which are likely to complicate recovery.
- Procedures of a controversial nature or type not in common use for the specified condition.
- Surgical cases where there are complications or unfavorable circumstances such as age, preexisting conditions or interference with occupational requirements, etc.

Surgery for Pre-Existing Conditions Aggravated by the Industrial Injury or Disease

Authorization for surgery might be requested for conditions which pre-existed the injury or were treated prior to the injury. The attending provider should be contacted and asked whether the surgery is needed as a result of the industrial injury or is due to the natural progression of the pre-existing condition.

Example: An injured worker had a previous total hip replacement which has become aggravated by the injury, and a new hip replacement is requested.

Transfer of Providers

[RCW 51.36.010](#) gives workers the right to choose the provider who will treat their industrial injury or occupational disease. This provider becomes the attending provider (AP) of record. The AP must be:

- Licensed in the state in which they are practicing.
- Conveniently located.
- Qualified to treat the area of injury or disease.

A worker may transfer to a new AP during the course of treatment; however [WAC 296-20-065](#) requires that all transfers must be approved by the insurer. Adequate time should be allowed for an appropriate treatment program prior to transfer of AP. Approval should be given for a transfer request unless there is a legitimate reason for denial. Denying a request to transfer AP **should not** be a casual decision. The decision to deny should be justified and well documented in a letter to all parties.

Transfer without a Specific Request

If a worker or provider has not specifically requested a transfer, but a transfer appears to be indicated from other information in the claim, the insurer should clarify the change with the worker and/or provider. Information that a worker has changed their AP may come in a number of ways (i.e., phone call, medical reports or bills from a provider other than the AP of record, etc.).

Transfer of Attending Provider for Surgery

When surgery is authorized or a worker is referred to another AP for surgery, the surgeon should be listed as the AP. Many surgical procedures have a flat fee (also called global surgical or follow-up) period. A flat fee period is a specific number of days following surgery when the

surgeon provides all follow-up care. Postoperative care is included in the surgical fee as a global surgical fee package.

An exception to this would be when the worker lives far enough from the surgeon to make aftercare by the surgeon impractical. If so, care is not transferred to the surgeon. Arrangements should be made before the surgery for the worker to receive postoperative care from the local AP. The doctors involved are to determine the apportionment of the total fee for the flat fee period.

Required Transfer of Attending Provider

[WAC 296-20-065](#) allows the insurer the right to require a worker to select another provider under the following conditions:

- A more conveniently located AP is qualified to provide the necessary treatment. There should be documentation from the AP that travel would delay recovery. The worker shouldn't be required to change to a closer AP just because of distance.
- The AP fails to observe and comply with the department rules.
- The worker is receiving time loss compensation benefits but isn't showing reasonable progress toward returning to work.
- The worker requires specialized treatment which the AP is not qualified to render, or is outside the scope of the AP's license to practice.
- The insurer finds a transfer of AP to be appropriate and has requested the worker to select another AP in accordance with this rule. The insurer may select a new AP if the worker unreasonably refuses or delays in selecting another AP.
- In cases where the AP is not qualified to treat each of the worker's accepted conditions. This doesn't preclude concurrent care ([WAC 296-20-071](#)) where indicated.
- No transfer will be approved to a consultant or special examiner without the approval of the AP and the worker.

Transfers will be authorized for the foregoing reasons or where the insurer in its discretion finds that a transfer is in the best interest of returning the worker to a productive role in society.

Travel Expenses

[WAC 296-20-1103](#) defines the requirements for reimbursement of workers' travel expenses.

Prior authorization is not required for travel expenses for:

- Insurer scheduled independent medical examinations (IMEs).
- Vocational services.

Exception: During Vocational Retraining, travel reimbursement must be authorized as part of the approved vocational retraining plan.

- Prosthetic or orthotic fittings or replacements.

Through date of service 8/31/10, prior authorization is required when the worker must travel more than 10 miles one way from the worker's home to the nearest point of adequate treatment or vocational retraining.

Effective 9/1/10, prior authorization is required for treatment or vocational retraining when the worker must travel more than 15 miles one-way from the worker's home to the nearest point of adequate treatment or vocational retraining. Travel expense *is not* payable when adequate treatment is available within 15 miles of injured worker's home, yet the injured worker prefers to report to an attending provider outside the worker's home area.

Effective 9/1/10, when travel expense is authorized the first 15 miles one-way are not payable. The first and last 15 miles are not payable on an authorized round trip.

Nearest Point of Adequate Treatment

[RCW 51.36.010](#) allows the worker to choose their attending provider (AP).

Travel is reimbursable with prior authorization when the worker must travel more than 10 miles (15 miles beginning 9/1/10) one way from their home to the nearest point of adequate treatment. Travel is not reimbursable when there is adequate treatment available within 10 miles (within 15 miles beginning 9/1/10) of the worker's home.

Adequate treatment means at least two (to allow a choice) L&I approved providers with the same specialty, available to treat.

- If there is only one L&I approved provider available within 10 miles (15 miles beginning 9/1/10) of the worker's home, and the worker doesn't choose to see that provider, travel is payable to the nearest point of adequate treatment (minus the first and last 15 round trip miles beginning 9/1/10).
- When adequate treatment is available within 10 miles (15 miles beginning 9/1/10) of the worker's home but the worker chooses to see a provider beyond 10 miles (15 miles beginning 9/1/10) of their home, travel expenses are not payable.
- **Through date of service 8/31/10**, when the nearest point of adequate treatment available is 15 miles from the worker's home, but the worker chooses to see a provider 20 miles

from their home, the insurer will only pay travel for 15 miles each way. The worker is responsible for the extra mileage beyond the nearest point of adequate treatment.

- **Beginning date of service 9/1/10**, when the nearest point of adequate treatment available is 20 miles from the worker's home, but the worker chooses to see a provider 25 miles from their home, the insurer will only pay travel for 5 miles each way. The first and last 15 miles of a round trip aren't payable. The worker is responsible for the extra mileage beyond the nearest point of adequate treatment.

Worker Requirements

Workers must pay their travel expenses and then submit travel reimbursement requests to the insurer. Receipts are required for all medical travel expenses, and for parking expenses over \$10.

The insurer must receive the worker's travel reimbursement request within one year after the date of the travel. ([WAC 296-20-1103](#).) Workers can obtain travel reimbursement request forms from several sources including the department, and vocational or medical providers.

The worker must submit:

- The correct, completed travel reimbursement request form.
 - For Independent Medical Examination (IME) travel, the IME Travel & Wage Reimbursement Request found in [Your Independent Medical Exam for Employees of Self-Insured Businesses](#) is the correct form. Only the worker needs to sign this travel reimbursement request.
 - For all other travel, the [Travel Reimbursement Request](#) is the correct form. Both the worker and the medical or vocational provider must sign this travel reimbursement request.
- Receipts for:
 - Food.
 - Lodging.
 - Fares.
 - Parking expenses over \$10.

Exception: When the insurer provides vouchers for lodging or fares, the lodging or fare provider will bill the insurer.

The worker must complete travel reimbursement requests. The insurer may return incorrect or incomplete forms to the worker for completion if, i.e., it needs a signature from the medical or vocational provider verifying each date traveled.

Companion travel - Companion travel must be preauthorized. When it is medically necessary for a companion to participate in the worker's treatment or provide travel assistance, the insurer

will reimburse the travel expenses for both. The worker must submit the travel reimbursement request covering both people.

Payment Rates

Mileage – Privately Owned Vehicle mileage is paid at the appropriate state of Washington rate found at the [Office of Financial Management](#) website.

Lodging & meals – Rates for lodging and/or meals within the contiguous 48 states are found at the [U.S. General Services Administration](#) website. From this website you may also access the rates for Alaska, Hawaii, U.S. Territories and Possessions, and Foreign countries.

- The maximum meal rate amounts for the contiguous 48 states include taxes, tips, and incidental expenses.
- The maximum lodging rate amounts for the contiguous 48 states don't include the applicable, payable, state and local taxes.

Parking, storage, ferry, tolls - Parking, vehicle storage, ferry, and bridge tolls, are reimbursable for authorized travel. Receipts are required for parking expenses over \$10.

Taxi/cabulance/bus/commuter train fare – Public transportation is payable for authorized travel to treatment over 15 miles (10 miles prior to 9/1/10) away from the worker's home.

Airfare - Airfare is payable for preauthorized long distance travel.

Travel-Related Expenses Not Payable

In addition to travel-related expenses in excess of the state rate, the insurer doesn't pay for:

- Car purchase, lease, licensing (car or driver), insurance, repair, or maintenance.
- Child care services or travel to child care services unless authorized as part of an approved vocational retraining plan.
- Travel on closed claims, except:
 - When the insurer asks the worker to attend a medical or vocational evaluation.
 - For travel dates on or after June 12, 2008, for repair, replacement, or alteration of insurer provided prosthetics, orthotics, or other similar permanent mechanical appliances (except hearing aids). ([RCW 51.36.020\(5\)\(b\)](#)).

Treatment During Protest or Appeal

When handling a claim that has an active protest/appeal the insurer needs to review the claim to determine the status and issue of the protest or appeal. Claims may be in a protest/appeal status for a variety of reasons, and ongoing treatment may continue in some cases.

It may be necessary to file a motion for a stay of medical benefits during an appeal. For more information, see [Protests and Appeals](#) and [Pay During Appeal](#) guidelines.

Treatment Not Authorized [WAC 296-20-03002](#)

The following treatment is not authorized:

- Use of diathermy, Thermanic (standard model only), Spectrowave, and Superpulse machines.
- Iontophoresis; prolotherapy; acupuncture; injections of fibrosing or sclerosing agents; injections of substances other than anesthetic or contrast into the subarachnoid space (intrathecal injections).
- Treatment to improve or maintain general health, i.e., prescriptions and/or injection of vitamins, or referrals to special programs such as health spas, swim programs, exercise programs, athletic-fitness clubs, diet programs, or social counseling.
- Continued treatment beyond stabilization of the industrial condition(s), i.e., maintenance care, except where necessary to monitor prescription of medication to maintain stabilization, i.e., anti-convulsive, anti-spasmodic, etc.
- Any treatment measure deemed to be dangerous or inappropriate for the injured worker.
- Treatment measures of an unusual, controversial, obsolete, or experimental nature (see [WAC 296-20-045](#)). Under certain conditions, the insurer may approve treatment in this category. Requests must contain a description of the treatment, the reason for the request, and the benefits and results expected.

Additional treatment that is not authorized can be found in the [Condition and Treatment Index](#) on L&I's website.

If an authorization request is received for treatment determined non-covered, the insurer should immediately advise all concerned it is not authorized.

If the injured worker persists in receiving, or has already received treatment which is non-covered, the insurer should advise all concerned that they will not accept responsibility for any conditions, residuals, or complications to the accepted condition, arising from non-covered treatment.

If the worker is unable to work due solely to complications or conditions resulting from non-covered, unauthorized treatment, time loss compensation is not payable.

Treatment on Pension Cases [RCW 51.36.010](#)

Coverage for medical treatment ends on the day before the pension goes into effect. An exception is made in some cases where continued treatment is needed to protect a worker's life. It is discussed under Medical Coverage in the [Pensions and Fatalities](#) section of the [Claim Adjudication Guidelines](#).