Washington State Department of
Labor & Industries
Workers' Compensation Services

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

Chapter 34: Chronic Pain Management

Effective July 1, 2016

Link: Look for possible **updates and corrections** to these payment policies at:

http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/

Note: Portions of these policies are supported by WAC 296-20-12055 through WAC 296-20-12095.

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Definitions

- **Important associated conditions:** Medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

- **SIMP (structured intensive multidisciplinary program):** A chronic pain management program with the following four components:

  - **Structured** means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed healthcare practitioners. Workers follow a **treatment plan** designed specifically to meet their needs, *and*
  - **Intensive** means the Treatment Phase is delivered on a daily basis, six to eight hours per day, five days per week, for up to four consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs, *and*
  - **Multidisciplinary** (interdisciplinary) means that structured care is delivered and directed by licensed healthcare 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, *and*
  - **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.

- **Treatment plan:** An individualized plan of action and care developed by licensed healthcare professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

- **Valid tests and instruments:** Those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

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Payment policy: Structured, intensive, multidisciplinary program (SIMP)

(See definition of **SIMP** in Definitions at the beginning of this chapter.)

Coverage decision

Injured workers eligible for benefits under RCW Title 51 may be evaluated for and enrolled in a comprehensive treatment program for chronic non-cancer pain if it meets the definition of a **SIMP**.

Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain. (See details about Prior authorization requirements later in this Payment policy section).

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic, non-cancer pain.

Note: Special requirements apply to workers who are considering having a lumbar intervertebral artificial disc replacement. **Links:** See more information in RCW Title 51 and WAC 296-20-12065.

Program design: Phases of an approved SIMP

An approved SIMP has three phases:

- Evaluation Phase,
- Treatment Phase, *and*
- Follow up Phase.

See below for details about each of these three phases.

Note: For information about how and when each phase may be prior authorized by the claim manager, see Prior authorization (below).

1. Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes **treatment plan** development and a report. Only one evaluation is allowed per authorization but it can be conducted over one to two days (see definition of **treatment plan** in Definitions at the beginning of this chapter).

The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pretreatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF), *and*

- Review of medical records and reports, including diagnostic tests and previous efforts at pain management, *and*

- Assessment of any **important associated conditions** that may hinder recovery, such as opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease (see definition of **important associated conditions** in Definitions at the beginning of this chapter), *and*

  Note: If such conditions exist, also see the information in Prior authorization, Provider requirements, and Worker requirements (below).

- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs, *and*

- Psychological and social assessment by a licensed clinical psychologist using **valid tests and instruments** (see definition of **valid tests and instruments** in Definitions at the beginning of this chapter), *and*

- Identification of the worker's family and support resources, *and*

- Identification of the worker's reasons and motivation for participation and improvement, *and*

- Identification of factors that may affect participation in the program, *and*

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- Assessment of pain and function using **valid tests and instruments**; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
  - Activities of Daily Living (ADLs),
  - Range of Motion (ROM),
  - Strength,
  - Stamina, *and*
  - Capacity for and interest in returning to work, *and*
- If the claim manager has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see Vocational services for SIMP claimants section of this chapter), *and*

A summary report of the evaluation and a preliminary recommended **treatment plan**. If there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances.

2. Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts six to eight hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- **Graded exercise**: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence, *and*
- **Cognitive behavioral therapy**: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner, *and*
- **Coordination of health services**: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the **treatment plan**, *and*

Education and skill development on the factors that contribute to pain, responses to pain, and effective pain management, *and*

- **Tracking of Pain and Function**: Individual medical assessment of pain and function levels using **valid tests and instruments**, *and*

- **Ongoing assessment** of **important associated conditions**, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment, *and*

- **Performance** of real or simulated work or daily functional tasks, *and*

- SIMP vocational services may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made, *and*

- A **discharge care plan** for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase, *and*

- A **report** at the conclusion of the Treatment Phase that addresses all the following questions:

  - To what extent did the worker meet his or her treatment goals?

  - What changes if any, have occurred in the worker's medical and psychosocial conditions, including dependence on opioids and other medications?

  - What changes if any, have occurred in the worker's pain level and functional capacity as measured by **valid tests and instruments**?

  - What changes if any, have occurred in the worker's ability to manage pain?

  - What is the status of the worker's readiness to return to work or daily activities?

  - What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?

  - How much and what kind of follow up care does the worker need?

3. Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within six months after the Treatment Phase has concluded. This phase isn't a substitute for and can't serve as an extended Treatment Phase.

The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;

- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;

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- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Follow up Phase site

The activities of the Follow up Phase may occur at the:

- Original multidisciplinary clinic (clinic based), *or*
- Worker's home, workplace, or healthcare provider's office (community based).

This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic, to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to healthcare resources.

Follow up Phase services: Face-to-face vs. non face-to-face

Follow up services are payable as face-to-face and non face-to-face services.

Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other healthcare providers.

Non face-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other healthcare providers to coordinate care in the worker's home community.

Both are subject to the following limits:

- Face-to-face services: up to 24 hours are allowed with a maximum of 4 hours per day
- Non face-to-face services: up to 40 hours are allowed.

Follow up Phase reporting requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems,
- What was done during the Follow up Phase,

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- What resulted from the follow up care, *and*
- Measures of pain and function using **valid tests and instruments**.

This summary report must be submitted at the following intervals:

- For non **lumbar artificial disc surgery candidates**: at one and three months
- For **lumbar artificial disc surgery candidates**: at one, three, and six months.

Follow up Phase activities

According to the worker's identified needs and goals, the Follow up Phase should include the following kinds of activities listed below, and may be done either:

- Face-to-face at the clinic or in the community, *or*
- As non face-to-face coordination of community based services.

Evaluation and assessment activities include:

- Assessing pain and function with **valid tests and instruments**, *and*
- Evaluating whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase, *and*
- Evaluating the worker's dependence, if any, on opioids and other medications for pain, *and*
- Assessing **important associated conditions** and psychological status especially as related to reintegration in the workplace, home, and community, *and*
- Assessing what kind of support the worker has in the work place, home, and community, *and*
- Assessing the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment activities include:

- Providing brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist, *and*
- Adjusting the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work, *and*
- Reinforcing goals to improve or maintain progress made during or since the Treatment Phase, *and*

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- Teaching new techniques or skills that were not part of the original Treatment Phase, *and*
- Addressing the goals listed in the Return to Work Action Plan if one was developed.

Community care coordination includes:

- Communicating with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain, *and*
- Making recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support activities include:

- Contacting or visiting the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources, *and*
- Holding case conferences with the:
  - Interdisciplinary team of clinicians, *and/or*
  - Worker's attending provider, *and/or*
  - Other individuals closely involved with the worker's care and functional recovery.

Follow up Phase special considerations

When determining what follow up services the worker needs, SIMP providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other healthcare providers who are treating the worker is subject to the 24 hour limit on face-to-face services, *and*
- If a SIMP provider plans to travel to the worker's community to deliver face-to-face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed, *and*
- The required follow up evaluations must be done face-to-face with the worker and are subject to the 24 hour limit on face-to-face services, *and*
- When the SIMP provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately, *and*
- Authorized follow up services can be provided, even if the worker has surgery during the follow up period, *and*

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- If a SIMP provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that these therapies are often subject to prior authorization and utilization review for workers covered by the State Fund.

Links: For more information about Helping Workers Get Back to Work, see: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/.

Prior authorization

General referral and prior authorization requirements

All SIMP services require:

- Prior authorization by the claim manager, *and*
- A referral from the worker's attending provider.

Note: An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this can't substitute for a referral from the attending provider.

SIMP referral

SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

When the attending provider refers a worker to a SIMP, the claim manager may authorize an evaluation if the worker:

- Has had unresolved chronic pain for longer than 3 months despite conservative care, *and*
- Has one or more of the following conditions:
  - Is unable to return to work due to the chronic pain, *or*
  - Has returned to work but needs help with chronic pain management, *or*
  - Has significant pain medication dependence, tolerance, abuse, or addiction

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Note: It is required that **lumbar artificial disc surgery candidates** be evaluated by a SIMP prior to requesting the surgery.

Evaluation Phase

Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the SIMP provider verifies the worker meets the requirements described in the Worker requirements in this Payment policy section (see below), and can fully participate in the program.

If the worker:

- **Meets the requirements** and the SIMP provider recommends the worker move on to the Treatment Phase, the SIMP provider must provide the insurer with a report and **treatment plan** as described under the Evaluation Phase, *or if the worker*
- **Doesn't meet the requirements**, the SIMP provider must provide the insurer with a report explaining:
  - What requirements aren't met, *and*
  - The goals the worker must meet before he or she can return and participate in the program, *also*

  If the worker is found to have **important associated conditions** during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the SIMP provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

Treatment Phase and Follow up Phase

The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

Lumbar Intervertebral Artificial Disc Replacement

Surgery candidates must successfully complete a SIMP to obtain authorization for a lumbar artificial disc surgery. Also:

- If a **lumbar artificial disc surgery candidate** previously participated in a SIMP as a **lumbar artificial disc surgery candidate** but didn't successfully complete treatment, one additional SIMP may be authorized only if:

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  - The worker obtains an additional surgical recommendation noting clinical changes one year or more after the date first referred to a SIMP, *or*
  - The reason the worker didn't participate fully or successfully complete a SIMP the first time was **important associated conditions** that are now fully resolved.
- If a **lumbar artificial disc surgery candidate** successfully completed a SIMP and didn't have the surgery, and in the future becomes a **lumbar artificial disc surgery candidate** again, another SIMP may be authorized, but isn't required.
- If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the claim manager may authorize resuming or restarting the SIMP if recommended by the SIMP provider.
- If a SIMP provider plans to travel to the worker's community to deliver face-to-face services, mileage may be reimbursed, but only if it is prior authorized. Also:
  - Lodging and meals (per diem expenses) aren't reimbursable, *and*
  - Actual travel time isn't included in the 24 hour limit, *and*
  - When requesting prior authorization for mileage, the SIMP provider must explain both the reason for the visit and how it will benefit the worker.

SIMP provider requirements

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all these requirements:

- Meet the definition of a **Structured Intensive Multidisciplinary Program** (see Definitions at the beginning of this chapter), *and*
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF; also see Note below this list), *and*
- Provide the services described in each phase, and
- Communicate with providers who are involved with the worker's care, *and*
- Ensure care is coordinated with the worker's attending provider, *and*
- Inform the claim manager if the worker:
  - Stops services prematurely,
  - Has unexpected adverse occurrences, or
  - Doesn't meet the worker requirements, *and*

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- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment, *and*
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed, *and*
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Note: Providers must maintain CARF accreditation and provide the Department of Labor & Industries (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.

Worker requirements

An injured worker must make a good faith effort to participate and comply with the **treatment plan** prescribed for him or her by the SIMP provider. To complete a SIMP successfully, the worker must meet all these requirements:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her **treatment plan**, *and*
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her **treatment plan**, *and*
- Agree to be evaluated and comply with treatment prescribed for any **important associated conditions** that hinder progress or recovery (for example, opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease), *and*
- Attend each day and each session that is part of his or her **treatment plan**. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward **treatment plan** goals, *and*
- Cooperate and comply with his or her **treatment plan**, *and*
- Not pose a threat or risk to himself or herself, to staff, or to others, *and*
- Review and sign a participation agreement with the provider, *and*
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

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Services that can be billed

SIMP fee schedule

The fee schedule and procedure codes for Evaluation, Treatment, and Follow up Phases are listed in the following table.

The fee schedule applies to injured workers only in an outpatient program:

Description	Local code	Duration/ limits	Units of service	Maximum fee
SIMP Evaluation Services	**2010M**	One evaluation per authorization, which may be conducted over one to two days.	Bill only 1 unit for evaluation even if conducted over 2 days	**$1,164.19**
SIMP Treatment Services, each 6-8 hour day	**2011M**	Not to exceed 20 treatment days (6-8 hours per day).	1 day equals 1 unit of service	**$745.69** per day
SIMP Follow up Services: **Face-to-face** services with the worker, the worker's family, employer, or healthcare providers, either in the clinic or in the worker's community	**2014M**	Not to exceed four hours per day and not to exceed 24 hours total (time must be billed in one minute units).	1 minute equals 1 unit of service	**$1.56** per minute (**$93.32** per hour)
SIMP Follow up Services: **Non face-to-face** coordination of services with the worker, the worker's family, employer, or healthcare providers in the worker's community	**2015M**	Not to exceed 40 hours (time must be billed in 1 minute units).	1 minute equals 1 unit of service	**$1.23** per minute (**$73.93** per hour)
Mileage for traveling to and from the worker's community	**0392R**	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

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Requirements for billing

Outpatient chronic pain management programs must bill using the local codes listed in the fee schedule (see above) on a **CMS-1500** form.

Billing for partial days for the treatment phase

Clinics can bill only for that percent of an eight hour day that has been provided, (even if the patient was scheduled for less than eight hours). Example:

- The worker has an unforeseen emergency and has to leave the clinic after two hours (25% of the treatment day). The clinic would bill **$745.69** x 25% = **$186.42**

Payment limits

SIMP evaluation services

Only one evaluation per authorization is allowed, which may be conducted over the course of one to two days. If the evaluation is conducted over a two day period, bill only one unit and span the dates.

SIMP treatment services

These services can't exceed 20 treatment days (6-8 hours per day).

SIMP follow up services

Non face-to-face services (local code **2015M**) can't exceed 40 hours.

Face-to-face services (local code **2014M**) can't:

- Exceed four hours per day, *and*
- 24 hours total.

Note: Mileage for travelling to and from the worker's community isn't included in the 24 hour limit (see more information in the SIMP fee schedule, above).

Payment policy: Vocational services for SIMP claimants

Prior authorization

Vocational referrals

Prior to authorizing participation in a SIMP, the claim manager will determine, based on the facts of each case, whether to make a vocational referral.

The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable.

The claim manager won't make a vocational referral when the worker:

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

Requirements for a 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 claim manager assigns a vocational counselor. The Return to Work Action Plan:

- Provides the focus for vocational services during a worker's participation in a chronic pain management program, *and*
- May be modified or adjusted during the Treatment or Follow up Phase as needed.

Note: 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.

If a vocational counselor is assigned, he or she 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.

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The specific roles and responsibilities of each are as follows:

- The **SIMP vocational counselor** will:
  - Co-develop the Return to Work Action Plan with the insurer assigned vocational counselor, *and*
  - Present 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, *and*
  - Communicate 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** will:
  - Co-develop the Return to Work Action Plan with the SIMP vocational counselor, *and*
  - Attend the chronic pain management program discharge conference and other conferences as needed either in person or by phone, *and*
  - Negotiate with the attending provider when the initial Return to Work Action Plan isn't approved in order to resolve the attending provider's concerns, *and*
  - Obtain the worker's signature on the Return to Work Action Plan, *and*
  - Communicate with the SIMP vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan, *and*
  - Implement the Return to Work Action Plan following the conclusion of the Treatment Phase.

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- The **attending provider** will:
  - Review and approve or disapprove the initial Return to Work Action Plan within 15 days of receipt, *and*
  - Review and sign the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt, *and*
  - Communicate 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, *and*
  - Review and sign the final Return to Work Action Plan, *and*
  - Cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan.

Note: If the worker fails to be cooperative, the sanctions as set out in RCW 51.32.110 will be applied.

Link: For more information about what can happen if the worker refuses to cooperate, see RCW 51.32.110.

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules supporting SIMP payment policies	Washington Administrative Code (WAC) 296-20-12055 through WAC 296-20-12095: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-12055
Becoming an L&I provider	L&I's website: http://www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Crime Victims Compensation Program contact information	Phone: **1-800-762-3716** (toll free) Fax: **1-360-902-5333** L&I's website: www.CrimeVictims.Lni.wa.gov
Fee schedules for all healthcare services	L&I's website: http://feeschedules.Lni.wa.gov
Return to work: "Helping Workers Get Back to Work"	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/
Self-insured claims authorization from the self-insured employer (SIE) or their third party administrator (TPA)	Contact list of SIE/TPAs on L&I's website: http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/
Worker refuses to cooperate with care plan: Legal issues defined in Washington state laws	Revised Code of Washington (RCW) 51.32.11: http://apps.leg.wa.gov/rcw/default.aspx?cite=51.32.110

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**

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