

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

WAC 296-20-03010 **What are the general principles the department uses to determine ((coverage on)) drug((s and medications)) coverage?** ((The department or self-insurer pays for drugs that are deemed proper and necessary to treat the industrial injury or occupational disease accepted under the claim. In general, the department will consider coverage for all FDA approved drugs for stated indications. The department or self-insurer may pay for prescriptions for off label indications when used within current medical standards and prescribed in compliance with published contraindications, precautions and warnings.)) In general, the department evaluates data on safety, health outcomes and cost-effectiveness for coverage. The department or self-insurer considers payment for drugs, including biologics and controlled substances, when:

● The drug is used to treat the industrial injury or occupational disease accepted under the claim; and

● The drug is prescribed consistent with the department's rules, guidelines and coverage decisions, and either:

- The drug is approved by the Food and Drug Administration (FDA) for that condition and prescribed in accordance with labeling, or is licensed by a regulatory entity similar to the FDA for workers who reside outside the United States; or

- If the drug is prescribed off-label, the use is supported by published scientific evidence of safety and effectiveness from high quality randomized trials (see WAC 296-20-02704). Off-label is defined as use of a FDA-approved drug for an indication which has not received FDA approval or is otherwise not consistent with the drug labeling.

AMENDATORY SECTION (Amending WSR 07-17-167, filed 8/22/07, effective 9/22/07)

WAC 296-20-03011 **What general limitations are in place for ((medications)) drugs?** (1) **Amount dispensed.** The department or self-insurer will pay for no more than a thirty-day supply of a ((medication)) drug dispensed at any one time except in pension cases (see subsection (6) of this section) and claims that are held open for life-sustaining treatment. In these cases, up to a ninety-day supply of the drug is payable when:

● Coverage has been authorized; and

- The drug is not a controlled substance; and
- The drug is obtained through a designated provider.

(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))~~ provider specifically indicates that substitution is not permitted. For example: The ~~((patient))~~ worker cannot tolerate substitution. Pharmacists are instructed to fill with generic drugs unless the ~~((attending physician))~~ provider 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 for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks 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."

(6) **Pension cases.** ~~((Once))~~ When the worker is placed on a pension, the department or self-insurer may pay, at the sole discretion of the supervisor of industrial insurance, for only those drugs ~~((and medications))~~ authorized for continued medical treatment ~~((for))~~ of previously accepted 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))~~;

(a) Coverage must be authorized before the treatment is rendered. ~~((In such pension cases, the department or self-insurer cannot pay for scheduled drugs))~~

(b) Controlled substances used to treat continuing pain resulting from an industrial injury or occupational disease are not payable.

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

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)) industrial insurance medical advisory committee.

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

● **Allowed**

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

Example: ((Nonscheduled drugs and other medications)) Preferred nonsteroidal anti-inflammatory drugs 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.

((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.

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

WAC 296-20-03015 What steps may the department or self-insurer take when concerned about the amount or appropriateness of drugs ((and medications)) prescribed ((to)) for the injured worker?

(1) The department or self-insurer may take any or all of the following steps when concerned about the amount or appropriateness of drugs the ((patient)) worker is receiving:

● Notify the ((attending physician)) provider of concerns regarding the ((medications)) drugs such as ((drug)) interactions, adverse reactions, or prescriptions by other providers;

● Notify the provider when opioid prescribing is not in

compliance with the department of health's (DOH) pain management rules, the department of labor and industries' (L&I) rules, the agency medical directors' group's interagency guideline on opioid dosing for chronic noncancer pain or L&I's guideline for prescribing opioids to treat pain in injured workers;

- Require that the ~~((attending physician))~~ provider send a treatment plan addressing the drug concerns;
- Request a consultation from an appropriate specialist;
- Request that the ~~((attending physician))~~ provider consider reducing the ~~((prescription,))~~ dose or discontinuing the drug and provide information on chemical dependency programs, if indicated;
- Limit the payment for drugs ~~((on a claim))~~ to one prescribing ~~((doctor))~~ provider.

(2) If the ~~((attending physician))~~ provider or worker does not comply with these requests, ~~((or if the probability of imminent harm to the worker is high,))~~ the department or self-insurer may discontinue payment for the drug after adequate prior notification has been given to the worker ~~((, pharmacy))~~ and ~~((physician))~~ the provider.

(3) ~~((Physician failure to reduce or terminate prescription of controlled substances, habit forming or addicting medications, or dependency inducing medications, after department or self-insurer request to do so for an injured worker may result in a transfer of the worker to another physician of the worker's choice. (See WAC 296-20-065.))~~ If the probability of imminent harm to the worker is high, as determined by the department's medical director, associate medical director or medical consultants, the department or self-insurer may require that the worker transfer care to another network provider.

(4) Other corrective actions may be taken in accordance with WAC ~~((296-20-015, Who may treat))~~ 296-20-01100, Risk of harm.

NEW SECTION

WAC 296-20-03030 Definitions associated with opioid authorization and payment. (1) Acute pain - Self-limiting pain that lasts from a few days to up to six weeks following an industrial injury or surgery.

(2) Catastrophic injury - A severe injury from which recovery of physical function is not expected, such as a spinal cord injury.

(3) Clinically meaningful improvement in function - Improvement in function of at least thirty percent as compared to baseline or in response to a dose change. Function can be measured using the two item graded chronic pain scale or other validated tools such as those referenced in the most current agency medical directors' group's interagency guideline on opioid dosing for chronic noncancer pain.

(4) Clinically meaningful improvement in pain - Improvement in

pain intensity of at least thirty percent as compared to baseline or in response to a dose change. Pain can be measured using the two item graded chronic pain scale or other validated tools such as those referenced in the most current agency medical directors' group's interagency guideline on opioid dosing for chronic noncancer pain.

(5) Chronic noncancer pain - Continuous or intermittent pain arising from a noncancerous condition, injury or surgery and lasting longer than three months.

(6) Morphine equivalent dose - Conversion of various opioids to an equivalent morphine dose by using the most current recognized conversion tables, such as the agency medical directors' group's dose calculator.

(7) Step 1 taper - Discontinuing opioids via a gradual dose reduction of approximately ten percent of the original dose per week in a community care setting.

(8) Step 2 taper - Detoxification through a licensed chemical dependency center and/or discontinuing opioids through a structured intensive multidisciplinary program (see WAC 296-20-12055 through 296-20-12095).

NEW SECTION

WAC 296-20-03035 Checking the prescription monitoring program data base. Checking the prescription monitoring program is recommended before prescribing opioids for new injuries. Providers must check the prescription monitoring program data base, if available, and document before prescribing opioids in the subacute phase and repeat during chronic opioid therapy at intervals according to the worker's risk category as described in the agency medical directors' group's guideline.

Any provider performing a preoperative evaluation for elective surgery in workers on chronic opioid therapy should also check the prescription monitoring program data base and document as part of a treatment plan for post-surgical pain management.

NEW SECTION

WAC 296-20-03040 Administering urine drug testing. Providers must administer a urine drug test and document results during the subacute phase and repeat at intervals according to the worker's risk category as described in the agency medical directors' group's guideline if prescribing chronic opioid therapy. The department or self-insurer may deny additional payment for urine drug testing

when opioid coverage is denied.

NEW SECTION

WAC 296-20-03045 Tracking function and pain. When prescribing opioids, providers must use validated instruments to track and document the worker's function and pain status during the acute and subacute phase and routinely, at least every ninety days, to monitor the worker's status and response to chronic opioid therapy.

NEW SECTION

WAC 296-20-03050 Preinjury opioid use. The department or self-insurer is not responsible for the continuation of preinjury opioid use or any adverse outcomes which may result. For workers with preinjury chronic opioid therapy, payment for opioids beyond the acute phase will not be authorized except:

- For catastrophic injuries (see WAC 296-20-03059); and
- For severe injuries, coverage may be extended through the subacute phase.

NEW SECTION

WAC 296-20-03055 Opioid authorization requirement for the acute phase (0-6 weeks). The department or self-insurer may cover opioids for up to six weeks when prescribed to treat pain from the acute industrial injury or after an authorized surgery. Providers must obtain and document the worker's baseline function and pain measurements during the acute phase if planning to prescribe opioids beyond this phase.

NEW SECTION

WAC 296-20-03056 Opioid authorization requirement for the subacute phase (6-12 weeks). Before the department or self-insurer authorizes payment for opioids beyond the acute phase, the provider must perform and document the following:

- Verify that the worker had clinically meaningful improvement in function and pain with the use of opioids in the acute phase.
- If indicated, use a validated instrument to screen the worker for comorbid psychiatric conditions (e.g., depression, anxiety, or post traumatic stress disorder) which may impact the response to opioid treatment.
- Verify that the worker has no contraindication to the use of opioids.
- Access the state's prescription monitoring program data base, if available, to ensure that the controlled substance history is consistent with the prescribing record and the worker's report.
- Use a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of opioid use disorder.
- Administer a baseline urine drug test to verify the absence of cocaine, amphetamines, alcohol, and nonprescribed opioids.
- Verify that the worker has no evidence of or is not at high risk for serious adverse outcomes from opioid use.

NEW SECTION

WAC 296-20-03057 Opioid authorization requirement for the chronic phase (> 12 weeks). Before the department or self-insurer authorizes payment for opioids beyond the subacute phase, the provider must perform, verify, and document the following best practices:

- Clinically meaningful improvement in function has been established with opioid use in the acute or subacute phase. If the opioid dose is increased, clinically meaningful improvement in function must be demonstrated in response to the dose change. Effective chronic opioid therapy should result in improved work capacity and/or the ability to progress in vocational retraining; and
- Reasonable alternatives to opioids have been tried and have failed; and
- The worker and the provider have signed a pain treatment agreement; and
- A consultation with a pain management specialist must take place before the worker's dose is increased above 120mg/d morphine equivalent or consistent with exceptions in DOH's pain management rules. Additional appropriate consultations are recommended if the worker has a comorbid substance use or poorly controlled mental

health disorder; and

- The worker has no contraindication to the use of opioids including, but not limited to, current substance use disorders (excluding nicotine) or history of opioid use disorder; and

- The worker has no evidence of or is not at high risk for having serious adverse outcomes from opioid use; and

- The worker has no pattern of recurrent (more than one) aberrant behavior identified by the prescription monitoring program data base, urine drug testing, or other source; and

- A time-limited treatment plan that demonstrates how chronic opioid therapy is likely to improve the worker's work capacity and/or the ability to progress in vocational retraining (e.g., work hardening, vocational services).

NEW SECTION

WAC 296-20-03058 Opioid authorization requirement for ongoing chronic opioid therapy. Before the department or self-insurer authorizes continued payment for chronic opioid therapy, the provider must routinely, at least every ninety days or more frequently, according to the worker's risk, review the effects of opioids to determine whether therapy should continue and document the following best practices:

- Clinically meaningful improvement in function or pain interference with function score of ≤ 4 on the two item graded chronic pain scale is maintained with stable dosing. If opioid dose is increased, clinically meaningful improvement in function must be demonstrated in response to the dose change; and

- A current signed pain treatment agreement; and

- The worker has no contraindication to the use of opioids including, but not limited to, current substance use disorders (excluding nicotine) or a history of opioid use disorder; and

- The worker has no evidence of or is not at high risk for serious adverse outcomes from opioid use; and

- A consultation with a pain management specialist must take place before the worker's dose is increased above 120mg/d morphine equivalent dose or consistent with exceptions in DOH's pain management rules. Additional appropriate consultations are recommended if the worker has a comorbid substance use or poorly controlled mental health disorder; and

- The worker has no pattern of recurrent (more than one) aberrant behavior identified by the prescription monitoring program data base, urine drug testing or other source.

Workers receiving chronic opioid therapy should be managed by a single prescribing provider. If the prescribing provider is unavailable, then refills should be addressed by the covering provider and allowed on a limited basis only. See WAC 296-20-03060, Episodic care for pain, regarding unscheduled visits to

emergency departments or urgent care facilities for pain management.

NEW SECTION

WAC 296-20-03059 Opioid authorization requirement for catastrophic injuries. Before the department or self-insurer authorizes payment for chronic opioid therapy for a catastrophic injury (see WAC 296-20-03030 for the definition of catastrophic injury), the provider must perform, verify, and document the following:

- A current signed pain treatment agreement; and
- A consultation with a pain management specialist must take place before the worker's dose is increased above 120mg/d morphine equivalent dose or consistent with exceptions in DOH's pain management rules; and
- The worker has no contraindication to the use of opioids including, but not limited to, current substance use disorders (excluding nicotine) or a history of opioid use disorder; and
- The dose is stable and the worker has no evidence of or is not at high risk for serious adverse outcomes from opioid use; and
- The worker has no pattern of recurrent (more than one) aberrant behavior identified by the prescription monitoring program data base, urine drug testing or other source.

Catastrophic injuries are exempt from the requirement of clinically meaningful improvement in function with opioid use.

NEW SECTION

WAC 296-20-03060 Episodic care for pain. The department or self-insurer may pay for one pain-related emergency or urgent care visit related to the accepted condition for a worker already receiving opioid therapy, but payment for additional emergency or urgent care visits may be denied. Urgent care visit includes any unscheduled visit to other than the usual place of care for pain management.

Workers receiving opioid therapy should be managed by a single prescribing provider.

NEW SECTION

WAC 296-20-03065 Managing surgical pain in workers on opioid therapy. The provider should taper the worker's total opioids to the preoperative dose or lower by six weeks after surgery. Upon request, and depending on the complexity of the surgery, the department or self-insurer may authorize an additional six weeks for the provider to taper opioids to the preoperative or lower dose.

NEW SECTION

WAC 296-20-03070 When opioid prescribing is not proper and necessary care. Continuing to prescribe opioids in the absence of clinically meaningful improvement in function or after the development of a severe adverse outcome, or prescribing opioids in escalating doses to the point of the worker developing opioid use disorder is not considered proper and necessary care in the Washington state workers' compensation system (see WAC 296-20-01002 for the definition of proper and necessary care). Further coverage of opioids under these circumstances is not payable.

NEW SECTION

WAC 296-20-03075 When to discontinue opioids. The prescriber must discontinue opioids under the following circumstances:

- The worker requests opioid discontinuation; or
- The attending provider, because of concern for potential adverse outcomes, requests opioid discontinuation; or
- The worker is maintained on opioids for at least three months and there is no sustained clinically meaningful improvement in function, as measured by validated instruments; or
- The worker's risk from continued treatment outweighs the benefit; or
- The worker has experienced an opioid overdose event related to aberrant behavior or substance use disorder (except nicotine) or a prescribing pattern that is not in compliance with DOH's pain management rules, L&I's rules, the agency medical directors' group's guideline or L&I's guideline for prescribing opioids to treat pain in injured workers or the worker has experienced any other severe adverse outcome; or
- There is a pattern of recurrent (more than one) aberrant behaviors (including, but not limited to, inconsistent urine drug test result, lost prescriptions, multiple requests for early

refills, multiple prescribers, unauthorized dose escalation, apparent intoxication); or

- Use of opioids is not in compliance with DOH's pain management rules, L&I's rules, the agency medical directors' group's guideline or L&I's guideline for prescribing opioids to treat pain in injured workers.

Under these circumstances, the department or self-insurer may pay for an opioid wean or detoxification to facilitate discontinuation of opioids (see WAC 296-20-03080, Weaning or detoxification). However, continued chronic opioid therapy is not payable.

NEW SECTION

WAC 296-20-03080 Weaning or detoxification. The department or self-insurer may pay for adjuvant treatment to aid with the weaning (see WAC 296-20-03030 for the definition of step 1 and 2 taper) or detoxification process, except for ultra-rapid detoxification (e.g., detoxification within three days using antagonist drugs with or without sedation). The department or self-insurer is not responsible for any adverse outcomes resulting from continued opioid use after completion of a detoxification program.

NEW SECTION

WAC 296-20-03085 Addiction treatment. The department or self-insurer may authorize payment for addiction management through a licensed chemical dependency treatment center for up to six months as an aid to recovery if the following conditions are met:

- The worker has failed steps 1 and 2 taper (see WAC 296-20-03030 for the definition of step 1 and 2 taper); and
- The worker is diagnosed with opioid use disorder and this condition is identified as a barrier to recovery; and
- The provider has documented how time-limited treatment of this condition will allow significantly improved work capacity and/or the ability to progress in vocational retraining; and
- The provider has submitted a time-limited treatment plan.

Payment for addiction treatment is limited to six months per worker.

AMENDATORY SECTION (Amending WSR 08-04-095, filed 2/5/08, effective 2/22/08)

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>
Report of Industrial Injury or Occupational Disease (form) Self-Insurance: Provider's Initial Report (form)	Immediately - <u>W</u> ithin five days of first visit.	See form If additional space is needed, please attach the information to the application. The claim number should be at the top of the page.	Only MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.
Sixty Day (narrative) Purpose: Support and document the need for continued care when conservative (nonsurgical) treatment is to continue beyond sixty days	Every sixty days when only conservative (nonsurgical) care has been provided.	(1) The conditions diagnosed , including ICD-9-CM codes and the subjective complaints and objective findings.	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.
		(2) The relationship of diagnoses , if any, to the industrial injury or exposure.	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.

<i>Report</i>	<i>Due/Needed by Insurer</i>	<i>What Information Should Be Included In the Report?</i>	<i>Special Notes</i>
		(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.	((Please see WAC 296-20-03021 and 296-20-03022 for documentation requirements for those workers receiving opioids to treat chronic noncancer pain.))
		(4) Current medications , including dosage and amount prescribed. With repeated prescriptions, include the plan and need for continuing medication.	Providers must include their name, address and date on all chart notes submitted.
		(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.	
		(6) If the worker has not returned to work, a doctor's estimate of physical capacities should be included.	
		(7) Response to any specific questions asked by the insurer or vocational counselor.	
<u>Opioid Authorization Requirement</u>	<u>Opioids in subacute phase - Six weeks from the date of injury or surgery.</u> <u>Opioids in chronic phase - Twelve weeks from the date of injury or surgery.</u> <u>Opioids for ongoing chronic therapy - Every ninety days.</u>	<u>Please see WAC 296-20-03056 through 296-20-03059 for documentation requirements for those workers receiving opioids.</u>	

<i>Report</i>	<i>Due/Needed by Insurer</i>	<i>What Information Should Be Included In the Report?</i>	<i>Special Notes</i>
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.
Consultation Examination Reports (narrative)	At one hundred twenty days if only conservative (nonsurgical) care has been provided.	(1) Detailed history.	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.
Purpose: Obtain an objective evaluation of the need for ongoing conservative medical management of the worker.		(2) Comparative history between the history provided by the attending or treating provider and injured worker.	
		(3) Detailed physical examination.	
The attending or treating provider may choose the consultant.		(4) Condition(s) diagnosed including ICD-9-CM codes, subjective complaints and objective findings.	A copy of the consultation report must be submitted to both the attending or treating provider and the department/insurer.
		(5) Outline of proposed treatment program: Its length, components, expected prognosis including when treatment should be concluded and condition(s) stable.	
		(6) Expected degree of recovery from the industrial condition.	
		(7) Probability of returning to regular work or modified work and an estimated return to work date .	
		(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.	

<i>Report</i>	<i>Due/Needed by Insurer</i>	<i>What Information Should Be Included In the Report?</i>	<i>Special Notes</i>
		(10) Reports of necessary, reasonable X ray and laboratory studies to establish or confirm diagnosis when indicated.	
Attending Provider Review of IME Report (form) Purpose: Obtain the attending provider'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 provider upon request of the department/insurer. PAs can concur with treatment recommendations but not PPD ratings.
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 attending or treating provider.
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, ARNP, PA, 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

Provider	Chart Notes	Reports
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

REPEALER

The following sections of the Washington Administrative Code are repealed:

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| WAC 296-20-03016 | Is detoxification and/or chemical dependency treatment covered? |
| WAC 296-20-03019 | Under what conditions will the department or self-insurer pay for oral opioid treatment for chronic, noncancer pain? |
| WAC 296-20-03020 | What are the authorization requirements for treatment of chronic, noncancer pain with opioids? |
| WAC 296-20-03021 | What documentation is required to be submitted for continued coverage of opioids to treat chronic, noncancer pain? |

WAC 296-20-03022

How long will the department or self-insurer continue to pay for opioids to treat chronic, noncancer pain?

WAC 296-20-03023

When may the department or self-insurer deny payment of opioid medications used to treat chronic, noncancer pain?

WAC 296-20-03024

Will the department or self-insurer pay for nonopioid medications for the treatment of chronic, noncancer pain?