

AMENDATORY SECTION (Amending WSR 90-22-054, filed 11/5/90, effective 12/6/90)

WAC 296-14-400 Reopenings for benefits. The director at any time may, upon the workers' application to reopen for aggravation or worsening of condition, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. This provision will not apply to total permanent disability cases, as provision of medical treatment in those cases is limited by RCW 51.36.010.

The seven-year reopening time limitation shall run from the date the first claim closure becomes final and shall apply to all claims regardless of the date of injury. In order for claim closure to become final on claims where closure occurred on or after July 1, 1981, the closure must include documentation of medical recommendation, advice or examination. Such documentation is not required for closing orders issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall for the purposes of this section only, be deemed issued on July 1, 1985.

The director shall, in the exercise of his or her discretion, reopen a claim provided objective evidence of worsening is present and proximately caused by a previously accepted asbestos-related disease.

In order to support a final closure based on medical recommendation or advice the claim file must contain documented information from a doctor, or nurse consultant (departmental) or nurse practitioner (~~(supervised by a doctor)~~). The doctor or nurse practitioner may be in private practice, acting as a member of a consultation group, employed by a firm, corporation, or state agency.

For the purpose of this section, a "doctor" is defined in WAC 296-20-01002.

When a claim has been closed by the department or self-insurer for sixty days or longer, the worker must file a written application to reopen the claim. An informal written request filed without accompanying medical substantiation of worsening of the condition will constitute a request to reopen, but the time for taking action on the request shall not commence until a formal application is filed with the department or self-insurer as the case may be.

A formal application occurs when the worker and doctor complete and file the application for reopening provided by the department. Upon receipt of an informal request without

accompanying medical substantiation of worsening of the worker's condition, the department or self-insurer shall promptly provide the necessary application to the worker for completion.

If, within seven years from the date the first closing order became final, a formal application to reopen is filed which shows by "sufficient medical verification of such disability related to the accepted condition(s)" that benefits are payable, the department, or the self-insurer, pursuant to RCW 51.32.210 and 51.32.190, respectively shall mail the first payment within fourteen days of receiving the formal application to reopen. If the application does not contain sufficient medical verification of disability, the fourteen-day period will begin upon receipt of such verification. If the application to reopen is granted, compensation will be paid pursuant to RCW 51.28.040. If the application to reopen is denied, the worker shall repay such compensation pursuant to RCW 51.32.240.

Applications for reopenings filed on or after July 1, 1988, must be acted upon by the department within ninety days of receipt of the application by the department or the self-insurer. The ninety-day limitation shall not apply if the worker files an appeal or request for reconsideration of the department's denial of the reopening application.

The department may, for good cause, extend the period in which the department must act for an additional sixty days. "Good cause" for such an extension may include, but not be limited to, the following:

(1) Inability to schedule a necessary medical examination within the ninety-day time period;

(2) Failure of the worker to appear for a medical examination;

(3) Lack of clear or convincing evidence to support reopening or denial of the claim without an independent medical examination;

(4) Examination scheduled timely but cannot be conducted and a report received in sufficient time to render a decision prior to the end of the ninety-day time period.

The department shall make a determination regarding "good cause" in a final order as provided in RCW 51.52.050.

The ninety-day limitation will not apply in instances where the previous closing order has not become final.

AMENDATORY SECTION (Amending WSR 04-08-040, filed 3/30/04, effective 5/1/04)

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 296-20-01502, When can a physician assistant have sole signature on the report of accident or physician's initial report? and WAC 296-23-241, Can advanced registered nurse practitioners independently perform the functions of an attending physician?

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 03-21-069, filed 10/14/03, effective 12/1/03)

WAC 296-20-01501 Physician(~~l~~s) assistant rules. (1) Physician(~~l~~s) assistants may perform only those medical services in industrial injury cases, for which the physician(~~l~~s) assistant is trained and licensed, under the control and supervision of a licensed physician. Such control and supervision shall not be construed to require the personal presence of the supervising physician.

(2) Physician(~~l~~s) assistants may perform those medical services which are within the scope of their physician's assistant license for industrial injury cases within the limitations of subsection (3) of this section.

(3) Advance approval must be obtained from the department to treat industrial injury cases. To be eligible to treat industrial injuries, the physician(~~l~~s) assistant must:

(a) Provide the department with a copy of his/her license.

(b) Provide the name and address and specialty of the supervising physician.

(c) Provide the department with the evidence of a reliable and rapid system of communication with the supervising physician.

(4) Physician(~~l~~s) assistants may prepare report of accident, time loss compensation certification, and progress reports for the supervising physician(~~l~~s) signature. Physician(~~l~~s) assistants cannot submit such information under his/her signature. Under certain circumstances, physician assistants can submit the report of accident or physician initial report under his or her signature. See WAC 296-20-01502.

NEW SECTION

WAC 296-20-01502 When can a physician assistant have sole signature on the report of accident or physician's initial report? (1) Physician assistants (PAs) may complete and have sole signature on the report of accident or the physician's initial report, where applicable, on simple industrial injury claims. This can occur for the period beginning July 1, 2004, and ending July 1, 2007.

PAs cannot certify entitlement to time-loss compensation, pension benefits, death benefits, or loss-of-earning power benefits.

(2) A simple industrial injury claim would include:

✍ No time lost from work after the date of injury; and

✍ A simple industrial injury limited to an insect bite, abrasion, contusion, laceration, blister, foreign body, open wound, sprain, strain, closed fracture, simple burn, or probable exposure to bloodborne pathogen due to a needlestick.

(Specific examples include 2nd degree burn, ICD-9 943.29, tibia fracture, closed, ICD-9 823.80.)

A simple industrial injury does not involve:

✍ Time lost from work after the date of injury; or

✍ Surgery or hospitalization on the date of the injury or date of first treatment; or

✍ Occupational diseases (e.g., dermatitis, carpal tunnel syndrome, hearing loss, asbestosis, exposure to blood with no needlestick); or

✍ Complex industrial injuries (e.g., hernias, head injuries (except simple lacerations or abrasions), mental health conditions, open fractures, extremity amputation, severe crush injuries, severe burns, spinal cord injuries, cancer, heart disease, stroke or chemical exposure).

(3) An attending physician must be assigned to the claim to certify any time off work after the date of injury.

(4) The PA must identify on the report of accident or physician's initial report the name of the doctor who will be supervising care under this claim and also list the corresponding labor and industries provider number for that doctor. The claim will be considered on its own merits regardless of the absence of the supervising physician's L&I number but payment of bills may be delayed.

(5) WAC 296-20-01502 expires July 1, 2007.

AMENDATORY SECTION (Amending WSR 00-01-190, filed 12/22/99, effective 1/24/00)

WAC 296-20-06101 What reports are health care providers required to submit to the insurer? The department or self-insurer requires different kinds of information at various stages of a claim in order to approve treatment, time loss compensation, and treatment bills. The department or self-insurer may request the following reports at specified points in the claim. The information provided in these reports is needed to adequately manage industrial insurance claims.

| <i>Report</i> | <i>Due/Needed by Insurer</i> | <i>What Information Should Be Included In the Report?</i> | <i>Special Notes</i> |
|--|--|--|---|
| <p>Report of Industrial Injury or Occupational Disease (form)</p> <p>Self-Insurance: Physician's Initial Report (form)</p> | <p>Immediately - within five days of first visit.</p> | <p>See form</p> <p>If additional space is needed, please attach the information to the application. The claim number should be at the top of the page.</p> | <p>Only MD, DO, DC, ND, DPM, DDS, <u>ARNP</u>, and OD may sign and be paid for completion of this form. <u>PAs may sign and be paid for completion of this form under the circumstances outlined in WAC 296-20-01502.</u></p> |
| <p>Sixty Day (narrative)</p> <p>Purpose: Support and document the need for continued care when conservative (nonsurgical) treatment is to continue beyond sixty days</p> | <p>Every sixty days when only conservative (nonsurgical) care has been provided.</p> | <p>(1) The conditions diagnosed, including ICD-9-CM codes and the subjective complaints and objective findings.</p> | <p>Providers may submit legible comprehensive chart notes in lieu of sixty day reports PROVIDED the chart notes include all the information required as noted in the "What Information Should Be Included?" column.</p> |
| | | <p>(2) The relationship of diagnoses, if any, to the industrial injury or exposure.</p> <p>(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 and the probability, if any, of permanent partial disability resulting from the industrial condition.</p> <p>(4) Current medications, including dosage and amount prescribed. With repeated prescriptions, include the plan and need for continuing medication.</p> | <p>However, office notes are not acceptable in lieu of requested narrative reports and providers may not bill for the report if chart notes are submitted in place of the report.</p> <p>Please see WAC 296-20-03021 and 296-20-03022 for documentation requirements for those workers receiving opioids to treat chronic noncancer pain. Providers must include their name, address and date on all chart notes submitted.</p> |

| | | | |
|--|---|---|---|
| | | <p>(5) If the worker has not returned to work, indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work and why.</p> <p>(6) If the worker has not returned to work, a doctor's estimate of physical capacities should be included.</p> <p>(7) Response to any specific questions asked by the insurer or vocational counselor.</p> | |
| Special Reports/Follow-up Reports (narrative) | As soon as possible following request by the department/insurer. | Response to any specific questions asked by the insurer or vocational counselor. | "Special reports" are payable only when requested by the insurer. |
| <p>Consultation Examination Reports (narrative)</p> <p>Purpose: Obtain an objective evaluation of the need for ongoing conservative medical management of the worker.</p> <p>The attending doctor may choose the consultant.</p> | At one hundred twenty days if only conservative (nonsurgical) care has been provided. | <p>(1) Detailed history.</p> <p>(2) Comparative history between the history provided by the attending doctor and injured worker.</p> <p>(3) Detailed physical examination.</p> <p>(4) Condition(s) diagnosed including ICD-9-CM codes, subjective complaints and objective findings.</p> <p>(5) Outline of proposed treatment program: Its length, components, expected prognosis including when treatment should be concluded and condition(s) stable.</p> <p>(6) Expected degree of recovery from the industrial condition.</p> <p>(7) Probability of returning to regular work or modified work and an estimated return to work date.</p> | <p>If the injured/ill worker had been seen by the consulting doctor within the past three years for the same condition, the consultation will be considered a follow-up office visit, not consultation.</p> <p>A copy of the consultation report must be submitted to both the attending doctor and the department/insurer.</p> |

| | | | |
|---|---|---|---|
| | | (8) Probability , if any, of permanent partial disability resulting from the industrial condition. (9) A doctor's estimate of physical capacities should be included if the worker has not returned to work. (10) Reports of necessary, reasonable X ray and laboratory studies to establish or confirm diagnosis when indicated. | |
| Supplemental Medical Report (form) | As soon as possible following request by the department/insurer. | See form | Payable only to the attending doctor upon request of the department/insurer. |
| Attending Doctor Review of IME Report (form) Purpose: Obtain the attending doctor's opinion about the accuracy of the diagnoses and information provided based on the IME. | As soon as possible following request by the department/insurer. | Agreement or disagreement with IME findings. If you disagree, provide objective/subjective findings to support your opinion. | Payable only to the attending doctor upon request of the department/insurer. |
| Loss of Earning Power (form) Purpose: Certify the loss of earning power is due to the industrial injury/occupational disease. | As soon as possible after receipt of the form. | See form | Payable only to the AP. |
| Application to Reopen Claim Due to Worsening of Condition (form) Purpose: Document worsening of the accepted condition and need to reopen claim for additional treatment. | Immediately following identification of worsening after a claim has been closed for sixty days. Crime Victims: Following identification of worsening after a claim has been closed for ninety days. | See form | Only MD, DO, DC, ND, DPM, DDS, <u>ARNP</u> , and OD may sign and be paid for completion of this form. |

What documentation is required for initial and follow up visits?

Legible copies of office or progress notes are required for the initial and all follow-up visits.

What documentation are ancillary providers required to submit to the insurer?

Ancillary providers are required to submit the following documentation to the department or self-insurer:

| Provider | Chart Notes | Reports |
|--------------------------|--------------------|----------------|
| Audiology | X | X |
| Biofeedback | X | X |
| Dietician | | X |
| Drug & Alcohol Treatment | X | X |

| | | |
|---|---|---|
| Free Standing Surgery | X | X |
| Free Standing Emergency Room | X | X |
| Head Injury Program | X | X |
| Home Health Care | | X |
| Infusion Treatment, Professional Services | | X |
| Hospitals | X | X |
| Laboratories | | X |
| Licensed Massage Therapy | X | X |
| Medical Transportation | | X |
| Nurse Case Managers | | X |
| Nursing Home | X | X |
| Occupational Therapist | X | X |
| Optometrist | X | X |
| Pain Clinics | X | X |
| Panel Examinations | | X |
| Physical Therapist | X | X |
| Prosthetist/Orthotist | X | X |
| Radiology | | X |
| Skilled Nursing Facility | X | X |
| Speech Therapist | X | X |

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

WAC 296-23-240 Licensed nursing rules. (1) Registered nurses and licensed practical nurses may perform private duty nursing care in industrial injury cases when the attending physician deems this care necessary. Registered nurses may be reimbursed for services as outlined by department policy. (See chapter 296-20 WAC for home nursing rules.)

(2) Advanced registered nurse practitioners (ARNPs) may perform advanced and specialized levels of nursing care on a fee for service basis in industrial injury cases within the limitations of this section. ARNPs may be reimbursed for services as outlined by department policy.

(3) In order to treat workers under the Industrial Insurance Act, the advanced registered nurse practitioner must be:

(a) Recognized by the Washington state board of nursing or other government agency as an advanced registered nurse practitioner (ARNP). For out-of-state nurses an equivalent title and training may be approved at the department's discretion.

(b) Capable of providing the department with evidence and documentation of a reliable and rapid system of obtaining physician consultations.

(4) Billing procedures outlined in the medical aid rules and fee schedules apply to all nurses.

~~((5) Advanced registered nurse practitioners cannot sign accident report forms or certify time loss compensation.))~~

NEW SECTION

WAC 296-23-241 Can advanced registered nurse practitioners independently perform the functions of an attending physician?

Advanced registered nurse practitioners (ARNPs) may for the period of July 1, 2004, through June 30, 2007, independently perform the functions of an attending physician under the Industrial Insurance Act, with the exception of rating permanent impairment. These functions are referenced in the medical aid rules as those of a physician, attending physician, or attending doctor and include, but are not limited to:

- ✎ Completing and signing the report of accident or physician's initial report, where applicable;
- ✎ Certifying time-loss compensation;
- ✎ Completing and submitting all required or requested reports;
- ✎ Referring workers for consultations;
- ✎ Performing consultations;
- ✎ Facilitating early return to work offered by and performed for the employer(s) of record;
- ✎ Doing all that is possible to expedite the vocational process, including making an estimate of the worker's physical or mental capacities that affect the worker's employability.

ARNPs can state whether a worker has permanent impairment, such as on the department's physician's final report (PFR). ARNPs cannot rate permanent impairment or perform independent medical examinations (IMEs).

WAC 296-23-241 expires on June 30, 2007.