AMENDATORY SECTION (Amending WSR 99-18-062, filed 8/30/99, effective 9/30/99)

WAC 296-14-410 Reduction, suspension, or denial of compensation as a result of noncooperation. (1) **Can the department or self-insurer reduce, suspend or deny industrial insurance benefits from a worker?** The department or the self-insurer, after receiving the department's order, has the authority to reduce, suspend or deny benefits when a worker (or worker's representative) is noncooperative with the management of the claim.

(2) **What does noncooperative mean?** Noncooperation is behavior by the worker (or worker's representative) which obstructs and/or delays the department or self-insurer from reaching a timely resolution of the claim.

(a) Noncooperation can include any one of the following:

(i) Not attending or cooperating with medical examinations or vocational evaluations requested by the department or self-insurer.

(ii) Failure to keep scheduled appointments or evaluations with ((~~attending physician~~)) the attending provider or vocational counselor.

(iii) Engaging in unsanitary or harmful actions that jeopardize or slow recovery.

(iv) Not accepting medical and/or surgical treatment that is considered reasonably essential for recovery from the industrial injury or occupational disease.

(3) **Are there ever exceptions to attending a scheduled examination or vocational evaluation?** The worker will not be considered uncooperative if refusal to attend a scheduled examination is for any one of the following reasons:

(a) The department or self-insurer did not mail notice to the worker and designated representative at least 14 but no more than 60 days prior to the examination. The notice must contain the date, time and location of the examination.

(b) If the worker is 30 or less minutes late for the appointment.

(c) If the worker has not been examined or evaluated and leaves after waiting for more than one hour after the scheduled time.

(4) **What actions are taken before reducing, suspending or denying industrial insurance benefits?**

(a) The department or self-insurer must first send a letter to the worker (or the worker's representative) advising that benefits may be suspended and asking for an explanation for the noncooperation, obstruction and/or delay of the management of the claim.

(b) The worker has 30 days to respond in writing to the letter. This written response should include the reason(s) the worker has for not cooperating with the department or self-insurer.

(5) **What are the actions the department can take if a worker (or a worker's representative) is determined to be noncooperative?** If the worker does not respond in 30 days to the letter asking for justification for not cooperating or it is determined there is no good cause the department or self-insurer, after receiving the department's order, may take the following action:

(a) Reduce current or future time-loss compensation by the amount of the charge incurred by the department or self-insurer for any examination, evaluation, or treatment that the worker failed to attend.

(b) Reduce, suspend or deny all or part of the time-loss benefits.

(c) Suspend or deny medical benefits.

AMENDATORY SECTION (Amending WSR 04-20-024, filed 9/28/04, effective 11/1/04)

WAC 296-14-4129 How will imputed wages be determined? (1) When the worker has performed work or work-type activities within the state of Washington, the department imputes wages based on information collected and reported by the department of employment security. This information may include wages for the same or similar jobs within the geographic area proximate to the worker and for the same or most proximate time period as the work or work-type activities performed.

(2) When the worker performed work or work-type activities outside the state of Washington for which wages are to be imputed, the department will use information collected and reported by the United States Department of Labor Statistics to determine the correct imputed wage.

(3) In no case shall the imputed wages equal less than the hourly minimum wage for the proximate time period and geographic area used.

(4) If the worker engaged in reduced work or work-type activities when compared to the employment at the time of injury, except in pension cases, the department shall calculate the loss-of-earning power benefits consistent with RCW 51.32.090(3) to which the worker would have been entitled based on the imputed wage.

Example of imputed wage: A worker received time-loss compensation benefits and contended he was unable to work in his regular job as a construction laborer. Investigation showed that he was working painting houses on a regular full-time basis. The work he performed was ongoing over an extended period of time. Payments for this work were reportedly on a cash basis and no records were kept.

Wages would be imputed based on the average wage of a painter in his local area as reported by the department of employment security.

Example of reduced work or work-type activity: A worker was receiving time-loss compensation benefits for a shoulder injury she suffered while working as a registered nurse. She contended she was unable to perform nursing duties. The department received evidence that she had in fact been working on a regular basis as a cashier in her husband's delicatessen. There were no wages reported for this work. The evidence also showed she had worked there for several months.

The medical and vocational providers were shown the investigative evidence and they determined the worker was able to work and had returned to work as a cashier.

The department would impute wages based on the average wage paid by the business owner to other employees in the same position. If there were no other employees, wages would be imputed based on the average wage of a cashier in the local area as reported by the department of employment security.

Example of release for work and no imputed wage: A worker, who was a carpenter on the date of injury, was receiving time-loss compensation benefits based on his alleged inability to return to work. He contended he had to use a wheelchair to get around.

Video evidence was obtained showing him performing extensive remodeling work on a rental home he owned. He did not use the wheelchair and there was no indication he had any difficulties performing the

work. His activities included installing siding and windows, painting, and performing other activities inconsistent with his alleged level of disability. He received no wages as the work was done on his personal property.

The video was shown to his attending ((~~physician~~)) provider. ((~~The physician~~)) That provider withdrew ((~~his~~)) their certification of the worker's entitlement to time-loss compensation benefits and released him to return to work at his job of injury effective the first date of the video surveillance.

There is no need to impute wages because the release for work was to the job of injury.

AMENDATORY SECTION (Amending WSR 06-06-065, filed 2/28/06, effective 4/1/06)

WAC 296-14-6226 What other information must be submitted to the department in a completed application for a residence modification? (1) The attending ((~~health services~~)) provider may need to submit medical documentation verifying the worker's condition and the necessity for any residence modification.

(2) The residence modification consultant must submit an evaluation, based on an in-home inspection, of the worker's needs for safety, mobility and activities of daily living. This evaluation must be in the form of a written report with pictures or drawings.

(3) Any additional information requested by the department or ((~~self-insured employer~~)) self-insurer that might be needed to evaluate a specific request.

AMENDATORY SECTION (Amending WSR 06-06-065, filed 2/28/06, effective 4/1/06)

WAC 296-14-6230 What will the supervisor consider when approving or denying a residence modification request? The supervisor will consider requests for residence modifications on a case-by-case basis. The supervisor may approve all or part of the requested modifications, based on what is reasonable and necessary for the individual worker.

In order to determine what is reasonable and necessary, the supervisor will review the completed application and will consider at least the following:

(1) Whether the worker is eligible to receive a residence modification benefit; and

(2) The needs and preferences of the individual worker, based on information provided by the injured worker; and

(3) Whether the proposed residence is appropriate for modification; and

(4) Whether the proposed modifications are appropriate for the style, nature and condition of the residence; and

(5) The attending ((~~health care~~)) provider's opinions of the medical condition, physical needs of the worker and whether the worker can reside in the residence after the modifications are complete; and

(6) The residence modification consultant's evaluation of whether the proposed modification is necessary to meet the worker's current need for safety, mobility and activities of daily living; and

(7) Whether the contractor's proposed plan will satisfy the necessary modification; and

(8) Whether the proposed plans submitted by the contractors are consistent with state guidelines for specially adapted residential housing, if any; and

(9) The contractor's proposed modification plan is consistent with the guidelines established by the United States Department of Veterans Affairs in their publication entitled "*Handbook for Design: Specially Adapted Housing*," or the recommendations published in "*The Accessible Housing Design File*" by Barrier Free Environments, Inc.; and

(10) Whether the proposed modifications are being provided at the least cost while maintaining quality.

AMENDATORY SECTION (Amending WSR 06-06-065, filed 2/28/06, effective 4/1/06)

WAC 296-14-6236 How is a worker advised that the supervisor has approved or denied the request for residence modification benefits? The department will notify the worker, contractors, homeowner (if not the worker), residence modification consultant, attending ((~~health services~~)) provider and employer of the supervisor's decision in writing.

AMENDATORY SECTION (Amending WSR 03-11-009, filed 5/12/03, effective 2/1/04)

WAC 296-19A-140 What information must a vocational rehabilitation provider include in a labor market survey? (1) The following information must be included in a labor market survey that is submitted to the department as documentation in support of a vocational recommendation. This information must be presented in the form of a summary report and accompanied by the results of the individual employer contacts:

(a) The specific job title surveyed and its DOT code. If the DOT code is not an accurate reflection/description of the job, then list the specific job surveyed, the occupational code and the source from which the occupational code was obtained;

(b) The name of the surveyor;

(c) A summary of all contacts and the dates of contact;

(d) A summary of whether or not the industrially injured or ill worker has the physical and mental/cognitive capacities to perform the job, based upon information from the attending ((~~physician~~)) provider or from a preponderance of medical information;

(e) A summary of whether the labor market matches the industrially injured or ill worker's work pattern;

(f) A summary of whether the labor market is considered positive or negative, as follows:

(i) If the labor market survey is conducted during an ability to work assessment, a labor market is considered positive if it shows that there are sufficient job opportunities in the worker's relevant labor market to enable the injured worker to become employable.

(ii) If the labor market is conducted during a plan development, a labor market is considered positive if it shows that jobs suitable for the injured worker for the proposed job goal exist in sufficient numbers to reasonably conclude that the worker will be employable at plan completion.

(g) Additional information may be presented in the summary, but only as a supplement to the labor market survey. Additional information may include, but is not limited to, published statistical data regarding occupations and projected job openings.

(2) The following information must be obtained from the individual employer contacts and submitted to the department with the summary report. If the information is not available, the ((~~VRC~~)) vocational rehabilitation counselor should document attempts made to obtain the information and why it was not available.

(a) The specific job title surveyed;

(b) All specific employer contacts, including their firm names, phone numbers, contact name and job title;

(c) Physical and mental/cognitive demands of the job in relation to the industrially injured or ill worker's physical and mental/cognitive capacities;

(d) Minimum hiring requirements and the skills and training commonly and currently necessary to be gainfully employed in the job;

(e) Work patterns;

(f) Number of positions per job title;

(g) Wage;

(h) Date of last hire;

(i) Number of current openings; and

(j) An indication of whether each contact was considered positive or negative. The vocational rehabilitation provider must include specific documentation to support why a contact was positive or negative for the recommended occupation or proposed vocational goal.

AMENDATORY SECTION (Amending WSR 17-16-133, filed 8/1/17, effective 9/1/17)

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~~)) worker'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 federally adopted edition of the International Classification of Diseases, Clinically Modified (ICD-CM). For mental health conditions, the condition being accepted must also be specified from the edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM) designated by the department.

Appointing authority: For the evidence-based prescription drug program, the appointing authority shall mean the following people acting jointly: The director of the health care authority 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 296-23-246 for more information.

Attending provider: For these rules, means a person ((~~licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry; and advanced registered nurse practitioner. An attending provider actively treats an injured or ill worker~~)) who is a member of the health care provider network established under RCW 51.36.010, is treating injured workers within their scope of practice, and is licensed under Title 18 RCW as one of the following: Physician, osteopathic physician, chiropractor, naturopath, podiatric physician, dentist, optometrist, advanced registered nurse practitioner, psychologist in the case of claims solely for mental health conditions, and physician assistant.

Attending provider report: This type of report ((~~may~~)) is 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 the current federally adopted ICD-CM codes and the ((~~objective and~~)) subjective and objective findings. For mental health conditions, the report must also include the condition(s) diagnosed using the edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM) designated by the department and the subjective and objective findings for that condition.

(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~~)) provider 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~~)) is unable to return to work, a ((~~doctor's~~)) provider'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.

(6) If the worker is unable to return to work due to an accepted mental health condition, a provider's estimate of functional status and barriers to work should be included with the report. If further information is needed or required, a mental health evaluation from an approved mental health provider can be requested.

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~~)) worker's previous physical and mental health.

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

(2) A comparison ((~~history~~)) between the history provided by the attending ((~~doctor~~)) provider and the 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 the current federally adopted ICD-CM codes ((~~found to be listed~~)) and the subjective and objective findings. For mental health conditions, the report must also include the condition(s) diagnosed using the edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM) designated by the department and the subjective and objective findings for that condition, and listed as:

(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 ((~~or attending doctor~~)): For these rules, means ((~~a person licensed to independently practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry. An attending doctor is a treating doctor.~~

~~Only those persons so licensed may sign report of accident forms, the provider's initial report, and certify time loss compensation; however, physician assistants (PAs) also may sign these forms pursuant to WAC 296-20-01501 (PAs may be "treating providers" pursuant to the definition contained in WAC 296-20-01002); and ARNPs may also sign these forms pursuant to WAC 296-23-241 (ARNPs may be "attending providers" consistent with the definition contained in WAC 296-20-01002)~~)) one or more of the following acting within the scope of their professional license: Physician, osteopathic physician, chiropractor, naturopath, podiatric physician, dentist, optometrist, or psychologist.

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 notified the health care authority that he or she agrees to allow therapeutic interchange.

Fatal: When the attending ((~~doctor~~)) provider has reason to believe a worker has died as a result of an industrial injury or exposure, ((~~the doctor~~)) that provider 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~~)) (also called maximum fee schedule(s)): The fee schedules consist of, but are not limited to, the following:

(1) Health Care Common Procedure Coding System Level I (Current Procedural Terminology CPT®) and Level II (HCPCS) codes, descriptions and modifiers that describe medical and other services, supplies and materials.

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

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

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

(5) 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.

Initial prescription drugs: Any drug prescribed for an alleged industrial injury or occupational disease during the initial visit.

Initial visit: The first visit to a health care provider during which the Report of ((~~Industrial~~)) Accident (Workplace Injury, Accident, or Occupational Disease) form or the Provider's Initial Report form, where applicable, is completed and the worker files a claim for workers compensation.

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 or, for an accepted mental health condition(s), the ability to engage in modified work, which may include relevant accommodations. 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~~)) attending provider and the worker with a statement describing the available work in terms that will enable the ((~~doctor~~)) attending provider to relate the physical activities of the job to the worker's physical limitations and capabilities. The ((~~doctor~~)) attending provider 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~~)) attending provider 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~~)) provider.

If the employer has no modified work available, the department should be notified immediately, so vocational assessment can be con-

ducted 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 ((~~or attending physician (AP)~~)): For these rules, means any person licensed to perform one ((~~or more~~)) of the following professions: Medicine and surgery; or osteopathic medicine and surgery. ((~~An AP is a treating physician.~~))

Practitioner ((~~or licensed health care provider~~)): 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; advanced registered nurse practitioners (ARNPs); certified medical physician assistants or osteopathic physician assistants; and massage therapy~~)) an "attending provider" or other licensed health care provider authorized to deliver services under Title 51 RCW.

Preferred drug: A drug selected by the appointing authority for inclusion in the Washington preferred drug list and designated for coverage by applicable state agencies or a drug selected for coverage by applicable state agencies.

Preferred drug list: Washington preferred drug list or "WPDL" is 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~~)) that 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~~)) worker, the ((~~claimant's~~)) worker's attending ((~~doctor~~)) provider, 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 nec-

essary. "Maximum medical improvement" is equivalent to "fixed and stable."

(4) In no case shall services ((~~which~~)) that 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.

Regular work status: The ((~~injured~~)) worker is ((~~physically~~)) capable of returning to ((~~his/her~~)) their regular work from physical, cognitive, emotional, and behavioral standpoints. It is the duty of the attending ((~~doctor~~)) provider 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~~)) provider 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~~)) provider 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~~)) worker may require continued treatment for conditions not related to the industrial condition; however, financial responsibility for such care must be the ((~~patient's~~)) worker's.

Therapeutic interchange: To dispense a preferred drug in place of a prescribed nonpreferred drug within the same therapeutic class listed on the Washington preferred drug list.

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~~)) provider feels a worker may be totally and permanently disabled, the attending ((~~doctor~~)) provider 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~~)) 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.

Treating provider: 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; advanced registered nurse practitioner (ARNP); and certified medical physician assistants or os-~~

~~teopathic physician assistants. A treating provider~~)) physician, osteopathic physician, chiropractor, naturopath, podiatric physician, dentist, optometrist, advanced registered nurse practitioner, psychologist, or physician assistant that actively treats an injured or ill worker.

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

Utilization review: The assessment of a ((~~claimant's~~)) worker'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 12-23-020, filed 11/13/12, effective 12/14/12)

WAC 296-20-01010 Scope of health care provider network. (1) The rules establish the development, enrollment, and oversight of a network of health care providers approved to treat injured workers. The health care provider network rules apply to care for workers covered by Washington state fund and self-insured employers.

(2) As of January 1, 2013, the following types of health care providers (hereafter providers) must be enrolled in the network with an approved provider agreement to provide and be reimbursed for care to injured workers in Washington state beyond the initial office or emergency room visit:

(a) Medical physicians and surgeons;
(b) Osteopathic physicians and surgeons;
(c) Chiropractic physicians;
(d) Naturopathic physicians;
(e) Podiatric physicians and surgeons;
(f) Dentists;
(g) Optometrists;
(h) Advanced registered nurse practitioners; ((~~and~~))
(i) Psychologists; and
(j) Physician assistants.

(3) The requirement in subsection (2) of this section does not apply to providers who practice exclusively in acute care hospitals or within inpatient settings in the following specialties:

(a) Pathologists;
(b) Consulting radiologists working within a hospital radiology department;
(c) Anesthesiologists or certified registered nurse anesthetists (CRNAs) except anesthesiologists and CRNAs with pain management practices in either hospital-based or ambulatory care settings;
(d) Emergency room providers; or
(e) Hospitalists.

(4) The department may phase implementation of the network to ensure access within all geographic areas. The director of the department shall determine, at ((~~his/her~~)) their discretion, whether to establish or expand the network, after consideration of at least the following:

• The percent of injured workers statewide who have access to at least five primary care providers within ((~~fifteen~~)) 15 miles, compared to a baseline established within the previous ((~~twelve~~)) 12 months;

• The percent of injured workers by county who have access to at least five primary care providers within ((~~fifteen~~)) 15 miles, compared to a baseline established within the previous ((~~twelve~~)) 12 months; and

• The availability within the network of a broad variety of specialists necessary to treat injured workers.

The department may expand the health care provider network scope to include additional providers not listed in subsection (2) of this section, listed in subsection (3) of this section, and to out-of-state providers. For providers outside the scope of the health care provider network rule, the department and ((~~self-insured employers~~)) self-insurers may reimburse for treatment beyond the initial office or emergency room visit.

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

WAC 296-20-01501 Physician assistant rules. (1) Physician assistants ((~~(PA)~~)) may be "((~~treating~~)) attending providers" pursuant to WAC 296-20-01002, under the workers' compensation system((~~, and~~)). They may be approved for payment for those medical services for which the physician 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~~)) a collaboration agreement with a licensed physician(s) as defined in RCW 18.71A.010.

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

(3) To be eligible to treat and be paid for workers' compensation related services, the physician assistant must obtain a provider number by:

(a) Providing the department with ((~~a copy of his/her license~~)) their license number and effective date of that license;

(b) Providing the name, address, specialty, and active provider number issued by the department of the supervising or collaborating physician(s) on the provider application ((~~(a PA~~)). A physician assistant may have to obtain more than one provider number if billing under multiple supervising or collaborating physicians((~~)~~)); and

(c) Notifying the department of any change of the parameters listed in (a) or (b) of this subsection.

(4) Physician assistants may ((~~sign and attest to any certificates, cards, forms or other required documentation required by the department that the physician assistant's supervising physician may sign provided that~~)) perform the functions of an attending provider when it is within the physician assistant's scope of practice and is consistent with the terms of the physician assistant's ((~~practice arrangement plan~~)) collaboration agreement as required by chapter((~~s 18.57A and~~)) 18.71A RCW. This includes, but is not limited to:

• Completing and signing the Report of Accident (Workplace Injury, Accident or Occupational Disease) form or the Provider's Initial Report form, where applicable;
• Certifying time-loss compensation;
• Completing and submitting all required or requested reports;
• Referring workers for consultations;
• Facilitating early return to work offered by and performed for the employer(s) of record; and
• 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.

(5) Physician assistants cannot:
• Rate permanent disability or impairment; and
• Perform independent medical examinations or consultations.

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-20-020 Acceptance of rules and fees. The filing of ((~~an accident report~~)) the Report of Accident (Workplace Injury, Accident or Occupational Disease) form or the Provider's Initial Report form, where applicable; or the rendering of treatment to a worker who comes under the department's or self-insurer's jurisdiction, as the case may be, constitutes acceptance of the department's medical aid rules and compliance with its rules and fees.

In accordance with RCW 51.28.020 of the industrial insurance law, when a ((~~doctor~~)) provider renders treatment to a worker entitled to benefits under the law, "it shall be the duty of ((~~the physician~~)) that provider to inform the worker of ((~~his~~)) their rights under this title and to lend all necessary assistance in making the application for compensation and such proof of other matters as required by the rules of the department without charge to the worker," a worker shall not be billed for treatment rendered for ((~~his~~)) their accepted industrial injury or occupational disease.

The department or self-insurer must be notified immediately, when an unrelated condition is being treated concurrently with an industrial injury. See WAC 296-20-055 for specific information required.

When there is questionable eligibility, (i.e., service is not usually allowed for industrial injuries or investigation is pending, etc.) the provider may require the worker to pay for the treatment rendered.

In cases of questionable eligibility where the provider has billed the worker or other insurance, and the claim is subsequently allowed, the provider shall refund the worker or insurer in full and bill the department or self-insurer for services rendered using billing instructions, codes, and policies as listed in the medical aid rules and fee schedules.

((~~Cases in which there is a question of medical ethics or quality of medical care, will be referred to the Washington state medical association's medical advisory and utilization review committee to the department of labor and industries for recommendations.~~))

AMENDATORY SECTION (Amending WSR 12-12-059, filed 6/5/12, effective 7/6/12)

WAC 296-20-030 Treatment not requiring authorization for accepted conditions. (1) A maximum of ((~~twenty~~)) 20 office calls for the treatment of the industrial condition, during the first ((~~sixty~~)) 60 days, following injury. Subsequent office calls must be authorized. Reports of treatment rendered must be filed at ((~~sixty~~)) 60-day intervals to include number of office visits to date. See chapter 296-20 WAC and department policies for report requirements and further information.

(2) Initial diagnostic X-rays necessary for evaluation and treatment of the industrial injury or condition. See WAC 296-20-121 for further information.

(3) The first ((~~twelve~~)) 12 physical therapy treatments as provided by chapters 296-21, 296-23, and 296-23A WAC, upon consultation by the attending ((~~doctor~~)) provider or under ((~~his~~)) their direct supervision. Additional physical therapy treatment must be authorized and the request substantiated by evidence of improvement. In no case will the department or self-insurer pay for inpatient hospitalization of a ((~~claimant~~)) worker to receive physical therapy treatment only. USE OF DIAPULSE, THERMATIC (standard model only), SPECTROWAVE AND SUPERPULSE MACHINES AND IONTOPHORESIS IS NOT AUTHORIZED FOR WORKERS ENTITLED TO BENEFITS UNDER THE INDUSTRIAL INSURANCE ACT.

(4) Routine laboratory studies reasonably necessary for diagnosis and/or treatment of the industrial condition. Other special laboratory studies require authorization.

(5) Routine standard treatment measures rendered on an emergency basis or in connection with minor injuries not otherwise requiring authorization.

(6) Consultation with specialist when indicated. See WAC 296-20-051 for consultation guidelines.

(7) Myelogram if prior to emergency surgery.

AMENDATORY SECTION (Amending WSR 15-17-104, filed 8/18/15, effective 10/1/15)

WAC 296-20-03001 Treatment requiring authorization. Certain treatment procedures require authorization by the department or self-insurer. Requests for authorization must include a statement of: The condition(s) diagnosed; the current federally adopted ICD-CM codes; their relationship, if any, to the industrial injury/exposure; an outline of the proposed treatment program, its length and components, procedure codes, and expected prognosis; and an estimate of when treatment would be concluded and condition stable.

(1) Office calls in excess of the first ((~~twenty~~)) 20 visits or ((~~sixty~~)) 60 days whichever occurs first.

(2) The department may designate those inpatient hospital admissions that require prior authorization.

(3) X-ray and radium therapy.

(4) Diagnostic studies other than routine X-ray and blood or urinalysis laboratory studies.

(5) Myelogram in nonemergent cases.

(6) Physical therapy treatment beyond initial ((~~twelve~~)) 12 treatments as outlined in chapters 296-21, 296-23, and 296-23A WAC.

(7) Diagnostic or therapeutic injections that include, but are not limited to:

(a) Therapeutic subarachnoid, epidural, or caudal injections for chronic pain;

(b) Diagnostic facet injections;

(c) Sacroiliac joint injections for chronic pain;

(d) Intra-muscular and trigger point injections of steroids and other nonscheduled medications are limited to three injections per ((~~patient~~)) worker. The attending ((~~doctor~~)) provider must submit justification for an additional three injections if indicated with a maximum of six injections to be authorized for any one ((~~patient~~)) worker.

Refer to fee schedule payment policies and coverage decisions for authorization criteria.

(8) Home nursing, attendant services or convalescent center care must be authorized per provisions outlined in WAC 296-20-091 or 296-23-246.

(9) Provision of prosthetics, orthotics, surgical appliances, special equipment for home or transportation vehicle; custom made shoes for ankle/foot injuries resulting in permanent deformity or malfunction of a foot; masking devices; hearing aids; etc., must be authorized in advance as per WAC 296-20-1101 and 296-20-1102.

(10) Biofeedback program; structured intensive multidisciplinary pain programs (SIMPs); pain clinic; weight loss program; psychotherapy; rehabilitation programs; and other programs designed to treat special problems must be authorized in advance. Refer to the department's medical aid rules and fee schedules for details.

(11) Prescription or injection of vitamins for specific therapeutic treatment of the industrial condition(s) when the attending ((~~doctor~~)) provider can demonstrate that published clinical studies indicate vitamin therapy is the treatment of choice for the condition. Authorization for this treatment will require presentation of facts to and review by department medical consultant.

(12) The long-term prescription of medication under the specific conditions and circumstances in (a) and (b) of this subsection are considered corrective therapy rather than palliative treatment and approval in advance must be obtained.

(a) Nonsteroidal anti-inflammatory agents for the treatment of degenerative joint conditions aggravated by occupational injury.

(b) Anticonvulsive agents for the treatment of seizure disorders caused by trauma.

(13) The department may designate those diagnostic and surgical procedures ((~~which~~)) that can be performed in other than a hospital inpatient setting. Where a worker has a medical condition ((~~which~~)) that necessitates a hospital admission, prior approval of the department or self-insurer must be obtained.

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-20-035 Treatment in cases that remain open beyond ((~~sixty~~)) 60 days. Conditions requiring treatment beyond ((~~sixty~~)) 60 days

are indicative of a major industrial condition or complication by other conditions. Except in cases of severe and extensive injuries, i.e., quadriplegia, paraplegia, multiple fractures, etc., when the worker requires treatment beyond ((~~sixty~~)) 60 days following injury, a complete examination is necessary to determine and/or establish need for continued treatment and/or payment of time-loss compensation. This may be accomplished either by the attending ((~~doctor~~)) provider or a consultation exam. In either case, a detailed exam report must be provided to the department or self-insurer. Refer to chapter 296-20 WAC (including the definition section) and department policy for the type of information that must be included in these reports.

AMENDATORY SECTION (Amending WSR 81-01-100, filed 12/23/80, effective 3/1/81)

WAC 296-20-055 Limitation of treatment and temporary treatment of unrelated conditions when retarding recovery. Conditions preexisting the injury or occupational disease are not the responsibility of the department. When an unrelated condition is being treated concurrently with the industrial condition, the attending ((~~doctor~~)) provider must notify the department or self-insurer immediately and submit the following:

(1) Diagnosis and/or nature of unrelated condition.

(2) Treatment being rendered.

(3) The effect, if any, on industrial condition.

Temporary treatment of an unrelated condition may be allowed, upon prior approval by the department or self-insurer, provided these conditions directly retard recovery of the accepted condition. The department or self-insurer will not approve or pay for treatment for a known preexisting unrelated condition for which the ((~~claimant~~)) worker was receiving treatment prior to ((~~his~~)) their industrial injury or occupational disease, which is not retarding recovery of ((~~his~~)) that industrial condition.

A thorough explanation of how the unrelated condition is affecting the industrial condition must be included with the request for authorization.

The department or self-insurer will not pay for treatment of an unrelated condition when it no longer exerts any influence upon the accepted industrial condition. When treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and the accepted industrial conditions.

The department or self-insurer will not pay for treatment for unrelated conditions unless specifically authorized. This includes prescription of drugs and medicines.

AMENDATORY SECTION (Amending WSR 15-17-104, filed 8/18/15, effective 10/1/15)

WAC 296-20-06101 What reports are health care providers required to submit to the ((~~insurer~~)) department or self-insurer? The depart-

ment 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 information provided in these reports is needed to adequately manage industrial insurance claims.

This list defines the provider types and associated acronyms used in the table below: Physician (MD), osteopathic physician (DO), psychologist (PhD/PsyD), chiropractor (DC), naturopath (ND), podiatric physician (DPM), dentist (DDS), advanced registered nurse practitioner (ARNP), physician assistant (PA), and optometrist (OD).

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Report of ((~~Industrial Injury~~)) Accident (Workplace Injury, Accident or Occupational Disease) (form) **Self-Insurance: Provider's Initial Report** (form)	Immediately - Within 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, PhD/PsyD, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.
Attending provider report, also known as the Sixty Day report (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 the current federally adopted ICD-CM codes and the subjective ((~~complaints~~)) and objective findings. For mental health conditions, the report must also include the condition(s) diagnosed using the edition of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM) designated by the department and the subjective and objective findings for that condition.	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. **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. Providers must **include** their **name, address, and date** on all chart notes submitted.
		(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.~~))
		(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.	

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
		(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~~)) is unable to return to work, a **((~~doctor's~~)) provider's estimate of physical capacities** should be included. If the worker is unable to return to work due to an accepted mental health condition, a provider's estimate of functional status and barriers to work should be included. If further information is needed or required, a mental health evaluation from an approved mental health provider can be requested.	
		(7) **Response to any specific questions** asked by the insurer or vocational counselor.	
Opioid Authorization Requirement	Opioids in subacute phase - Six weeks from the date of injury or surgery. Opioids in chronic phase - Twelve weeks from the date of injury or surgery. Opioids for ongoing chronic therapy - Every ninety days.	Please see WAC 296-20-03056 through 296-20-03059 for documentation requirements for those workers receiving opioids.	
Special Reports/Follow-up Reports (narrative)	As soon as possible following request by the ((~~department/insurer~~)) department or self-insurer.	**Response to any specific questions** asked by the insurer or vocational counselor.	"Special reports" are payable only when requested by the ((~~insurer~~)) department or self-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 a consultation.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Purpose: Obtain an objective evaluation of the need for ongoing conservative medical management of the worker.		(2) **((~~Comparative history~~)) A comparison** between the history provided by the attending ((~~or treating~~)) provider and the injured worker.	
		(3) Detailed physical examination.	
The attending ((~~or treating~~)) provider may choose the consultant.		(4) The **condition(s) diagnosed,** including the current federally adopted ICD-CM codes((~~,~~)) and the subjective ((~~complaints~~)) and objective findings. For mental health conditions, the report must also include the condition(s) diagnosed using the edition of the DSM designated by the department and the subjective and objective findings for that condition.	A copy of the consultation report must be submitted to both the attending ((~~or treating~~)) provider and the ((~~department/insurer~~)) department or self-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~~)) provider's **estimate of physical capacities** should be included if the worker has not returned to work. If the worker is unable to return to work due to an accepted mental health condition, a provider's estimate of functional status and barriers to work should be included.	
		(10) **Reports** of necessary, reasonable **X-ray** and **laboratory** studies to establish or confirm diagnosis when indicated.	

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
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~~)) or self-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~~)) or self-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, PhD/PsyD, 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
Dietician		X
Drug & Alcohol Treatment	X	X
Free Standing Surgery	X	X
Free Standing Emergency Room	X	X
((~~Head~~)) Brain 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

Provider	Chart Notes	Reports
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~~)) Language Pathologist	X	X

AMENDATORY SECTION (Amending WSR 09-14-104, filed 6/30/09, effective 7/31/09)

WAC 296-20-071 Concurrent treatment. In some cases, treatment by more than one practitioner may be allowed. The department or self-insurer will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system and/or require specialty or multidisciplinary care.

When requesting consideration for concurrent treatment, the attending ((~~doctor~~)) provider must provide the department or self-insurer with the following:

The name, address, discipline, and specialty of all other practitioners assisting in the treatment of the injured worker and an outline of their responsibility in the case and an estimate of the length of the period of concurrent care.

When concurrent treatment is allowed, the department or self-insurer will recognize one primary attending provider, who will be responsible for directing the over-all treatment program, including monitoring or prescribing medications when appropriate, providing copies of all reports and other data received from the involved practitioners and, in time-loss cases, providing adequate certification evidence of the worker's inability to work. The department or self-insurer may allow a concurrent care provider to prescribe medications. In such cases, the concurrent care provider is required to send the attending provider and the department or self-insurer all required reports, including a report of the medications prescribed.

The department or self-insurer will approve concurrent care on a case-by-case basis. Consideration will be given to all factors in the case including availability of providers in the worker's geographic location.

AMENDATORY SECTION (Amending WSR 81-01-100, filed 12/23/80, effective 3/1/81)

WAC 296-20-09701 Request for reconsideration. On occasion, a claim may be closed prematurely or in error or other adjudication action may be taken, which may seem inappropriate to the ((~~doctor~~)) attending provider or injured worker. When this occurs the attending ((~~doctor~~)) provider should submit immediately in writing ((~~his~~)) a request for reconsideration of the adjudication action, supported by an outline of:

(1) The ((~~claimant's~~)) worker's current condition.

(2) The treatment program being received.

(3) The prognosis of when stabilization will occur.

All requests for reconsideration must be received by the department or self-insurer within ((~~sixty~~)) 60 days from date of the order and notice of closure. Request for reconsideration of other department or self-insurer orders or actions must be made in writing by either the ((~~doctor~~)) attending provider or the injured worker within ((~~sixty~~)) 60 days of the date of the action or order.

AMENDATORY SECTION (Amending WSR 05-23-143, filed 11/22/05, effective 1/3/06)

WAC 296-20-1102 Special equipment rental and purchase prosthetic and orthotics equipment. The department or self-insurer will authorize and pay rental fee for equipment or devices if the need for the equipment will be for a short period of treatment during the acute phase of condition. Rental extending beyond ((~~sixty~~)) 60 days requires prior authorization. If the equipment will be needed on long-term basis, the department or self-insurer will consider purchase of the equipment or device. The department's or self-insurer's decision to rent or purchase an item of medical equipment will be based on a comparison of the projected rental costs of the item with its purchase price. An authorized representative of the department or self-insurer will decide whether to rent or purchase certain items, provided they are appropriate and medically necessary for treatment of the worker's accepted industrial condition. Decisions to rent or purchase items will be based on the following information:

(1) Purchase price of the item.

(2) Monthly rental fee.

(3) The prescribing ((~~doctor's~~)) provider's estimate of how long the item will be needed.

The prescribing ((~~doctor~~)) provider must obtain prior authorization from the department or self-insurer, for rental or purchase of special equipment or devices. Also, all equipment (rentals and purchases), prosthetics, and orthotics must be billed using the appropriate codes, and billing forms, as determined by the medical aid rules and fee schedules.

The department or self-insurer will authorize and pay for prosthetics and orthotics as needed by the worker and substantiated by the attending ((~~doctor~~)) provider. If such items are furnished by the attending ((~~doctor~~)) provider, the department or self-insurer will reimburse the ((~~doctor his~~)) provider for their cost for the item. See

chapter 296-20 WAC (including WAC 296-20-124) and the fee schedules for information regarding replacement of such items on closed claims.

The department or self-insurer will repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation and substantiation from the attending ((~~doctor~~)) provider.

Provision of such equipment requires prior authorization.

THE GRAVITY GUIDING SYSTEM, GRAVITY LUMBAR REDUCTION DEVICE, BACKSWING AND OTHER INVERSION TRACTION EQUIPMENT MAY ONLY BE USED IN A SUPERVISED SETTING. RENTAL OR PURCHASE FOR HOME USE WILL NOT BE ALLOWED NOR PAID BY THE DEPARTMENT OR SELF-INSURER.

EQUIPMENT NOT REQUIRING PRIOR AUTHORIZATION INCLUDES CRUTCHES, CERVICAL COLLARS, LUMBAR AND RIB BELTS, AND OTHER COMMONLY USED ORTHOTICS OF MINIMAL COST.

PERSONAL APPLIANCES SUCH AS VIBRATORS, HEATING PADS, HOME FURNISHINGS, HOT TUBS, WATERBEDS, EXERCISE BIKES, EXERCISE EQUIPMENT, JACUZZIES, PILLOWS, CASSETTE TAPES, EDUCATIONAL MATERIALS OR BOOKS, AND OTHER SIMILAR ITEMS WILL NOT BE AUTHORIZED OR PAID.

In no case will the department or self-insurer pay for rental fees once the purchase price of the rented item has been reached with the exception of oxygen equipment. The department or self-insurer may pay for rental fees of oxygen equipment beyond its purchase price.

AMENDATORY SECTION (Amending WSR 86-06-032, filed 2/28/86, effective 4/1/86)

WAC 296-20-121 X-rays. Recognizing the greatest need for access to X-rays lies with the attending ((~~doctor~~)) provider, the department or self-insurer requires only submission of X-ray findings and does not require submission of the actual films except upon specific request when needed for purposes of permanent disability rating, other administrative or legal decisions, or in litigation cases. The department or self-insurer requires the attending ((~~doctor~~)) provider retain X-rays for a period of not less than ((~~ten~~)) 10 years. In transfer cases, the X-rays in the possession of the current attending ((~~doctor~~)) provider must be made available to the new attending ((~~doctor~~)) provider.

When requesting consultation, the attending ((~~doctor~~)) provider should make any X-rays in ((~~his~~)) their possession available to the consultant.

When a special exam has been arranged for the worker by the department or self-insurer, the worker's existing X-rays should be provided to the special examiner. The worker may carry such X-rays to the exam.

When the ((~~doctor's~~)) provider's office is closed because of death, retirement or leaving the state, arrangements must be made with the department or self-insurer regarding custody of X-rays to insure availability on request. When submitting billing for X-ray service, a copy of the X-ray findings is required. No payment will be made for excessive or unnecessary X-rays. No payment will be made on closed or rejected claims, except under conditions outlined in WAC 296-20-124.

Prior authorization is required for X-rays subsequent to the initial study. Repeat or serial radiology examinations may be performed only upon adequate clinical justification to confirm changes in the condition(s) accepted. The subjective complaints and the objective findings substantiating the repeat study must be submitted by the

practitioner in the request for authorization to the department or self-insurer.

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-20-200 General information for impairment rating examinations by attending ((~~doctors~~)) providers, consultants or independent medical examination (IME) providers. (1) The department of labor and industries has promulgated the following rules and categories to provide a comprehensive system of classifying unspecified permanent partial disabilities in the proportion they reasonably bear to total bodily impairment. The department's objectives are to reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities pursuant to RCW 51.32.080(2).

(2) The following system of rules and categories directs the provider's attention to the actual conditions found and establishes a uniform system for conducting rating examinations and reporting findings and conclusions in accord with broadly accepted medical principles.

The evaluation of bodily impairment must be made by experts authorized to perform rating examinations. After conducting the examination, the provider will choose the appropriate category for each bodily area or system involved in the particular claim and include this information in the report. The provider will, therefore, in addition to describing the worker's condition in the report, submit the conclusions as to the relative severity of the impairment by giving it in terms of a defined condition rather than a personal opinion as to a percentage figure. In the final section of this system of categories and rules are some rules for determining disabilities and the classification of disabilities in bodily impairment is listed for each category. These last provisions are for the department's administrative use in acting upon the expert opinions which have been submitted to it.

(3) In preparing this system, the department has complied with its duty to enact rules classifying unspecified disabilities in light of statutory references to nationally recognized standards or guides for determining various bodily impairments. Accordingly, the department has obtained and acted upon sound established medical opinion in thus classifying unspecified disabilities in the reasonable proportion they bear to total bodily impairment. In framing descriptive language of the categories and in assigning a percentage of disability, careful consideration has been given to nationally recognized medical standards and guides. Both are matters calling for the use of expert medical knowledge. For this reason, the meaning given the words used in this set of categories and accompanying rules, unless the text or context clearly indicates the contrary, is the meaning attached to the words in normal medical usage.

(4) The categories describe levels of physical and mental impairment. Impairment is anatomic or functional abnormality or loss of function after maximum medical improvement has been achieved. This is the meaning of "impairment" as the word is used in the guides mentioned above. This standard applies to all persons equally, regardless of factors other than loss of physical or mental function. Impairment

is evaluated without reference to the nature of injury or the treatment therefore, but is based on the functional loss due to the injury or occupational disease. The categories have been framed to include conditions in other bodily areas which derive from the primary impairment. The categories also include the presence of pain, tenderness and other complaints. Workers with comparable loss of function thus receive comparable awards.

(5) These rules and categories (WAC 296-20-200 through 296-20-690) shall only be applicable to compensable injuries occurring on or after the effective date of these rules and categories.

(6) These rules and categories (WAC 296-20-200 through 296-20-690) shall be applicable only to cases of permanent partial disability. They have no applicability to determinations of permanent total disability.

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-20-2010 General rules for impairment rating examinations by attending ((~~doctors~~)) providers and consultants. These general rules must be followed by ((~~doctors~~)) providers who perform examinations or evaluations of permanent bodily impairment.

(1) Impairment rating examinations shall be performed only by ((~~doctors~~)) attending providers and consultants currently licensed in both medicine and surgery (including osteopathic and podiatric) or dentistry, and department-approved chiropractors subject to RCW 51.32.112. ((~~The department or self-insurer may request the worker's attending doctor conduct the impairment rating when appropriate. If the attending doctor is unable or unwilling to perform the impairment rating examination, a consultant, at the attending doctor's request, may conduct a consultation examination and provide an impairment rating based on the findings. The department or self-insurer can also request an impairment rating examination from an independent medical examination (IME) provider. A chiropractic impairment rating examination may be performed only when the worker has been clinically managed by a chiropractor.~~))

(a) When the worker's attending provider is eligible to perform impairment ratings according to this section, the department or self-insurer may request that the attending provider conduct the impairment rating when appropriate.

(b) If the attending provider is unable or unwilling to perform the impairment rating examination, a consultant, at the attending provider's request according to this section, may conduct a consultation examination and provide an impairment rating based on the findings.

(c) The department or self-insurer can also request an impairment rating examination from an independent medical examination (IME) provider.

(d) A chiropractic impairment rating examination may be performed only when the worker has been clinically managed by a chiropractor.

(2) Whenever an impairment rating examination is made, the attending ((~~doctor~~)) provider or consultant must complete a rating report that includes, at a minimum, the following:

(a) Statement that the ((~~patient~~)) worker has reached maximum medical improvement (MMI) and that no further curative treatment is recommended;

(b) Pertinent details of the physical examination performed (both positive and negative findings);

(c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam;

(d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the AMA *Guides to the Evaluation of Permanent Impairment* and edition used, or the Washington state category rating system - refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

(e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

(3) It is the responsibility of attending ((~~doctors~~)) providers and consultants to be familiar with the contents of the *Medical Examiner Handbook* section on how to rate impairment.

(4) Attending ((~~doctors~~)) providers and consultants performing impairment ratings must be available and willing to testify on behalf of the department or self-insurer, worker or employer and accept the department fee schedule for testimony.

(5) A complete impairment rating report must be sent to the department or self-insurer within ((~~fourteen~~)) 14 calendar days of the examination date, or within ((~~fourteen~~)) 14 calendar days of receipt of the results of any special tests or studies requested as a part of the examination. Job analyses (JAs) sent to the IME provider at the time of the impairment rating exam must be completed and submitted with the impairment rating report.

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-20-2015 What rating systems are used for determining an impairment rating conducted by the attending ((~~doctor~~)) provider or a consultant? The following table provides guidance regarding the rating systems generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation

Rating System	Used for These Conditions	Form of the Rating
AMA *Guides to the Evaluation of Permanent Impairment*	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-20-2025 May a worker bring someone with them to an impairment rating examination conducted by the attending ((~~doctor~~)) provider or a consultant? (1) Workers can bring an adult friend or family member to the impairment rating examination to provide comfort and reassurance. The accompanying person may attend the physical examination but may not attend a psychiatric examination.

(2) The accompanying person cannot be compensated for attending the examination by anyone in any manner.

(3) The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

(4) The purpose of the impairment rating examination is to provide information to assist in the determination of the level of any permanent impairment, not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:

(a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

(b) The worker's attending ((~~doctor~~)) provider, any other provider involved in the worker's care, or any other personnel employed by the attending ((~~doctor~~)) provider or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the impairment rating examination.

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-20-2030 May the worker videotape or audiotape the impairment rating examination conducted by the attending ((~~doctor~~)) provider or a consultant? The use of recording equipment of any kind by the worker or accompanying person is not allowed.

AMENDATORY SECTION (Amending WSR 14-23-064, filed 11/18/14, effective 1/1/15)

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~~)) provider, within the limitations listed below.

The physical medicine services must be personally performed by the:

- Physical medicine and rehabilitation physician; or
- Attending ((~~doctor~~)) provider; or
- Licensed physical therapist; or
- Physical therapist assistant employed by and serving under the direction of a licensed physical therapist, physical medicine and rehabilitation physician, or attending ((~~doctor~~)) provider 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~~)) provider 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~~)) provider for physical medicine services?** The department or self-insurer may pay the attending ((~~doctor~~)) provider to provide physical medicine modalities and/or procedures in the following situations:

(a) The attending ((~~doctor's~~)) provider'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~~)) provider. 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~~)) worker's accepted condition(s) may be authorized and paid to the attending ((~~doctor~~)) provider. Payments will be made in accordance with the department's fee schedules and payment policies.

(e) The attending ((~~doctor~~)) provider 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~~)) providers must use the local codes, rules and payment policies published in the department's *Medical Aid Rules and Fee Schedules* or provider bulletins.

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-23-140 Custody of X-rays. (1) Radiographs should not be sent to the department or self-insurer unless they are requested for comparison and interpretation in determining a permanent disability, administrative or legal decisions, and for cases in litigation. X-rays must be retained for a period of ((~~ten~~)) 10 years by the radiologist or the attending ((~~doctor~~)) provider.

(2) X-rays must be made available upon request to consultants, to medical examiners, to the department, to self-insurers, and/or the board of industrial insurance appeals.

(3) In cases where the worker transfers from one ((~~doctor~~)) provider to another, the former attending ((~~doctor~~)) provider will immediately forward all films in his possession to the new attending ((~~doctor~~)) provider.

(4) When a ((~~doctor's~~)) provider's office is closed because of death, retirement, or upon leaving the state, department approved custodial arrangements must be made to insure availability on request. If a radiological office is closed for any of the previously listed reasons or because the partnership or corporation is being dissolved, disposition of X-rays for industrial injuries will be handled in the same manner. In the event custodial arrangements are to be made, the department must approve the arrangements prior to transfer of X-rays to the custodian so as to assure their availability to the department or self-insurer upon request.

(5) Refer to chapter 296-20 WAC (including WAC 296-20-125) and to chapter 296-21 WAC for additional information.

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-23-145 Duplication of X-rays and extra views. Every attempt should be made to minimize the number of X-rays taken for workers. The attending ((~~doctor~~)) provider or any other person or institution having possession of X-rays which pertain to the injury and are deemed to be needed for diagnostic or treatment purposes should make these X-rays available upon request.

The department or self-insurer will not authorize or pay for additional X-rays when recent X-rays are available except when presented with adequate information regarding the need to re-X-ray.

AMENDATORY SECTION (Amending WSR 01-18-041, filed 8/29/01, effective 10/1/01)

WAC 296-23-165 Miscellaneous services and appliances. (1) The department or self-insurer will reimburse for certain proper and necessary miscellaneous services and items needed as a result of an industrial accident. Nursing care, attendant services, transportation, hearing aids, eyeglasses, orthotics and prosthetics, braces, medical

supplies, oxygen systems, walking aids, and durable medical equipment are included in this classification.

(a) When a fee maximum has been established, the rate of reimbursement for miscellaneous services and items will be the supplier's usual and customary charge or the department's current fee maximum, whichever is less. In no case may a supplier or provider charge a worker the difference between the fee maximum and their usual and customary charge.

(b) When the department or self-insurer has established a purchasing contract with a qualified supplier through an open competitive request for proposal process, the department or self-insurer will require that workers obtain specific groups of items from the contractor. When items are obtained from a contractor, the contractor will be paid at the rates established in the contract. When a purchasing contract for a selected group of items exists, suppliers who are not named in the contract will be denied reimbursement if they provide a contracted item to a worker. The noncontracting supplier, not the worker, will be financially responsible for providing an item to a worker when it should have been supplied by a contractor. This rule may be waived by an authorized representative of the department or self-insurer in special cases where a worker's attending ((~~doctor~~)) provider recommends that an item be obtained from another source for medical reasons or reasons of availability. In such cases, the department may authorize reimbursement to a supplier who is not named in a contract. Items or services may be provided on an emergency basis without prior authorization, but will be reviewed for appropriateness to the accepted industrial condition and medical necessity on a retrospective basis.

(2) The department or self-insurer will inform providers and suppliers of the selected groups of items for which purchasing contracts have been established, including the beginning and ending dates of the contracts.

(3) Prior authorization by an authorized representative of the department or self-insurer will be required for reimbursement of selected items and services which are provided to workers. Payment will be denied for selected items or services supplied without prior authorization. The supplier, not the worker, will be financially responsible for providing selected items or services to workers without prior authorization. In cases where a worker's ((~~doctor~~)) provider recommends rental or purchase of a contracted item from a supplier who lacks a contract agreement, prior authorization will be required.

The decision to grant or deny prior authorization for reimbursement of selected services or items will be based on the following criteria:

(a) The worker is eligible for coverage.

(b) The service or item prescribed is appropriate and medically necessary for treatment of the worker's accepted industrial condition.

(4) The decision to rent or purchase an item will be made based on a comparison of the projected rental costs of the item with its purchase price. An authorized representative of the department or self-insurer will decide whether to rent or purchase certain items provided they are appropriate and medically necessary for treatment of the worker's accepted condition. Decisions to rent or purchase items will be based on the following information:

(a) Purchase price of the item.

(b) Monthly rental fee.

(c) The prescribing ((~~doctor's~~)) provider's estimate of how long the item will be needed.

(5) The department will review the medical necessity, appropriateness, and quality of items and services provided to workers.

(6) The department's STATEMENT FOR MISCELLANEOUS SERVICES form or electronic transfer format specifications must be used for billing the department for miscellaneous services, equipment, supplies, appliances, and transportation. Bills must be itemized according to instructions in WAC 296-20-125 and the department or self-insurer's billing instructions. Bills for medical appliances and equipment must include the type of item, manufacturer name, model name and number, and serial number.

(7) All miscellaneous materials, supplies and services must be billed using the appropriate HCPCS Level II codes and billing modifiers. HCPCS codes are listed in the fee schedules.

AMENDATORY SECTION (Amending WSR 24-11-122, filed 5/21/24, effective 7/1/24)

WAC 296-23-205 General instructions—Naturopathic physicians. General instructions for naturopathic physicians:

(1) Refer to WAC 296-20-010 through 296-20-125 for general rules and billing procedures including, but not limited to:

(a) WAC 296-20-06101 for reporting requirements.

(b) WAC 296-20-01002 for the definition of "proper and necessary" health care services.

(c) WAC 296-20-03002 for treatment not authorized by the department.

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

(3) Refer to WAC 296-23-135 through 296-23-145 and 296-20-121 for requirements for X-rays.

(4) Refer to chapter 246-836 WAC for scope of practice including prescribing authority and injection requirements.

(5) Refer to WAC 296-21-290 for physical medicine limitations for attending ((~~doctors~~)) providers.

AMENDATORY SECTION (Amending WSR 04-22-085, filed 11/2/04, effective 12/15/04)

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~~)) provider 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 sec-

tion. 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.

AMENDATORY SECTION (Amending WSR 09-14-104, filed 6/30/09, effective 7/31/09)

WAC 296-23-241 Advanced registered nurse practitioners. (1) Advanced registered nurse practitioners (ARNPs) may independently perform the functions of an attending provider under the Industrial Insurance Act and applicable rules in Title 296 WAC, with the exception of rating permanent impairment. These functions ((~~are referenced in the medical aid rules as those of an attending or treating provider, and~~)) include, but are not limited to:

• Completing and signing the Report of Accident (Workplace Injury, Accident, or Occupational Disease) form or the Provider's Initial Report form, 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.

(2) Psychiatric advanced registered nurse practitioners can provide psychiatric services as defined in WAC 296-21-270.

(3) ARNPs can state whether a worker has permanent impairment, such as on the department's activity prescription form (APF). ARNPs cannot rate permanent impairment or perform independent medical examinations (IMEs).

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

WAC 296-23-246 Attendant services. (1) **What are attendant services?** Attendant services are proper and necessary personal care services provided to maintain the injured worker in ((~~his or her~~)) their residence.

(2) **Who may receive attendant services?** Workers who are temporarily or permanently totally disabled and rendered physically helpless by the nature of their industrial injury or occupational disease may receive attendant services.

(3) **Is prior authorization required for attendant services?** Yes. To be covered by the department, attendant services must be requested by the attending ((~~physician~~)) provider and authorized by the department before care begins.

(4) **What attendant services does the department cover?** The department covers proper and necessary attendant services that are provided consistent with the injured worker's needs, abilities and safety. Only attendant services that are necessary due to the physical restrictions caused by the accepted industrial injury or occupational disease are covered.

The following are examples of attendant services that may be covered:

- Bathing and personal hygiene;
- Dressing;
- Administration of medications;
- Specialized skin care, including changing or caring for dressings or ostomies;
- Tube feeding;
- Feeding assistance (not meal preparation);
- Mobility assistance, including walking, toileting and other transfers;
- Turning and positioning;
- Bowel and incontinent care; and
- Assistance with basic range of motion exercises.

Services the department considers everyday environmental needs, unrelated to the medical care of the worker are not covered. The following chore services are examples of services that are not covered: Housecleaning, laundry, shopping, meal planning and preparation, transportation of the injured worker, errands for the injured worker, recreational activities, yard work, and child care.

(5) **Who may provide attendant services?** Attendant services provided on or after June 1, 2002, must be provided through an agency licensed, certified or registered to provide home care or home health services.

EXCEPTION: A worker who received department approved attendant services from a spouse prior to October 1, 2001, may continue to receive attendant services from that spouse as long as all of the following criteria are met.
The attendant service spouse provider:
(a) Had an active provider account with the department on September 30, 2001; and
(b) Maintains an active provider account with the department; and
(c) Remains legally married to the injured worker; and
(d) Allows the department or its designee to perform periodic independent nursing evaluations in the worker's residence.

(6) **What are the treatment limits for attendant services?** The department will determine the maximum hours of authorized attendant care services based on an independent nursing assessment of the worker's care needs.

Spouses eligible to provide attendant services are limited to a maximum of ((~~seventy~~)) 70 hours of attendant services per week or to the maximum hours authorized for the worker, whichever is less. Workers who are receiving attendant services from spouses and whose care needs exceed ((~~seventy~~)) 70 hours per week must receive attendant services in excess of ((~~seventy~~)) 70 hours from an agency eligible to provide attendant services.

EXCEPTION: The department may exempt a spouse from the ((~~seventy~~)) 70-hour limit if, after review by the department and based on independent nursing assessment:
(a) The injured worker is receiving proper and necessary care; and
(b) The worker's care needs exceed ((~~seventy~~)) 70 hours per week; and
(c) No eligible agency provider is available.

(7) **Will the department review attendant services?** Yes. The department or its designee will perform periodic independent nursing evaluations of attendant services. Evaluations may include, but are not limited to, on-site review of the injured worker and review of medical records.

AMENDATORY SECTION (Amending WSR 08-09-120, filed 4/22/08, effective 7/1/08)

WAC 296-23-250 Massage 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. See WAC 296-20-125 for billing instructions.

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

Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker's attending ((~~doctor. In addition, physician assistants may order massage therapy under these rules for the attending doctor~~)) provider.

A progress report must be submitted to the attending ((~~doctor~~)) provider and the department or the self-insurer following six treatment visits or one month, whichever comes first. Massage therapy treatment beyond the initial six treatments will be authorized only upon substantiation of improvement in the worker's condition in terms of functional modalities, i.e., range of motion; sitting and standing tolerance; reduction in medication; etc. In addition, an outline of the proposed treatment program, the expected restoration goals, and the expected length of treatment will be required.

Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the department or self-insurer.

No inpatient massage 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.

Massage therapy treatments exceeding once per day must be justified by the attending ((~~doctor~~)) provider.

Maximum daily reimbursement levels for massage therapy are ((~~seventy-five~~)) 75 percent of the maximum daily reimbursement levels for physical and occupational therapy services that may be found in WAC 296-23-220 and 296-23-230.

Billing codes, reimbursement levels, and supporting policies for massage therapy services are listed in the fee schedules.

AMENDATORY SECTION (Amending WSR 22-07-110, filed 3/23/22, effective 4/23/22)

WAC 296-23-302 Definitions. Approved independent medical examination (IME) provider - A licensed ((~~doctor~~)) provider or firm whose credentials are approved to conduct an independent medical examination, rating evaluation, or provide IME associated services including, but not limited to, file preparation, scheduling of examinations, and processing billing. An approved IME provider is assigned a unique provider number.

Case progress examination - An examination requested for an accepted condition because:

(a) A proper and necessary treatment plan, per the definition of "proper and necessary" found in WAC 296-20-01002, is not in place; or

(b) The treatment plan has stalled or been completed without resulting in objective or functional improvement for physical conditions, or clinically meaningful signs of improvement for mental health conditions.

Department - For the purpose of this section, department means the department of labor and industries industrial insurance workers' compensation state fund and self-insured programs.

Direct patient care - For the purpose of meeting the qualifications of an independent medical examination (IME) provider, direct patient care means face-to-face contact with the ((~~patient~~)) worker for the purpose of evaluation and management of care that includes, but is not limited to:

- History taking and review of systems;
- Physical examination;
- Medical decision making;
- Coordination of care with other providers and agencies.

This does not include time spent in independent medical examinations.

Impairment rating examination - An examination to determine whether or not the injured/ill worker has any permanent impairment(s) as a result of the industrial injury or illness after the worker has reached maximum medical improvement. An impairment rating may be conducted by a qualified attending provider, a medical consultant, or an approved examiner. An impairment rating may be a component of an IME.

Independent medical examination (IME) - An objective medical-legal examination requested (by the department or self-insurer) to establish medical findings, opinions, and conclusions about a worker's physical condition. These examinations may only be conducted by department-approved examiners.

Independent medical examination (IME) provider - A firm, partnership, corporation, or individual licensed doctor (examiner) who has been approved and given an independent medical examination (IME) provider number by the department to perform IMEs.

Medical director - A licensed ((~~doctor~~)) provider and approved IME examiner in the firm, partnership, corporation or other legal entity responsible to provide oversight on quality of independent medical examinations, impairment ratings and reports.

Medical Examiners' Handbook - A handbook developed by the department containing department policy and information to assist providers who perform independent medical examinations and impairment rating examinations.

Patient related services - Patient related services are defined as one or more of the following professional activities:

• Direct patient care;

• Locum tenens;

• Clinical consultations for ((~~treating/attending doctors~~)) attending providers;

• Clinical instruction of medical, osteopathic, dental, podiatry, or chiropractic students and/or residents;

• On-call emergency services;

• Volunteer clinician providing direct patient care services in ((~~his or her~~)) their specialty.

Provider number - A unique number(s) assigned to a provider by the department of labor and industries. The number identifies the provider and is linked to a tax identification number that has been designated by the provider for payment purposes. A provider may have more than one provider number assigned by the department.

Suspension - A department action during which the provider is approved by the department but not available to accept referrals.

Temporarily unavailable - Provider is approved by the department but is temporarily unavailable to accept referrals. Temporarily unavailable applies at the provider's request for personal reasons or by the department as part of an administrative action. Provider remains unavailable until the issue is resolved.

Termination - The permanent removal of a provider from the list of approved IME examiners. All IME provider numbers assigned to the examiner are inactivated.

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-23-347 What are the independent medical examination (IME) provider's responsibilities in an examination? (1) The IME provider's responsibilities prior to the examination are to:

(a) Be familiar with the contents of the medical examiner's handbook;

(b) Review all claim documents provided by the department or ((~~self-insured employer~~)) self-insurer;

(c) Contact the worker prior to the examination to confirm the appointment date, time and location; and

(d) Review the purpose of the examination and the questions to be answered in the examination report.

(2) The IME provider's responsibilities during the examination are to:

(a) Introduce ((~~himself or herself~~)) themselves to the worker;

(b) Verify the identity of the worker;

(c) Let the worker know that the claim documents from the department or self-insurer have been reviewed;

(d) Explain the examination process and answer the worker's questions about the examination process;

(e) Advise the worker that ((~~he/she~~)) they should not perform any activities beyond their physical capabilities;

(f) Allow the worker to remain fully dressed while taking the history;

(g) Ensure adequate draping and privacy if the worker needs to remove clothing for the examination;

(h) Refrain from expressing personal opinions about the worker, the employer, the attending ((~~doctor~~)) provider, or the care the worker has received;

(i) Conduct an examination that is unbiased, sound and sufficient to achieve the purpose and reason the examination was requested;

(j) Conduct the examination with dignity and respect for the worker;

(k) Ask if there is any further information the worker would like to provide; and

(l) Close the examination by telling the worker that the examination is over.

(3) The IME provider's responsibilities following the examination are to:

(a) Send a complete IME report to the department or self-insurer within ((~~fourteen~~)) 14 calendar days of the examination date, or within ((~~fourteen~~)) 14 calendar days of receipt of the results of any special tests or studies requested as a part of the examination. Reports received after ((~~fourteen~~)) 14 calendar days may be paid at a lower rate per the fee schedule. The report must meet the requirements of WAC 296-23-382; and

(b) The claim file information received from the department or self-insurer should be disposed of in a manner used for similar health records containing private information after completion of the IME or any follow-up test results are received. IME reports should be retained per WAC 296-20-02005.

AMENDATORY SECTION (Amending WSR 04-04-029, filed 1/27/04, effective 3/1/04)

WAC 296-23-377 If an independent medical examination (IME) provider is asked to do an impairment rating examination only, what information must be included in the report? When doing an impairment rating examination, the IME provider must first review the determination by the attending ((~~doctor~~)) provider that the worker has reached maximum medical improvement (MMI).

(1) If, after reviewing the records, taking a history from the worker and performing the examination, the IME provider concurs with the attending ((~~doctor's~~)) provider's determination of MMI, the impairment rating report must, at a minimum, contain the following:

(a) A statement of concurrence with the attending ((~~doctor's~~)) provider's determination of MMI;

(b) Pertinent details of the physical or psychiatric examination performed (both positive and negative findings);

(c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of pertinent tests with the report;

(d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the AMA *Guides to the Evaluation of Permanent Impairment* and edition used, or the Washington state category rating system - refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

(e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

(2) If, after review of the records, a history from the worker and the examination, the IME provider does not concur with the attending ((~~doctor's~~)) provider's determination of MMI, an IME report must be completed. (See WAC 296-23-382.)