

AMENDATORY SECTION (Amending WSR 03-21-069, filed 10/14/03, effective 12/1/03)

**WAC 296-20-01002 Definitions. Acceptance, accepted condition:** Determination by a qualified representative of the department or self-insurer that reimbursement for the diagnosis and curative or rehabilitative treatment of a claimant's medical condition is the responsibility of the department or self-insurer. The condition being accepted must be specified by one or more diagnosis codes from the current edition of the International Classification of Diseases, Clinically Modified (ICD-CM).

**Appointing authority:** For the evidence-based prescription drug program of the participating agencies in the state purchased health care programs, appointing authority shall mean the following persons acting jointly: The administrator of the health care authority, the secretary of the department of social and health services, and the director of the department of labor and industries.

**Attendant care:** Those proper and necessary personal care services provided to maintain the worker in his or her residence. Refer to WAC 296-20-303 for more information.

**Attending doctor report:** This type of report may also be referred to as a "60 day" or "special" report. The following information must be included in this type of report. Also, additional information may be requested by the department as needed.

(1) The condition(s) diagnosed including ICD-9-CM codes and the objective and subjective findings.

(2) Their relationship, if any, to the industrial injury or exposure.

(3) Outline of proposed treatment program, its length, components, and expected prognosis including an estimate of when treatment should be concluded and condition(s) stable. An estimated return to work date should be included. The probability, if any, of permanent partial disability resulting from industrial conditions should be noted.

(4) If the worker has not returned to work, the attending doctor should indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work and why.

(5) If the worker has not returned to work, a doctor's estimate of physical capacities should be included with the report. If further information regarding physical capacities is

needed or required, a performance-based physical capacities evaluation can be requested. Performance-based physical capacities evaluations should be conducted by a licensed occupational therapist or a licensed physical therapist. Performance-based physical capacities evaluations may also be conducted by other qualified professionals who provided performance-based physical capacities evaluations to the department prior to May 20, 1987, and who have received written approval to continue supplying this service based on formal department review of their qualifications.

**Authorization:** Notification by a qualified representative of the department or self-insurer that specific proper and necessary treatment, services, or equipment provided for the diagnosis and curative or rehabilitative treatment of an accepted condition will be reimbursed by the department or self-insurer.

**Average wholesale price (AWP):** A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

**Baseline price (BLP):** Is derived by calculating the mean average for all NDC's (National Drug Code) in a specific product group, determining the standard deviation, and calculating a new mean average using all prices within one standard deviation of the original mean average. "Baseline price" is a drug pricing mechanism developed and updated by First Data Bank.

**Bundled codes:** When a bundled code is covered, payment for them is subsumed by the payment for the codes or services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.) Bundled codes and services are identified in the fee schedules.

**By report:** BR (by report) in the value column of the fee schedules indicates that the value of this service is to be determined by report (BR) because the service is too unusual, variable or new to be assigned a unit value. The report shall provide an adequate definition or description of the services or procedures that explain why the services or procedures (e.g., operative, medical, radiological, laboratory, pathology, or other similar service report) are too unusual, variable, or complex to be assigned a relative value unit, using any of the following as indicated:

- (1) Diagnosis;
- (2) Size, location and number of lesion(s) or procedure(s) where appropriate;
- (3) Surgical procedure(s) and supplementary procedure(s);
- (4) Whenever possible, list the nearest similar procedure

by number according to the fee schedules;

(5) Estimated follow-up;

(6) Operative time;

(7) Describe in detail any service rendered and billed using an "unlisted" procedure code.

The department or self-insurer may adjust BR procedures when such action is indicated.

**Chart notes:** This type of documentation may also be referred to as "office" or "progress" notes. Providers must maintain charts and records in order to support and justify the services provided. "Chart" means a compendium of medical records on an individual patient. "Record" means dated reports supporting bills submitted to the department or self-insurer for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in a chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible, and shall include, but are not limited to:

(1) Date(s) of service;

(2) Patient's name and date of birth;

(3) Claim number;

(4) Name and title of the person performing the service;

(5) Chief complaint or reason for each visit;

(6) Pertinent medical history;

(7) Pertinent findings on examination;

(8) Medications and/or equipment/supplies prescribed or provided;

(9) Description of treatment (when applicable);

(10) Recommendations for additional treatments, procedures, or consultations;

(11) X rays, tests, and results; and

(12) Plan of treatment/care/outcome.

**Consultation examination report:** The following information must be included in this type of report. Additional information may be requested by the department as needed.

(1) A detailed history to establish:

(a) The type and severity of the industrial injury or occupational disease.

(b) The patient's previous physical and mental health.

(c) Any social and emotional factors which may effect recovery.

(2) A comparison history between history provided by attending doctor and injured worker, must be provided with exam.

(3) A detailed physical examination concerning all systems affected by the industrial accident.

(4) A general physical examination sufficient to demonstrate any preexisting impairments of function or concurrent condition.

(5) A complete diagnosis of all pathological conditions including ICD-9-CM codes found to be listed:

(a) Due solely to injury.

(b) Preexisting condition aggravated by the injury and the extent of aggravation.

(c) Other medical conditions neither related to nor aggravated by the injury but which may retard recovery.

(d) Coexisting disease (arthritis, congenital deformities, heart disease, etc.).

(6) Conclusions must include:

(a) Type of treatment recommended for each pathological condition and the probable duration of treatment.

(b) Expected degree of recovery from the industrial condition.

(c) Probability, if any, of permanent disability resulting from the industrial condition.

(d) Probability of returning to work.

(7) Reports of necessary, reasonable X-ray and laboratory studies to establish or confirm the diagnosis when indicated.

**Doctor:** For these rules, means a person licensed to practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry.

Only those persons so licensed may sign report of accident forms and certify time loss compensation except as provided in chapter 296-20 WAC.

**Emergent hospital admission:** Placement of the worker in an acute care hospital for treatment of a work related medical condition of an unforeseen or rapidly progressing nature which if not treated in an inpatient setting, is likely to jeopardize the workers health or treatment outcome.

**Endorsing practitioner:** A practitioner who has reviewed the preferred drug list and has notified the health care authority that he or she has agreed to allow therapeutic interchange of a preferred drug for any nonpreferred drug in a given therapeutic class.

**Fatal:** When the attending doctor has reason to believe a worker has died as a result of an industrial injury or exposure, the doctor should notify the nearest department service location or the self-insurer immediately. Often an autopsy is required by the department or self-insurer. If so, it will be authorized by the service location manager or the self-insurer. Benefits payable include burial stipend and monthly payments to the surviving spouse and/or dependents.

**Fee schedules or maximum fee schedule(s):** The fee schedules consist of, but are not limited to, the following:

(a) Health Care Common Procedure Coding System Level I and II Codes, descriptions and modifiers that describe medical and other services, supplies and materials.

(b) Codes, descriptions and modifiers developed by the department.

(c) Relative value units (RVUs), calculated or assigned dollar values, percent-of-allowed-charges (POAC), or diagnostic related groups (DRGs), that set the maximum allowable fee for services rendered.

(d) Billing instructions or policies relating to the submission of bills by providers and the payment of bills by the department or self-insurer.

(e) Average wholesale price (AWP), baseline price (BLP), and policies related to the purchase of medications.

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

**Home nursing:** Those nursing services that are proper and necessary to maintain the worker in his or her residence. These services must be provided through an agency licensed, certified or registered to provide home care, home health or hospice services. Refer to WAC 296-20-091 for more information.

**Independent or separate procedure:** Certain of the fee schedule's listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "independent procedure" is applicable.

**Medical aid rules:** The Washington Administrative Codes (WACs) that contain the administrative rules for medical and other services rendered to workers.

**Modified work status:** The worker is not able to return to their previous work, but is physically capable of carrying out work of a lighter nature. Workers should be urged to return to modified work as soon as reasonable as such work is frequently beneficial for body conditioning and regaining self confidence.

Under RCW 51.32.090, when the employer has modified work available for the worker, the employer must furnish the doctor and the worker with a statement describing the available work in terms that will enable the doctor to relate the physical activities of the job to the worker's physical limitations and capabilities. The doctor shall then determine whether the worker is physically able to perform the work described. The employer may not increase the physical requirements of the job without requesting the opinion of the doctor as to the worker's

ability to perform such additional work. If after a trial period of reemployment the worker is unable to continue with such work, the worker's time loss compensation will be resumed upon certification by the attending doctor.

If the employer has no modified work available, the department should be notified immediately, so vocational assessment can be conducted to determine whether the worker will require assistance in returning to work.

**Nonemergent (elective) hospital admission:** Placement of the worker in an acute care hospital for medical treatment of an accepted condition which may be safely scheduled in advance without jeopardizing the worker's health or treatment outcome.

**Physician:** For these rules, means any person licensed to perform one or more of the following professions: Medicine and surgery; or osteopathic medicine and surgery.

**Practitioner:** For these rules, means any person defined as a "doctor" under these rules, or licensed to practice one or more of the following professions: Audiology; physical therapy; occupational therapy; pharmacy; prosthetics; orthotics; psychology; nursing; physician or osteopathic assistant; and massage therapy.

**Preferred drug list:** The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for the purchase of drugs in state purchased health care programs.

**Proper and necessary:**

(1) The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.

(2) Under the Industrial Insurance Act, "proper and necessary" refers to those health care services which are:

(a) Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;

(b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;

(c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and

(d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

(3) The department or self-insurer stops payment for health

care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

(4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

**Refill:** The continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral or immunosuppressive drug.

**Regular work status:** The injured worker is physically capable of returning to his/her regular work. It is the duty of the attending doctor to notify the worker and the department or self-insurer, as the case may be, of the specific date of release to return to regular work. Compensation will be terminated on the release date. Further treatment can be allowed as requested by the attending doctor if the condition is not stationary and such treatment is needed and otherwise in order.

**Temporary partial disability:** Partial time loss compensation may be paid when the worker can return to work on a limited basis or return to a lesser paying job is necessitated by the accepted injury or condition. The worker must have a reduction in wages of more than five percent before consideration of partial time loss can be made. No partial time loss compensation can be paid after the worker's condition is stationary. **All time loss compensation must be certified by the attending doctor based on objective findings.**

**Termination of treatment:** When treatment is no longer required and/or the industrial condition is stabilized, a report indicating the date of stabilization should be submitted to the department or self-insurer. This is necessary to initiate closure of the industrial claim. The patient may require continued treatment for conditions not related to the industrial condition; however, financial responsibility for such care must

be the patient's.

**Therapeutic alternative:** Drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses.

**Therapeutic interchange:** To dispense with the endorsing practitioner's authorization, a therapeutic alternative to the prescribed drug.

**Total permanent disability:** Loss of both legs or arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful employment. When the attending doctor feels a worker may be totally and permanently disabled, the attending doctor should communicate this information immediately to the department or self-insurer. A vocational evaluation and an independent rating of disability may be arranged by the department prior to a determination as to total permanent disability. Coverage for treatment does not usually continue after the date an injured worker is placed on pension.

**Total temporary disability:** Full-time loss compensation will be paid when the worker is unable to return to any type of reasonably continuous gainful employment as a direct result of an accepted industrial injury or exposure.

**Unusual or unlisted procedure:** Value of unlisted services or procedures should be substantiated "by report" (BR).

**Utilization review:** The assessment of a claimant's medical care to assure that it is proper and necessary and of good quality. This assessment typically considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the accepted condition being treated.

AMENDATORY SECTION (Amending WSR 00-01-037, filed 12/7/99, effective 1/8/00)

**WAC 296-20-02704 What criteria does the director or director's designee use to make medical coverage decisions?** (1)  
In making medical coverage decisions, the director or the director's designee considers information from a variety of sources. These sources include, but are not limited to:

-  Scientific evidence;
-  National and community-based opinions;
-  Informal syntheses of provider opinion;
-  Experience of the department and other entities;

✍ Regulatory status.

Because of the unique nature of each health care service, the type, quantity and quality of the information available for review may vary. The director or director's designee weighs the quality of the available evidence in making medical coverage decisions.

(2) Scientific evidence.

(a) "Scientific evidence" includes reports and studies published in peer-reviewed scientific and clinical literature. The director or the director's designee will consider the nature and quality of the study, its methodology and rigorousness of design, as well as the quality of the journal in which the study was published.

✍ For treatment services, studies addressing safety, efficacy, and effectiveness of the treatment or procedure for its intended use will be considered.

✍ For diagnostic devices or procedures, studies addressing safety, technical capacity, accuracy or utility of the device or procedure for its intended use will be considered.

(b) The greatest weight will be given to the most rigorously designed studies and on those well-designed studies that are reproducible. The strength of the design will depend on such scientifically accepted methodological principles as randomization, blinding, appropriateness of outcomes, spectrum of cases and controls, appropriate power to detect differences, magnitude and significance of effect. Additional consideration will be given to those studies that focus on sustained health and functional outcomes of workers with occupational conditions rather than unsustained clinical improvements.

(3) National and community-based opinion.

(a) "National opinion" includes, but is not limited to, syntheses of clinical issues that may take the form of published reports in the scientific literature, national consensus documents, formalized documents addressing standards of practice, practice parameters from professional societies or commissions, and technology assessments produced by independent evidence-based practice centers.

The director or the director's designee will consider the nature and quality of the process used to reach consensus or produce the synthesis of expert opinion. This consideration will include, but may not be limited to, the qualifications of participants, potential biases of sponsoring organizations, the inclusion of graded scientific information in the deliberations, the explicit nature of the document, and the processes used for broader review.

(b) "Community-based opinion" refers to advice and recommendations of formal committees made up of clinical providers within the state of Washington. As appropriate to the subject matter, this may include recommendations from the

department's formal advisory committees:

✍ The industrial insurance and rehabilitation committee of the Washington State Medical Association, which includes a representative from the Washington Osteopathic Medical Association;

✍ The chiropractic advisory committee.

✍ The Washington state pharmacy and therapeutics committee.

(4) "Informal syntheses of provider opinion" includes, but is not limited to, professional opinion surveys.

(5) Experience of the department and other entities.

The director or director's designee may consider data from a variety of sources including the department, other state agencies, federal agencies and other insurers regarding studies, experience and practice with past coverage. Examples of these include, but are not limited to, formal outcome studies, cost-benefit analyses, and adverse event, morbidity or mortality data.

(6) Regulatory status.

The director or director's designee will consider related licensing and approval processes of other state and federal regulatory agencies. This includes, but is not limited to:

✍ The federal food and drug administration's (FDA) regulation of drugs and medical devices (21 U.S.C. 301 et seq. and 21 CFR Chapter 1, Subchapters C, D, & H consistent with the purposes of this chapter, and as now or hereafter amended); and

✍ The Washington state department of health's regulation of scope of practice and standards of practice for licensed health care professionals regulated under Title 18 RCW.

AMENDATORY SECTION (Amending WSR 00-01-037, filed 12/7/99, effective 1/8/00)

**WAC 296-20-02705 What are treatment and diagnostic guidelines and how are they related to medical coverage decisions?**

(1) Treatment and diagnostic guidelines are recommendations for the diagnosis or treatment of accepted conditions. These guidelines are intended to guide providers through the range of the many treatment or diagnostic options available for a particular medical condition. Treatment and diagnostic guidelines are a combination of the best available scientific evidence and a consensus of expert opinion.

(2) The department may develop treatment or diagnostic guidelines to improve outcomes for workers receiving covered health services. As appropriate to the subject matter, the department may develop these guidelines in collaboration with

the department's formal advisory committees:

✍ The industrial insurance and rehabilitation committee of the Washington State Medical Association, which includes a representative from the Washington Osteopathic Medical Association;

✍ The chiropractic advisory committee.

✍ The Washington state pharmacy and therapeutics committee.

(3) In the process of implementing these guidelines, the department may find it necessary to make a formal medical coverage decision on one or more of the treatment or diagnostic options. The department, not the advisory committees, is responsible for implementing treatment guidelines and for making coverage decisions that result from such implementation.

AMENDATORY SECTION (Amending WSR 00-01-040, filed 12/7/99, effective 1/20/00)

**WAC 296-20-03011 What general limitations are in place for medications?** (1) **Amount dispensed.** The department or self-insurer will pay for no more than a thirty-day supply of a medication dispensed at any one time.

(2) **Over-the-counter drugs.** Prescriptions for over-the-counter items may be paid. Special compounding fees for over-the-counter items are not payable.

(3) **Generic drugs.** Prescriptions are to be written for generic drugs unless the attending physician specifically indicates that substitution is not permitted. For example: The patient cannot tolerate substitution. Pharmacists are instructed to fill with generic drugs unless the attending physician specifically indicates substitution is not permitted.

(4) **Evidence-based prescription drug program.** In accordance with RCW 70.14.050, the department in cooperation with other state agencies may develop a preferred drug list. Any pharmacist filling a prescription under state purchased health care programs as defined in RCW 41.05.011(2) shall substitute, where identified, a preferred drug for any nonpreferred drug in a given therapeutic class, unless the endorsing practitioner has indicated on the prescription that the nonpreferred drug must be dispensed as written, or the prescription is for a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug (see RCW 69.41.190) or the nonendorsing practitioner has received prior authorization from the department to fill the prescription as written, in which case the pharmacist shall dispense the prescribed nonpreferred drug.

(5) **Prescriptions for unrelated medical conditions.** The department or self-insurer may consider temporary coverage of prescriptions for conditions not related to the industrial injury when such conditions are retarding recovery. Any treatment for such conditions must have prior authorization per WAC 296-20-055. This would apply to any prescription for such conditions even when the endorsing practitioner indicates "dispense as written."

((5)) (6) **Pension cases.** Once the worker is placed on a pension, the department or self-insurer may pay for only those drugs and medications authorized for continued medical treatment for conditions previously accepted by the department. Authorization for continued medical and surgical treatment is at the sole discretion of the supervisor of industrial insurance and must be authorized before the treatment is rendered. In such pension cases, the department or self-insurer cannot pay for scheduled drugs used to treat continuing pain resulting from an industrial injury or occupational disease.

AMENDATORY SECTION (Amending WSR 00-01-040, filed 12/7/99, effective 1/20/00)

**WAC 296-20-03012 Where can I find the department's outpatient drug and medication coverage decisions?** The department's outpatient drug and medication coverage decisions are contained in the department's formulary, as developed by the department in collaboration with the Washington state pharmacy and therapeutics committee and the Washington State Medical Association's Industrial Insurance and Rehabilitation Committee.

In the formulary, drugs are listed in the following categories:

 **Allowed**

Drugs used routinely for treating accepted industrial injuries and occupational illnesses, including those on the preferred drug list.

Example: Nonscheduled drugs and other medications during the acute phase of treatment for the industrial injury or condition.

 **Prior authorization required**

Drugs used routinely to treat conditions not normally accepted as work related injuries, drugs which are used to treat unrelated conditions retarding recovery from the accepted condition on the claim, and drugs for which less expensive alternatives exist. ~~((Example: All drugs to treat hypertension because hypertension is not normally an accepted industrial~~

~~condition.))~~ For example: All drugs to treat hypertension require prior authorization because hypertension is not normally an accepted industrial condition. In addition, nonendorsing practitioners must obtain prior authorization for a nonpreferred drug when the category of drugs has a preferred drug.

 **Denied**

Drugs not normally used for treating industrial injuries or not normally dispensed by outpatient pharmacies.

Example: Most hormones, most nutritional supplements.