

AMENDATORY SECTION (Amending WSR 14-09-094, filed 4/22/14, effective 7/1/14)

**WAC 296-23-220 Physical therapy rules.** Practitioners should refer to WAC 296-20-010 through 296-20-125 for general information and rules pertaining to the care of workers.

Refer to WAC 296-20-132 and 296-20-135 regarding the use of conversion factors.

All supplies and materials must be billed using HCPCS Level II codes. Refer to chapter 296-21 WAC for additional information. HCPCS codes are listed in the fee schedules.

Refer to chapter 296-20 WAC (WAC 296-20-125) and to the department's billing instructions for additional information.

Physical therapy treatment will be reimbursed only when ordered by the worker's attending doctor and rendered by a licensed physical therapist ((~~or~~)), a physical therapist assistant serving under the direction of a licensed physical therapist as required in RCW 18.74.180 (3)(a), or a licensed athletic trainer serving under the direction of a licensed physical therapist as required in RCW 18.250.010 (4)(a)(v). In addition, physician assistants may order physical therapy under these rules for the attending doctor. Doctors rendering physical therapy should refer to WAC 296-21-290.

The department or self-insurer will review the quality and medical necessity of physical therapy services provided to workers. Practitioners should refer to WAC 296-20-01002 for the department's rules regarding medical necessity and to WAC 296-20-024 for the department's rules regarding utilization review and quality assurance.

The department or self-insurer will pay for a maximum of one physical therapy visit per day. When multiple treatments (different billing codes) are performed on one day, the department or self-insurer will pay either the sum of the individual fee maximums, the provider's usual and customary charge, or \$122.00 whichever is less. These limits will not apply to physical therapy that is rendered as part of a physical capacities evaluation, work hardening program, or pain management program, provided a qualified representative of the department or self-insurer has authorized the service.

The department will publish specific billing instructions, utilization review guidelines, and reporting requirements for physical therapists who render care to workers.

Use of diapulse or similar machines on workers is not authorized. See WAC 296-20-03002 for further information.

A physical therapy progress report must be submitted to the attending doctor and the department or the self-insurer following twelve treatment visits or one month, whichever occurs first. Physical therapy treatment beyond initial twelve treatments will be authorized only upon substantiation of improvement in the worker's condition. An outline of the proposed treatment program, the expected restoration goals, and the expected length of treatment will be required.

Physical therapy services rendered in the home and/or places other than the practitioner's usual and customary office, clinic, or business facilities will be allowed only upon prior authorization by the department or self-insurer.

No inpatient physical therapy treatment will be allowed when such treatment constitutes the only or major treatment received by the worker. See WAC 296-20-030 for further information.

The department may discount maximum fees for treatment performed on a group basis in cases where the treatment provided consists of a nonindividualized course of therapy (e.g., pool therapy; group aerobics; and back classes).

Biofeedback treatment may be rendered on doctor's orders only. The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of a licensed physical therapist. See chapter 296-21 WAC for rules pertaining to conditions authorized and report requirements.

Billing codes and reimbursement levels are listed in the fee schedules.

**WAC 296-21-290 Physical medicine.** (1) **Whom does the department authorize and pay for physical medicine or physical therapy services?** The department or self-insurer may authorize and pay for physical medicine services from the following providers:

- A medical or osteopathic physician who is "board certified or board qualified" in the field of physical medicine and rehabilitation; or
- A licensed physical therapist; or
- The injured worker's attending doctor, within the limitations listed below.

The physical medicine services must be personally performed by the:

- Physical medicine and rehabilitation physician; or
- Attending doctor; or
- Licensed physical therapist; or
- Physical therapist assistant employed by and serving under the direction of a ((registered)) licensed physical therapist, physical medicine and rehabilitation physician, or attending doctor as required in RCW 18.74.180 (3)(a); or
- Licensed athletic trainer employed by and serving under the direction of a licensed physical therapist, physical medicine and rehabilitation physician, or attending doctor as required in RCW 18.250.010 (4)(a)(v).

Note: Licensed physical therapy provider rules are contained in chapter 296-23 WAC.

(2) **When may the department or self-insurer pay the attending doctor for physical medicine services?** The department or self-insurer may pay the attending doctor to provide physical medicine modalities and/or procedures in the following situations:

(a) The attending doctor's scope of practice includes physical medicine modalities and procedures.

(b) Only the physical medicine modalities and procedures allowed under the department's fee schedules and payment policies will be authorized or paid.

(c) No more than six physical medicine visits may be authorized and paid to the attending doctor. If the worker requires treatment beyond six visits, the worker must be referred to a licensed physical therapist or a board certified or qualified physical medicine and rehabilitation physician for such treatment. Payments will be made in accordance with the department's fee schedules and payment policies.

(d) In remote areas, where no physical medicine and rehabilitation specialist, licensed physical therapist or physical therapist assistant is available, physical medicine visits required by the patient's accepted condition(s) may be authorized and paid to the attending doctor. Payments will be made in accordance with the department's fee schedules and payment policies.

(e) The attending doctor may bill for office visits in addition to the physical medicine services only when a separately identifiable office visit service is provided in addition to the physical medicine service.

(3) **What codes and fees are payable for physical medicine services?**

- The codes, reimbursement levels, and other policies for physical medicine services are listed in the department's *Medical Aid Rules and Fee Schedules*. Physicians licensed in physical medicine and licensed physical therapists use CPT and/or HCPCS codes, rules and payment policies as listed in the department's *Medical Aid Rules and Fee Schedules* or provider bulletins.

- Attending doctors must use the local codes, rules and payment policies published in the department's *Medical Aid Rules and Fee Schedules* or provider bulletins.