Chapter 296-20 WAC
MEDICAL AID RULES

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

296-20-01502 When can a physician assistant have sole signature on the report of accident or physician's initial report? [Statutory Authority: 2004 c 65 and 2004 c 163. 04-22-085, § 296-20-01502, filed 11/2/04, effective 12/15/04.] Repealed by 08-04-095, filed 2/5/08, effective 2/22/08. Statutory Authority: 2007 c 263, RCW 51.04.020 and 51.04.030.

296-20-02001 Penalties. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-02001, filed 2/2/90, effective 3/5/90. Statutory Authority: RCW 51.04.020 (4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-02001, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-02001, filed 11/24/76, effective 1/1/77.] Repealed by 02-21-108, filed 10/22/02, effective 12/1/02. Statutory Authority: RCW 51.04.020.

296-20-03003 Drugs and medication. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-03003, filed 2/28/86, effective 4/1/86; 83-16-066 (Order 83-23), § 296-20-03003, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-03003, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-03003, filed 12/23/80, effective 3/1/81; Order 77-27, § 296-20-03003, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-03003, filed 11/24/76, effective 1/1/77.] Repealed by 00-01-040, filed 12/7/99, effective 1/20/00. Statutory Authority: RCW 51.04.020 and 51.04.030.

296-20-040 Modalities not requiring prior authorization after sixty days. [Order 68-7, § 296-20-040, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71.

296-20-050 Periodical clinical reports. [Order 68-7, § 296-20-050, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71. Later promulgation, see WAC 296-20-061.

296-20-060 Fees for concurrent treatment. [Order 68-7, § 296-20-060, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71. Later promulgation, see WAC 296-20-071.

296-20-061 Periodic clinical progress reports. [Order 71-6, § 296-20-061, filed 6/1/71; Order 70-12, § 296-20-061, filed 12/1/70, effective 1/1/71. Formerly WAC 296-20-050.] Repealed by Order 74-39, filed 11/22/74.

296-20-070 Consultations. [Order 68-7, § 296-20-070, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71. Later promulgation, see WAC 296-20-051.

296-20-080 Private room—Special nurses. [Order 68-7, § 296-20-080, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71. Later promulgation, see WAC 296-20-091.

296-20-085 Isolation of infected cases. [Order 71-6, § 296-20-085, filed 6/1/71; Order 70-12, § 296-20-085, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-085, filed 11/27/68, effective 1/1/69.] Repealed by 81-01-100 (Order 80-29), filed 12/23/80, effective 3/1/81. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3).

296-20-090 Reopenings. [Order 68-7, § 296-20-090, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71. Later promulgation, see WAC 296-20-097.

296-20-095 Unrelated elective surgery. [Order 68-7, § 296-20-095, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71. Later promulgation, see WAC 296-20-081.

296-20-105 Laboratory. [Order 68-7, § 296-20-105, filed 11/27/68, effective 1/1/69.] Repealed by Order 70-12, filed 12/1/70, effective 1/1/71.

296-20-115 Flat fees. [Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-115, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-115, filed 6/1/71; Order 70-12, § 296-

20-115, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-115, filed 11/27/68, effective 1/1/69.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-20-12502 Physician assistant modifiers. [Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-12502, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-12502, filed 12/23/80, effective 3/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-12502, filed 11/30/79, effective 1/1/80.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-20-130 Medical aid contracts. [Order 74-7, § 296-20-130, filed 1/30/74; Order 70-12, § 296-20-130, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-130, filed 11/27/68, effective 1/1/69.] Repealed by Order 77-27, filed 11/30/77, effective 1/1/78.

296-20-131 Advance authorization required for nonstandard treatment. [Order 74-7, § 296-20-131, filed 1/30/74.] Repealed by Order 76-34, filed 11/24/76, effective 1/1/77.

296-20-140 Conversion factor table—Anesthesia. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-004 (Order 86-45), § 296-20-140, filed 1/8/87; 83-24-016 (Order 83-35), § 296-20-140, filed 11/30/83, effective 1/1/84; 82-24-050 (Order 82-39), § 296-20-140, filed 11/29/82, effective 7/1/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-140, filed 11/30/81, effective 1/1/82; 80-18-033 (Order 80-24), § 296-20-140, filed 12/1/80, effective 1/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-140, filed 11/30/79, effective 1/1/80; Order 77-27, § 296-20-140, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-140, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-140, filed 11/28/75, effective 1/1/76; Order 74-39, § 296-20-140, filed 11/22/74, effective 4/1/75; Order 74-7, § 296-20-140, filed 1/30/74.] Repealed by 88-24-011 (Order 88-28), filed 12/1/88, effective 1/1/89. Statutory Authority: RCW 51.04.020(4) and 51.04.030.

296-20-14001 Conversion factor table—Hospital. [Order 75-39, § 296-20-14001, filed 11/28/75, effective 1/1/76.] Repealed by Order 76-34, filed 11/24/76, effective 1/1/77.

296-20-145 Conversion factor table—Surgery. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-004 (Order 86-45), § 296-20-145, filed 1/8/87; 83-24-016 (Order 83-35), § 296-20-145, filed 11/30/83, effective 1/1/84; 82-24-050 (Order 82-39), § 296-20-145, filed 11/29/82, effective 7/1/83. Statutory Authority: RCW 51.04.020 (4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-145, filed 11/30/81, effective 1/1/82; 80-18-033 (Order 80-24), § 296-20-145, filed 12/1/80, effective 1/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-145, filed 11/30/79, effective 1/1/80; Order 77-27, § 296-20-145, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-145, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-145, filed 11/28/75, effective 1/1/76; Order 74-7, § 296-20-145, filed 1/30/74.] Repealed by 88-24-011 (Order 88-28), filed 12/1/88, effective 1/1/89. Statutory Authority: RCW 51.04.020(4) and 51.04.030.

296-20-150 Conversion factor table—Radiology. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-004 (Order 86-45), § 296-20-150, filed 1/8/87; 83-24-016 (Order 83-35), § 296-20-150, filed 11/30/83, effective 1/1/84. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-150, filed 11/30/81, effective 1/1/82; 80-18-033 (Order 80-24), § 296-20-150, filed 12/1/80, effective 1/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-150, filed 11/30/79, effective 1/1/80; Order 77-27, § 296-20-150, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-150, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-150, filed 11/28/75, effective 1/1/76; Order 74-7, § 296-20-150, filed 1/30/74.] Repealed by 88-24-011 (Order 88-28), filed 12/1/88, effective 1/1/89. Statutory Authority: RCW 51.04.020(4) and 51.04.030.

296-20-155 Conversion factor table—Pathology. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-004 (Order 86-45), § 296-20-155, filed 1/8/87; 83-24-016 (Order 83-35), § 296-20-155, filed 11/30/83, effective 1/1/84. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-155, filed 11/30/81, effective 1/1/82; 80-18-033 (Order 80-24), § 296-20-155, filed 12/1/80, effective 1/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-155, filed 11/30/79, effective 1/1/80; Order 77-27, § 296-20-155, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-155, filed 11/24/76, effective 1/1/77; Order 74-7, § 296-20-155, filed 1/30/74.] Repealed by 88-24-011 (Order 88-28), filed 12/1/88, effective 1/1/89. Statutory Authority: RCW 51.04.020(4) and 51.04.030.

296-20-17003 Fees. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 83-24-016 (Order 83-35), § 296-20-17003, filed 11/30/83, effective 1/1/84. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 80-18-033 (Order 80-24), § 296-20-17003, filed 12/1/80, effective 1/1/81; Order 77-27, § 296-20-17003, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-17003, filed 11/24/76, effective 1/1/77.] Repealed by 95-16-031, filed 7/21/95, effective 8/22/95. Statutory Authority: RCW 51.04.030, 70.14.050 and 51.04.020 (4).

296-20-210 General rules. [Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.112, 51.32.114 and 51.36.015. 97-09-036, § 296-20-210, filed 4/14/97 effective 5/15/97. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 88-14-012 (Order 88-09), § 296-20-210, filed 6/24/88; Order 74-32, § 296-20-210, filed 6/21/74, effective 10/1/74.] Repealed by 04-04-029, filed 1/27/04, effective 3/1/04. Statutory Authority: RCW 51.32.055, 51.32.112, 51.32.114, 51.36.060, and 51.36.070.

296-20-303 Attendant services. [Statutory Authority: RCW 51.04.-020, 51.04.030, 51.32.060, 51.32.072, and 7.68.070. 01-18-041, § 296-20-303, filed 8/29/01, effective 10/1/01.] Decodified by 03-21-069, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020. Recodified as WAC 296-23-246.

WAC 296-20-010 General information. (1) The following rules are promulgated pursuant to RCW 51.04.020 and 51.04.030. The department or self-insurer may purchase necessary physician and other provider services according to the fee schedules. The fee schedules shall be established in consultation with interested persons and updated at times determined by the department in consultation with those interested persons. Prior to the establishment or amendment of the fee schedules, the department will give at least thirty calendar days notice by mail to interested persons who have made timely request for advance notice of the establishment or amendment of the fee schedules. To request advance notice of the establishment or amendment of the fee schedules, interested persons must contact the department at the following address:

Department of Labor and Industries
Health Services Analysis
Interested Person's Mailing List for the Fee Schedules
P.O. Box 44322
Olympia, WA 98504-4322

As an alternative, interested persons may subscribe to the L&I medical provider news listserv. To subscribe, go to the department's web site at www.lni.wa.gov and click on the link "Provider billing & payment." Look for the icon that says "Get E-mail Updates" and click on it.

The department or self-insurer will require the current version of the federal Health Care Common Procedure Coding System (HCPCS) Level I (or CPT) and II codes on Janu-

ary 1st, of each new year. CPT refers to the American Medical Association's Physicians' Current Procedural Terminology codes.

The adoption of these codes on an annual basis is designed to reduce the administrative burden on providers and lead to more accurate reporting of services. However, the inclusion of a service, product or supply within these new codes does not necessarily imply coverage, reimbursement or endorsement, by the department or self-insurer. The department will make coverage and reimbursement decisions for these new codes on an individual basis.

If there are any services, procedures or narrative text contained in the new HCPCS Level I and II codes that conflict with the medical aid rules or fee schedules, the department's rules and policies take precedence.

Copies of the HCPCS Level I and II codes are available for public inspection. These documents are available in each of the department's service locations.

Copies of the HCPCS Level II codes may be purchased from:

The Superintendent of Documents
United States Government Printing Office
Washington, DC 20402
202-783-3238

Copies of the Level I (or CPT) codes may be purchased from:

The American Medical Association
Chicago, Illinois 60601
800-621-8335

In addition to the sources listed above, both the Level I and II codes may be purchased from a variety of private sources.

(2) The fee schedules are intended to cover all services for accepted industrial insurance claims. All fees listed are the maximum fees allowable. Practitioners shall bill their usual and customary fee for services. **If a usual and customary fee for any particular service is lower to the general public than listed in the fee schedules, the practitioner shall bill the department or self-insurer at the lower rate.** The department or self-insurer will pay the lesser of the billed charge or the fee schedules' maximum allowable.

(3) The rules contained in the introductory section pertain to *all* practitioners regardless of specialty area or limitation of practice. Additional rules pertaining to specialty areas will be found in the appropriate section of the medical aid rules.

(4) The methodology for making conversion factor cost of living adjustments is listed in WAC 296-20-132. The conversion factors are listed in WAC 296-20-135.

(5) L&I or self-insurers will not pay for a missed appointment unless the appointment is for an examination arranged by the department or self-insurer.

(6) Other than missed appointments for examinations arranged by the department or self-insurer, a provider may bill an injured worker for a missed appointment if:

(a) The provider has a missed appointment policy that applies to all patients without regard as to which insurer or entitlement program may be responsible for payment; and

(b) The provider routinely notifies all patients of the missed appointment policy.

The implementation and enforcement of the policy is a matter between the provider and the injured worker. L&I is not responsible for the implementation and/or enforcement of the provider's policy.

(7) When a claim has been accepted by the department or self-insurer, no provider or his/her representative may bill the worker for the difference between the allowable fee and the usual and customary charge. Except for missed appointment fees under subsection (6) of this section, the worker may not be charged a fee, either for interest or completion of forms, related to services for the industrial injury or condition.

(8) Practitioners must maintain documentation in claimant medical or health care service records adequate to verify the level, type, and extent of services provided to claimants. A health care practitioner's bill for services, appointment book, accounting records, or other similar methodology do not qualify as appropriate documentation for services rendered. Refer to chapter 296-20 WAC and department policy for reporting requirements.

(9) Except as provided in WAC 296-20-055 (Limitation of treatment and temporary treatment of unrelated conditions when retarding recovery), practitioners shall bill, and the department or self-insurer shall pay, only for proper and necessary medical care required for the diagnosis and curative or rehabilitative treatment of the accepted condition.

(10) When a worker is being treated concurrently for an unrelated condition the fee allowable for the service(s) rendered must be shared proportionally between the payors.

(11) Correspondence: Correspondence pertaining to state fund and department of energy claims should be sent to: Department of Labor and Industries, Claims Administration, P.O. Box 44291, Olympia, Washington 98504-4291.

Accident reports should be sent to: Department of Labor and Industries, P.O. Box 44299, Olympia, Washington 98504-4299.

Send all provider bills and adjustments to: Department of Labor and Industries, P.O. Box 44269, Olympia, Washington 98504-4269.

State fund claims have six digit numbers or a letter and five digits preceded by a letter other than "S," "T," or "W."

All correspondence and billings pertaining to *crime victims* claims should be sent to Crime Victims Division, Department of Labor and Industries, P.O. Box 44520, Olympia, Washington 98504-4520.

Crime victim claims have six digit numbers preceded by a "V" or five digit numbers preceded by "VA," "VB," "VC," "VH," "VJ," or "VK."

All correspondence and billings pertaining to self-insured claims should be sent directly to the employer or the service representative as the case may be.

Self-insured claims are six digit numbers or a letter and five digits preceded by an "S," "T," or "W."

Communications to the department or self-insurer must show the patient's full name and claim number. If the claim number is unavailable, providers should contact the department or self-insurer for the number, indicating the patient's name, Social Security number, the date and the nature of the injury, and the employer's name. A communication should refer to one claim only. Correspondence must be legible and

reproducible, as department records are microfilmed. Correspondence regarding specific claim matters should be sent directly to the department in Olympia or self-insurer in order to avoid rehandling by the service location.

(12) The department's various local service locations should be utilized by providers to obtain information, supplies, or assistance in dealing with matters pertaining to industrial injuries.

[Statutory Authority: RCW 51.04.020. 12-05-098, § 296-20-010, filed 2/21/12, effective 3/23/12. Statutory Authority: RCW 51.04.020, 51.36.080, 7.68.030, 7.68.080. 07-08-088, § 296-20-010, filed 4/3/07, effective 5/23/07. Statutory Authority: RCW 51.04.020. 05-09-063, § 296-20-010, filed 4/19/05, effective 7/1/05; 03-21-069, § 296-20-010, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 96-10-086, § 296-20-010, filed 5/1/96, effective 7/1/96. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 94-14-044, § 296-20-010, filed 6/29/94, effective 7/30/94; 93-16-072, § 296-20-010, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-20-010, filed 12/1/92, effective 1/1/93; 90-04-057, § 296-20-010, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-010, filed 11/30/87, effective 1/1/88; 86-20-074 (Order 86-36), § 296-20-010, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-010, filed 2/28/86, effective 4/1/86; 83-16-066 (Order 83-23), § 296-20-010, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-010, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-010, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-010, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-010, filed 11/28/75, effective 1/1/76; Order 74-7, § 296-20-010, filed 1/30/74; Order 70-12, § 296-20-010, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-010, filed 11/27/68, effective 1/1/69.]

WAC 296-20-0100 Industrial insurance chiropractic advisory committee. (1)(a) The director shall appoint an industrial insurance chiropractic advisory committee (committee) composed of up to nine members licensed to practice chiropractic in Washington from the nominations provided by statewide associations.

(b) At least two of the total nine members must be chiropractors who are recognized for expertise in evidence-based practice or occupational health, or both.

(c) To the extent possible, all members shall have experience or knowledge of treating injured workers or evidence-based practice, or both.

(d) The director may, at his or her discretion, exclude or remove any nominee, committee member, or hired expert if the person does not meet a condition of appointment, including but not limited to:

(i) Having, or failing to disclose, a conflict of interest;

(ii) Breaching a statute, rule, or the committee's bylaws, including a quality of care concern or professional related action alleged by a government agency; or

(iii) If the committee or committee chair recommends removal for good cause shown.

(e) Appointments to the committee shall be up to three year terms, which the department may renew.

(2)(a) The committee will function as an advisor to the department with respect to the provision of safe, effective, and cost-effective health care for injured workers, including but not limited to, policy development regarding chiropractic care for injured workers, the development of practice guidelines and coverage criteria, review of coverage decisions and technology assessments, review of chiropractic programs, and review of rules pertaining to health care issues.

(b) The committee may provide peer review and advise and assist the department in the resolution of controversies, disputes, and issues between the department and the providers of chiropractic care.

(c) After approval by the department, the committee may consult with experts, services, and form ad hoc groups, committees, or subcommittees for the purpose of advising the department on specific topics to fulfill the purposes of the committee. Such experts or ad hoc groups will develop recommendations for the committee's approval.

(d) The committee's function may include, but is not limited to, the following:

(i) Advising the department on coverage decisions from technology assessments based on the best available scientific evidence, from which the department may use the committee's advice for making coverage decisions and for making proper and necessary industrial insurance claim decisions for covered services (see WAC 296-20-02704 for coverage decision criteria);

(ii) Advising the department on treatment guidelines for covered services based on proper and necessary standards, the best available scientific evidence, and the expert opinion of the industrial insurance chiropractic advisory committee. The department may use the committee's advice for provider education, for criteria for the department's utilization review program, and for making proper and necessary industrial insurance claim decisions;

(iii) Advising the department on criteria related to definitions of quality of care and patterns of harmful care;

(iv) Advising the department on issues related to emerging medical conditions and the scientific evidence related to them; and

(v) Advice to the department in (d)(i) through (iv) of this subsection shall not pertain to nor include the review of a specific individual claim.

(e) Committee approval regarding advice to the department shall be based on a consensus of the members present. If after all reasonable efforts a consensus cannot be reached, the committee shall vote using the procedure described in the bylaws. A quorum, which shall be half plus one of the appointed members, must be present to vote and provide approval regarding advice to the department. Implementation of the committee's advice by the department is discretionary and solely the responsibility of the department.

(3) The members of the committee, including hired experts and any ad hoc group or subcommittee:

(a) Are immune from civil liability for any official acts performed in good faith to further the purposes of the industrial insurance chiropractic advisory committee; and

(b) May be compensated for participation in the work of the industrial insurance chiropractic advisory committee in accordance with a personal services contract to be executed after appointment and before commencement of activities related to the work of the industrial insurance chiropractic advisory committee.

(4) The committee shall coordinate with the state health technology assessment program and the state prescription drug program. With regard to issues in which the committee's opinion may differ with findings of the state health technology assessment program or the state prescription drug program, the department must give greater weight to the findings of the state's health technology assessment program and the state's prescription program.

(5) The committee shall operate under conditions set out in bylaws as approved by the department and ratified by the committee.

(6)(a) The committee and ad hoc group or subcommittee shall meet on a schedule as set by the department.

(b) The department shall collaborate with the committee to prepare the agenda for each meeting, including prioritization of issues to be addressed, with the final approval of the agenda given to the department.

(c) All meetings of the committee or ad hoc subcommittee(s) are subject to chapter 42.30 RCW, the Open Public Meetings Act. Notice as to the date, time, location and agenda or topics shall be published on the department's web site, and in the *Washington State Register*. Additional notification via electronic communication shall be provided to committee members and other interested parties. Publication of the committee meeting shall occur with enough notice to ensure committee members or members of the public who have disabilities have an equal opportunity to participate.

[Statutory Authority: 2007 c 282, RCW 51.04.02 [51.04.020], 51.04.030. 08-02-020, § 296-20-0100, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 88-24-011 (Order 88-28), § 296-20-0100, filed 12/1/88, effective 1/1/89.]

WAC 296-20-01001 Industrial insurance medical advisory committee. (1)(a) The director shall appoint an industrial insurance medical advisory committee (committee) composed of up to fourteen members.

(b) The appointments shall include twelve members from the nominations provided by statewide clinical groups, specialties, and associations and shall be consistent with the specialty types required by law.

(c) At least two of the total fourteen members must be physicians who are recognized for expertise in evidence-based medicine.

(d) The director may choose up to two of the fourteen members, not necessarily from the nominations submitted, who have expertise in occupational medicine.

(e) To the extent possible, members shall be chosen from nominees with experience or knowledge of treating injured workers or evidence-based medicine, or both.

(f) The director may, at his or her discretion, exclude or remove any nominee, committee member, or hired expert if the person does not meet a condition of appointment, including but not limited to:

(i) Having, or failing to disclose, a conflict of interest;

(ii) Breaching a statute, rule, or the committee's bylaws, including a quality of care concern or professional related action alleged by a government agency; or

(iii) If the committee or committee chair recommends removal for good cause shown.

(g) Appointments to the committee shall be up to three year terms, which the department may renew.

(2)(a) The committee will function as an advisor to the department with respect to the provision of safe, effective, and cost-effective health care for injured workers, including but not limited to the development of practice guidelines, and coverage criteria, review of coverage decisions and technology assessments, review of medical programs, and review of rules pertaining to health care issues.

(b) The committee may provide peer review and advise and assist the department in the resolution of controversies, disputes, and issues between the department and the providers of medical care.

(c) After approval by the department, the committee may consult with experts, services, and form ad hoc groups, committees, or subcommittees for the purpose of advising the department on specific topics to fulfill the purposes of the committee. Such experts or ad hoc groups will develop recommendations for the committee's approval.

(d) The committee's function may include but is not limited to the following:

(i) Advising the department on coverage decisions from technology assessments based on the best available scientific evidence, from which the department may use the committee's advice for making coverage decisions and for making proper and necessary industrial insurance claim decisions for covered services (see WAC 296-20-02704 for medical coverage decision criteria);

(ii) Advising the department on treatment guidelines for covered services based on proper and necessary standards, the best available scientific evidence, and the expert opinion of the medical advisory committee. The department may use the committee's advice for provider education, for criteria for the department's utilization review program, and for making proper and necessary industrial insurance claim decisions;

(iii) Advising the department on criteria related to definitions of quality of care and patterns of harmful care;

(iv) Advising the department on issues related to emerging medical conditions and the scientific evidence related to them; and

(v) Advice to the department in (d)(i) through (iv) of this subsection shall not pertain to nor include the review of a specific individual claim.

(e) Committee approval regarding advice to the department shall be based on a consensus of the members present. If after all reasonable efforts a consensus cannot be reached, the committee shall vote using the procedure described in the bylaws. A quorum, which shall be half plus one of the appointed members, must be present to vote and provide approval regarding advice to the department. Implementation of the committee's advice by the department is discretionary and solely the responsibility of the department.

(3) The members of the committee, including hired experts and any ad hoc group or subcommittee:

(a) Are immune from civil liability for any official acts performed in good faith to further the purposes of the industrial insurance medical advisory committee; and

(b) May be compensated for participation in the work of the industrial insurance medical advisory committee in accordance with a personal services contract to be executed after appointment and before commencement of activities related to the work of the industrial insurance medical advisory committee.

(4) The committee shall coordinate with the state health technology assessment program and the state prescription drug program. With regard to issues in which the committee's opinion may differ with findings of the state health technology assessment program or the state prescription drug program, the department must give greater weight to the findings

of the state's health technology assessment program and the state's prescription program.

(5) The committee shall operate under conditions set out in bylaws as approved by the department and ratified by the committee.

(6)(a) The committee and ad hoc group or subcommittee shall meet on a schedule as set by the department.

(b) The department shall collaborate with the committee to prepare the agenda for each meeting, including prioritization of issues to be addressed, with the final approval of the agenda given to the department.

(c) All meetings of the committee or ad hoc subcommittee(s) are subject to chapter 42.30 RCW, the Open Public Meetings Act. Notice as to the date, time, location and agenda or topics shall be published on the department's web site, and in the *Washington State Register*. Additional notification via electronic communication shall be provided to committee members and other interested parties. Publication of the committee meeting shall occur with enough notice to ensure committee members or members of the public who have disabilities have an equal opportunity to participate.

[Statutory Authority: 2007 c 282, RCW 51.04.02 [51.04.020], 51.04.030. 08-02-019, § 296-20-01001, filed 12/21/07, effective 1/21/08; Order 77-27, § 296-20-01001, filed 11/30/77, effective 1/1/78; Emergency Order 77-26, § 296-20-01001, filed 12/1/77; Emergency Order 77-16, § 296-20-01001, filed 9/6/77; Order 76-34, § 296-20-01001, filed 11/24/76, effective 1/1/77.]

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

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

Attendant care: Those proper and necessary personal care services provided to maintain the worker in his or her residence. Refer to WAC 296-23-246 for more information.

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

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

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

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

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

(5) If the worker has not returned to work, a doctor's estimate of physical capacities should be included with the report. If further information regarding physical capacities is needed or required, a performance-based physical capacities evaluation can be requested. Performance-based physical capacities evaluations should be conducted by a licensed occupational therapist or a licensed physical therapist. Performance-based physical capacities evaluations may also be conducted by other qualified professionals who provided performance-based physical capacities evaluations to the department prior to May 20, 1987, and who have received written approval to continue supplying this service based on formal department review of their qualifications.

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.

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

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

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

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

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

(1) Diagnosis;

(2) Size, location and number of lesion(s) or procedure(s) where appropriate;

(3) Surgical procedure(s) and supplementary procedure(s);

(4) Whenever possible, list the nearest similar procedure by number according to the fee schedules;

(5) Estimated follow-up;

(6) Operative time;

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

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

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

(1) Date(s) of service;

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

(3) Claim number;

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

(5) Chief complaint or reason for each visit;

(6) Pertinent medical history;

(7) Pertinent findings on examination;

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

(9) Description of treatment (when applicable);

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

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

(12) Plan of treatment/care/outcome.

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

(1) A detailed history to establish:

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

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

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

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

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

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

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

(a) Due solely to injury.

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

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

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

(6) Conclusions must include:

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

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

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

(d) Probability of returning to work.

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

Doctor 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).

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

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

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

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

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

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

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

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

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

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

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

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

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 Injury or Occupational Disease* 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. Workers should be urged to return to modified work as soon as reasonable as such work is frequently beneficial for body conditioning and regaining self confidence.

Under RCW 51.32.090, when the employer has modified work available for the worker, the employer must furnish the doctor and the worker with a statement describing the available work in terms that will enable the doctor to relate the physical activities of the job to the worker's physical limitations and capabilities. The doctor shall then determine whether the worker is physically able to perform the work described. The employer may not increase the physical requirements of the job without requesting the opinion of the doctor as to the worker's ability to perform such additional work. If after a trial period of reemployment the worker is unable to continue with such work, the worker's time loss compensation will be resumed upon certification by the attending doctor.

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

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

Physician 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.

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

Proper and necessary:

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

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

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

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

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

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

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

(4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and nec-

essary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

Refill: The continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral or immunosuppressive drug, or for the refill of an immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

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

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

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

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

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

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

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

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 osteopathic physician assistants. A treating provider 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 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.

[Statutory Authority: RCW 51.04.020, 51.04.030, and Title 51 RCW. 08-24-047, § 296-20-01002, filed 11/25/08, effective 12/26/08. Statutory Authority: 2007 c 263, RCW 51.04.020 and 51.04.030. 08-04-095, § 296-20-01002, filed 2/5/08, effective 2/22/08. Statutory Authority: RCW 51.04.020, 51.04.030 and 2007 c 134. 08-02-021, § 296-20-01002, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020, 51.04.030. 07-17-167, § 296-20-01002, filed 8/22/07, effective 9/22/07. Statutory Authority: 2004 c 65 and 2004 c 163. 04-22-085, § 296-20-01002, filed 11/2/04, effective 12/15/04. Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-01002, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020. 03-21-069, § 296-20-01002, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.010, 51.04.-020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-01002, filed 10/22/02, effective 12/1/02. Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.060, 51.32.072, and 7.68.070. 01-18-041, § 296-20-01002, filed 8/29/01, effective 10/1/01. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-039, § 296-20-01002, filed 12/7/99, effective 1/8/00. Statutory Authority: RCW 51.04.030, 70.14.050 and 51.04.020 (4). 95-16-031, § 296-20-01002, filed 7/21/95, effective 8/22/95. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-01002, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 92-24-066, § 296-20-01002, filed 12/1/92, effective 1/1/93; 92-05-041, § 296-20-01002, filed 2/13/92, effective 3/15/92. Statutory Authority: RCW 51.04.020. 90-14-009, § 296-20-01002, filed 6/25/90, effective 8/1/90. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-01002, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-01002, filed 11/30/87, effective 1/1/88; 86-20-074 (Order 86-36), § 296-20-01002, filed 10/1/86, effective 11/1/86; 83-24-016 (Order 83-35), § 296-20-01002, filed 11/30/83, effective 1/1/84; 83-16-066 (Order 83-23), § 296-20-01002, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-01002, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-01002, filed 12/23/80, effective 3/1/81.]

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) 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 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 miles, compared to a baseline established within the previous twelve months;

• The percent of injured workers by county who have access to at least five primary care providers within fifteen miles, compared to a baseline established within the previous twelve 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 may reimburse for treatment beyond the initial office or emergency room visit.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-23-020, § 296-20-01010, filed 11/13/12, effective 12/14/12; 12-02-058, § 296-20-01010, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01020 Health care provider network enrollment. (1) The department or its delegated entity will review the provider's application, supporting documents, and any other information requested or accessed by the department that is relevant to verifying the provider's application, clinical experience or ability to meet or maintain provider network requirements.

(2) The department will notify providers of incomplete applications, including when credentialing information obtained from other sources materially varies from information on the provider application. The provider may submit a supplement to the application with corrections or supporting documents to explain discrepancies within thirty days of the date of the notification from the department. Incomplete applications will be considered withdrawn within forty-five days of notification.

(3) The provider must produce adequate and timely information and timely attestation to support evaluation of the application. The provider must produce information and respond to department requests for information that will help resolve any questions regarding qualifications within the time frames specified in the application or by the department.

(4) The department's medical director or designee is authorized to approve, deny, or further review complete applications consistent with department rules and policies. Providers will be notified in writing of their approval or denial, or that their application is under further review within a reasonable period of time.

(5) Providers who meet the minimum provider network standards, have not been identified for further review, and are in compliance with department rules and policies, will be approved for enrollment into the network.

(6) Enrollment of a provider is effective no earlier than the date of the approved provider application. The department and self-insured employers will not pay for care provided to workers prior to application approval, regardless of whether the application is later approved or denied, except as provided in subsection (7) of this section.

(7) The department and self-insured employers may pay a provider without an approved application only when:

(a) The provider is outside the scope of the provider network per WAC 296-20-01010; or

(b) The provider is provisionally enrolled by the department after it obtains:

(i) Verification of a current, valid license to practice;

(ii) Verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query; and

(iii) A current and signed application with attestation.

(c) A provider may only be provisionally enrolled once and for no more than sixty calendar days. Providers who have previously participated in the network are not eligible for provisional enrollment.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-23-020, § 296-20-01020, filed 11/13/12, effective 12/14/12; 12-02-058, § 296-20-01020, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01030 Minimum health care provider network standards. The department will deny an application if a provider does not meet minimum health care provider network standards. To be eligible for enrollment and participation in the provider network, a provider must meet and maintain the following minimum health care provider network standards:

(1) The provider must submit an accurate and complete provider application, including any required supporting documentation and sign without modification, a provider agreement with the department.

(2) The provider must have current professional liability coverage, individually or as a member of a group, through a commercial carrier or provide documentation of self-insurance.

(a) Professional liability coverage must be at least in the amounts of one million dollars per occurrence and three million dollars annual aggregate; or in the amounts otherwise

published by the department for the provider type's scope of practice, after notice and opportunity for comment.

(b) Providers in a group practice who are self-insured for professional liability coverage must provide evidence that liabilities in amounts at least equivalent to liability limits in (a) of this subsection are booked on audited financial statements in accordance with generally accepted accounting standards.

(3) The provider must not have had clinical admitting and management privileges denied, limited or terminated for quality of care issues.

(4) The provider must not have been excluded, expelled, terminated, or suspended from any federally or state funded health care programs including, but not limited to, medicare or medicaid programs based on cause or quality of care issues.

(5) The provider must not have made any material misstatement or omission to the department concerning licensure, registration, certification, disciplinary history or any other material matter covered in the application or credentialing materials.

(6) The provider must not have been convicted of a felony or pled guilty or no contest to a felony for a crime including, but not limited to, health care fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of controlled substances.

The department may grant an exception for a felony that the provider has had expunged (vacated criminal conviction) from the provider's record.

(7) The provider must be currently licensed, certified, accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant treats injured workers.

(a) The license, registration or certification must be free of any restrictions, limitations or conditions relating to the provider's clinical practice.

(b) The provider must not have surrendered, voluntarily or involuntarily his or her professional state license in any state while under investigation or due to findings by the state resulting from the provider's acts, omissions, or conduct.

(c) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature or for a case where the restriction, limitation, or condition has been removed.

(8) The provider must have a current Drug Enforcement Administration (DEA) registration, if applicable to the provider's scope of licensure.

(a) The DEA registration must be free of restrictions, limitations or conditions related to the provider's acts, omissions or conduct.

(b) The provider must not have surrendered, voluntarily or involuntarily his or her DEA registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct.

(c) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature or for a case where the restriction, limitation or condition has been removed.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01030, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01040 Health care provider network continuing requirements. To continue to provide care for workers and be paid for those services, a provider must:

(1) Provide services without unlawful discrimination;

(2) Provide services and bill according to federal and state laws and rules, department rules, policies, and billing instructions;

(3) Maintain material compliance with minimum provider network standards, department credentialing and recredentialing standards, and department's evidence-based coverage decisions and treatment guidelines, policies; and must follow other national treatment guidelines appropriate for their patient;

(4) Inform the department or an applicable delegated credentialing entity of any material changes to the provider's application or agreement within fourteen calendar days including, but not limited to, changes in:

(a) Ownership or business name;

(b) Address or telephone number;

(c) Professionals practicing under the billing provider number;

(d) Any informal or formal disciplinary order, decision, disciplinary action or other action(s), including any criminal action, in any state;

(e) Provider clinical privileges;

(f) Malpractice claims or professional liability coverage;

(5) Retain a current professional state license, registration, certification and/or applicable business license for the service being provided, and update the department of all changes;

(6) Comply with department recredentialing process; and

(7) Comply with the instructions contained in a department action, including documentation of compliance and participation in mentoring, monitoring, or restrictions.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01040, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01050 Health care provider network further review and denial. (1) The department may further review a complete provider application based on information within the application or credentialing information obtained from other sources.

(2) For complete applications requiring further review, the department's medical director or designee has the authority to approve or deny consistent with department rules and policies, and may seek advice, expertise, consultation or recommendations on applications from:

(a) Peer or clinical review individuals or entities;

(b) The industrial insurance medical or chiropractic advisory committee (including a subcommittee);

(c) A department appointed credentialing committee.

(3) The department may deny a provider application during credentialing or recredentialing based on the provider's professional qualifications and practice history including:

(a) The provider fails to meet minimum health care provider network standards;

(b) The provider has been disciplined based on an allegation of sexual misconduct or admitted to sexual misconduct;

(c) The provider is noncompliant with the department of health's or other state health care agency's stipulation to infor-

mal disposition (STID), agreed order, or similar licensed restriction;

(d) The provider has any pending statement of charges or notice of proposed disciplinary action or equivalent from any state or governmental professional disciplinary board at the time of application or recredentialing;

(e) The provider is excluded, expelled, terminated, or suspended by medicare, medicaid or any other state or federally funded health care program;

(f) The provider has a denial, suspension or termination of participation or privileges by any health care institution, insurance plan, facility, or clinic; except where such decision was solely related to broad network or business management changes, instead of an individual determination;

(g) The provider has surrendered, voluntarily or involuntarily, his or her hospital privileges in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct;

(h) The provider performs invasive or surgical procedures without:

(i) Clinical admitting and management privileges, in good standing; or

(ii) An inpatient coverage plan with participating practitioner(s), hospitalists, or inpatient service teams for the purpose of admitting patients. Any inpatient coverage plan must be specified by the provider and found to be acceptable by the department.

(i) The provider has significant malpractice claims or professional liability claims (based on materiality to current practice, severity, recency, frequency, or repetition);

(j) The provider has been materially noncompliant with the department's rules, administrative and billing policies, evidence-based coverage decisions and treatment guidelines, and policies and other national treatment guidelines appropriate for their patient (based on severity, recency, frequency, repetition, or any mitigating circumstances);

(k) The provider was or is found to be involved in acts of dishonesty, fraud, deceit or misrepresentation that, in the department's determination, could relate to or impact the provider's professional conduct or the safety or welfare of injured or ill workers;

(l) The provider was or is found to have committed negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow-up treatment which results in injury to a worker or creates unreasonable risk that a worker may be harmed (based on severity, recency, frequency, repetition, or any mitigating circumstances);

(m) The provider uses health care providers or health care staff who are unlicensed to practice or who provide health care services outside their recognized scope of practice or the standard of practice in Washington state;

(n) The provider with a history of alcohol or chemical dependency fails to furnish documentation demonstrating that the provider complied or is complying with all conditions limitations, or restrictions to the provider's practice and received or is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice;

(o) The provider has informal licensure actions, conditions, agreements, orders;

(p) The provider has a history of probation, suspension, termination, revocation or a surrendered professional license, certification, accreditation, or registration listed in the National Provider Data Bank/Healthcare Integrity and Protection Data Bank or any like entity; or by a nationally recognized specialty board; or by a state authority in any jurisdiction including, but not limited to, the Washington state department of health, when such charges involve conduct or behavior as defined under chapter 18.130 RCW, Uniform Disciplinary Act;

(q) The provider engaged in billing fraud or abuse or has a history of other significant billing irregularities;

(r) There are material complaints or allegations demonstrating a pattern of behavior(s) or misrepresentations including, but not limited to incidents, misconduct, or inappropriate prescribing of controlled substances (based on severity, recency, frequency, repetition, or any mitigating circumstances);

(s) The provider has a criminal history which includes, but is not limited to, any criminal charges, criminal investigations, convictions, no contest pleas and guilty pleas; or

(t) A finding of risk of harm pursuant to WAC 296-20-01100.

(4) The department and self-insured employers will not pay for any care to injured workers, other than an initial visit, by a provider whose application has been denied.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01050, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01060 Delegation of credentialing and recredentialing activities. (1) The department may delegate credentialing and recredentialing review activities to the following entities:

(a) Medical and dental group(s) and clinics;

(b) Physician organizations;

(c) Credentials verification organizations (CVOs); or

(d) Other organizations that employ and/or contract with providers.

(2) Any delegation by the department of credentialing or recredentialing review activities will be documented through a written delegation agreement.

(3) The department retains the authority to review, approve, suspend, deny, or terminate any provider who has been credentialed by a delegated entity.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01060, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01070 Waiting periods for reapplying to the network. (1) Providers are not eligible to reapply for enrollment in the network if they have been denied or removed from network participation due to:

(a) A finding of risk of harm, pursuant to WAC 296-20-01100;

(b) Having been excluded, expelled or suspended, other than for convenience, from any federally or state funded programs including, but not limited to, medicare or medicaid programs;

(c) Having been convicted of a felony or pled guilty to a felony for a crime and the felony has not been expunged from the provider's record including, but not limited to, health care

fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of controlled substances;

(d) Sexual misconduct as defined in profession specific rules of any state or jurisdiction, including Washington state department of health.

(2) Providers who are denied or removed from the network or terminated for any other reason than those set forth in subsection (1) of this section are not eligible to reapply for enrollment in the network for five years. The department may grant an exception where the reason for denial or removal is related to pending actions or charges which have been resolved or deemed by the department to be minor or clerical in nature.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01070, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01080 Management of the provider network. (1) Appropriate action(s) by the department to monitor quality of care and assure efficient management of the provider network may include, but are not limited to:

(a) Monitoring the provider;

(b) Mentoring the provider;

(c) Restricting payment for services rendered by the provider;

(d) Suspending the provider from the network; or

(e) Removing the provider from the network.

(2) The department must first notify the provider, and may take action in any order or combination, depending on the severity of the issue or risk of harm.

(3) For risk of harm issues, where imminent or actual harm is not life-threatening or substantially disabling, the department may provide an opportunity for the provider to remediate through education or other less severe actions first. Where the department action includes suspension or removal from the network for risk of harm issues, the department may also request expedited hearing and immediate suspension of authority to provide services under RCW 51.52.075.

(4) In taking appropriate action for risk of harm issues, the department will take into account unique mitigating circumstances related to the clinical severity and complexity of the providers' patient population. Unique mitigating circumstances could include practice at a care facility recognized for its receipt of particularly severe cases, such as catastrophic injuries. Duration of disability and/or chronic pain shall not, in and of themselves, be considered uniquely mitigating.

The department may not take action against a provider for risk of harm, if the harm was related to an isolated instance of health care service delivery that was conducted within coverage policies and treatment guidelines established by the department or other evidence-based coverage decisions made by the Washington state health technology committee, or the prescription drug program and appropriate to the patient's specific circumstances.

(5) The department may also terminate a provider network agreement for cause based on the provider's professional qualifications, billing, and practice history including, but not limited to, the following:

(a) The provider fails to maintain the minimum health care provider network standards per WAC 296-20-01030;

(b) The provider fails to comply with health care provider network continuing requirements per WAC 296-20-01040;

(c) The provider engages in action or inaction for which the department may deny an application;

(d) The provider violates the terms of the agreement; or

(e) A finding of risk of harm, pursuant to WAC 296-20-01100 including, but not limited to, prescribing drug therapy in an unsafe manner and/or failure to identify substance abuse/addiction or failure to refer the patient for substance abuse treatment once abuse/addiction is identified.

(6) The department will notify the provider of agreement termination according to the terms of the agreement, identify the reason for agreement termination, and include an effective date of termination. If a provider agreement is terminated for cause, the department or self-insured employer will pay for authorized services provided only up to the date specified in the notice.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01080, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01090 Request for reconsideration of department decision. (1) A provider may request reconsideration of the department's decision to deny enrollment or remove or suspend a provider from the health care provider network. The request for reconsideration must be received by the department within sixty calendar days from the date the department's decision is communicated to the provider.

(2) A provider must:

(a) Specify the department decision(s) that the provider is disputing;

(b) State the basis for disputing the department's decision; and

(c) Include documentation to support the provider's position.

(3) The department may request additional information or documentation. The provider must submit the additional information within thirty calendar days of the date on the department's request.

(4) The department will review the original decision, information supporting the original decision, the provider's reconsideration request and supporting documentation and will notify the provider of the status of its reconsideration decision within ninety days. This is the final department decision, and a provider may appeal pursuant to chapter 51.52 RCW.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01090, filed 1/3/12, effective 2/3/12.]

WAC 296-20-01100 Risk of harm. (1) It is the intent of the department, through authority granted by RCW 51.36.010 to protect workers from physical or psychiatric harm by identifying, and taking appropriate action, including removal of providers from the statewide network, when:

(a) There is **harm**; and

(b) There is a **pattern(s)** of **low quality care;** and

(c) The harm is related to the pattern(s) of low quality care.

(2) It is not the intent of the department to remove or otherwise take action when providers are practicing within department policies and guidelines, or within best practices

established or developed by the department, or established in collaboration with its industrial insurance medical and chiropractic advisory committees.

(3) The department may permanently remove a provider from the statewide network or take other appropriate action when that provider's treatment of injured workers exhibits a **pattern or patterns** of conduct of **low quality care** that exposes patients to a risk of physical or psychiatric **harm** or death.

(4) **Harm** is defined as (intended or unintended) physical or psychiatric injury resulting from, or contributed to, by health care services that result in the need for additional monitoring, treatment or hospitalization or that worsens the condition(s), increases disability, or causes death. Harm includes increased, chronic, or prolonged pain or decreased function.

(5) **Pattern or patterns** of low quality care is/are defined as including one or more of the following:

(a) For health services where the department can calculate normative data on frequency, a provider's cases are in the lowest decile (at or below the tenth percentile); or

(b) For health services where the department cannot calculate normative data on frequency, at least twenty percent of requested or conducted services meet the definition of low quality care; or

(c) For health services where department data or scientific literature has reported expected rates of adverse events, a provider's adverse event rates are at least twenty percent above the expected rate; or

(d) A review of a random sample of the provider's cases demonstrates that at least twenty percent of cases do not meet peer matched criteria for acceptable quality; or

(e) Two or more deaths or life-threatening events; or

(f) Provider behavior(s) and/or practices that result in revocation or limitation of hospital privileges or professional licensure sanctions.

(6) **Low quality care in the statewide workers' compensation network is defined as treatments or treatment regimens:**

(a) That have not been shown to be safe or effective or for which it has been shown that the risks of harm exceed the benefits that can reasonably be expected, based on available peer-reviewed scientific studies; or

(b) That uses diagnostic tests or treatment interventions not in compliance with the department's policies, the department's applicable utilization review criteria, or the department's guidelines; or

(c) That includes repeated unsuccessful surgical or other invasive procedures; or

(d) That is outside the provider's scope of practice or training; or

(e) That results in revocation or limitation of hospital privileges or in professional licensure sanctions; or

(f) That fails to include or deliver appropriate and timely health care services as identified in available department guidelines or policies; or

(g) That includes repetitive provision of care that is not curative or rehabilitative per WAC 296-20-01002 for extended periods that does not contribute to recovery, return to work, or claim resolution; or

(h) That includes repeated testing including, but not limited to, routine use of a diagnostic test or procedure by either the provider prescribing or the provider performing the test, when any of the following apply:

(i) The test(s) have been demonstrated to be unsafe or of poor quality; or

(ii) High quality, peer-reviewed scientific studies do not show that the test has the technical capacity (reliable and valid) and accuracy to result in successful clinical outcomes for their intended use (utility); or

(iii) The test is conducted or interpreted in a manner inconsistent with high quality evidence-based clinical practice guidelines; or

(iv) The test is likely to lead to treatment that does not meet department guidelines or policies or is otherwise harmful.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-02-058, § 296-20-01100, filed 1/3/12, effective 2/3/12.]

WAC 296-20-015 Who may treat. To treat workers under the Industrial Insurance Act, a health care provider must qualify as an approved provider under the department's rules. The department must approve the health care provider before the health care provider is eligible for payment for services.

(1) A provider must:

(a) Apply and be enrolled in the provider network per WAC 296-20-01010; or

(b) If the provider network scope in WAC 296-20-01010 is not applicable, apply and obtain a provider account number per WAC 296-20-12401.

(2) If the provider or service is within the scope of the provider network under WAC 296-20-01010:

(a) A nonnetwork provider is not authorized to treat and will not be reimbursed by the department or self-insurer for services other than the initial office or emergency room visit. The following services are considered part of the initial office or emergency room visit:

(i) Services that are bundled with those performed during the initial visit where no additional payment is due (as defined in WAC 296-20-01002); and

(ii) In the case of an injured worker directly hospitalized from an initial emergency room visit, all services related to the industrial injury or illness provided through the hospital discharge.

(b) A nonnetwork provider must refer injured workers to network providers when additional treatment is needed, and must provide timely copies of medical records to the other provider.

(3) Para-professionals, who are not independently licensed, must practice under the direct supervision of a licensed health care professional whose scope of practice and specialty training includes the service provided by the para-professional. The department may deny direct reimbursement to the para-professional for services rendered, and may instead directly reimburse the licensed and supervising health care professional for covered services. Payment rules for para-professionals may be determined by department policy.

(4) Procedures and evaluations requiring specialized skills and knowledge will be limited to board certified or board qualified physicians, or osteopathic physicians as specified by the American Medical Association or the American Osteopathic Association.

(5) The department as a trustee of the medical aid fund has a duty to supervise provision of proper and necessary medical care that is delivered promptly, efficiently, and economically. The department can deny, revoke, suspend, limit, or impose conditions on a health care provider's authorization to treat workers under the Industrial Insurance Act. Reasons for denying issuance of a provider number or imposing any of the above restrictions include, but are not limited to the following:

(a) Incompetence or negligence, which results in injury to a worker or which creates an unreasonable risk that a worker may be harmed.

(b) The possession, use, prescription for use, or distribution of controlled substances, legend drugs, or addictive, habituating, or dependency-inducing substances in any way other than for therapeutic purposes.

(c) Any temporary or permanent probation, suspension, revocation, or type of limitation of a practitioner's license to practice by any court, board, or administrative agency.

(d) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the provider's profession. The act need not constitute a crime. If a conviction or finding of such an act is reached by a court or other tribunal pursuant to plea, hearing, or trial, a certified copy of the conviction or finding is conclusive evidence of the violation.

(e) The failure to comply with the department's orders, rules, or policies.

(f) The failure, neglect, or refusal to:

(i) Provide records requested by the department pursuant to a health care services review or an audit.

(ii) Submit complete, adequate, and detailed reports or additional reports requested or required by the department regarding the treatment and condition of a worker.

(g) The submission or collusion in the submission of false or misleading reports or bills to any government agency.

(h) Billing a worker for:

(i) Treatment of an industrial condition for which the department has accepted responsibility; or

(ii) The difference between the amount paid by the department under the maximum allowable fee set forth in these rules and any other charge.

(i) Repeated failure to notify the department immediately and prior to burial in any death, where the cause of the death is not definitely known and possibly related to an industrial injury or occupational disease.

(j) Repeated failure to recognize emotional and social factors impeding recovery of a worker who is being treated under the Industrial Insurance Act.

(k) Repeated unreasonable refusal to comply with the recommendations of board certified or qualified specialists who have examined a worker.

(l) Repeated use of:

(i) Treatment of controversial or experimental nature;

(ii) Contraindicated or hazardous treatment; or

(iii) Treatment past stabilization of the industrial condition or after maximum curative improvement has been obtained.

(m) Declaration of mental incompetency by a court or other tribunal.

(n) Failure to comply with the applicable code of professional conduct or ethics.

(o) Failure to inform the department of any disciplinary action issued by order or formal letter taken against the provider's license to practice.

(p) The finding of any peer group review body of reason to take action against the provider's practice privileges.

(q) Misrepresentation or omission of any material information in the application for authorization to treat workers, chapter 51.04 RCW.

(6) If the department finds reason to take corrective action, the department may also order one or more of the following:

(a) Recoupment of payments made to the provider, including interest, chapter 51.04 RCW;

(b) Denial or reduction of payment;

(c) Assessment of penalties for each action that falls within the scope of subsection (5)(a) through (q) of this section, chapter 51.48 RCW;

(d) Placement of the provider on a prepayment review status requiring the submission of supporting documents prior to payment;

(e) Requirement to satisfactorily complete remedial education courses and/or programs; and

(f) Imposition of other appropriate restrictions or conditions on the provider's privilege to be reimbursed for treating workers under the Industrial Insurance Act.

(7) The department shall forward a copy of any corrective action taken against a provider to the applicable disciplinary authority.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-06-066, § 296-20-015, filed 3/6/12, effective 4/6/12. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-015, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-015, filed 2/2/90, effective 3/5/90; 86-20-074 (Order 86-36), § 296-20-015, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-015, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-015, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-015, filed 11/24/76; effective 1/1/77; Order 74-4, § 296-20-015, filed 1/30/74; Order 71-6, § 296-20-015, filed 6/1/71; Order 70-12, § 296-20-015, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-015, filed 11/27/68, effective 1/1/69.]

WAC 296-20-01501 Physician assistant rules. (1) Physician assistants (PA) may be "treating 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.

(2) Physician assistants may perform those medical services which are within the scope of their physician's assistant license 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;

(b) Providing the name, address, specialty, and provider number issued by the department of the supervising physi-

cian(s) on the provider application (a PA may have to obtain more than one provider number if billing under multiple supervising 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 it is within the physician assistant's scope of practice and is consistent with the terms of the physician assistant's practice arrangement plan as required by chapters 18.57A and 18.71A RCW. This includes but is not limited to:

• Completing and signing the report of accident or provider's initial report, 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.

[Statutory Authority: 2007 c 263, RCW 51.04.020 and 51.04.030. 08-04-095, § 296-20-01501, filed 2/5/08, effective 2/22/08. Statutory Authority: 2004 c 65 and 2004 c 163. 04-22-085, § 296-20-01501, filed 11/2/04, effective 12/15/04. Statutory Authority: RCW 51.04.020. 03-21-069, § 296-20-01501, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-01501, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4), 51.04.-030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-01501, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-01501, filed 12/23/80, effective 3/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-01501, filed 11/30/79, effective 1/1/80.]

WAC 296-20-01505 Provider types and services not covered. The department will not pay for services performed by the following practitioners:

Acupuncturists
Herbalists
Christian Science practitioners or theological healers
Homeopathists
Noncertified physician assistants
Operating room technicians
Certified surgical technicians
Certified surgical assistants

Any other licensed or unlicensed practitioners not otherwise specifically provided for by the department.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 94-14-044, § 296-20-01505, filed 6/29/94, effective 7/30/94.]

WAC 296-20-020 Acceptance of rules and fees. The filing of an accident report 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 renders treatment to a worker entitled to benefits under the law, "it shall be the duty of the physician to inform the worker of his 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 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.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-020, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-020, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-020, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-020, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-020, filed 11/28/75, effective 1/1/76; Order 74-39, § 296-20-020, filed 11/22/74, effective 1/1/75; Order 71-6, § 296-20-020, filed 6/1/71; Order 70-12, § 296-20-020, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-020, filed 11/27/68, effective 1/1/69.]

WAC 296-20-02005 Keeping of records. A health services provider who requests from the department payment for providing services shall maintain all records necessary for the director's authorized auditors to audit the provision of services. A provider shall keep all records necessary to disclose the extent of services the provider furnishes to industrially injured workers. At a minimum, these records must provide and include prompt and specific documentation of the level and type of service for which payment is sought. Records must be maintained for audit purposes for a minimum of five years.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-20-074 (Order 86-36), § 296-20-02005, filed 10/1/86, effective 11/1/86.]

WAC 296-20-02010 Review of health services providers. (1) The department may review providers' patient and billing related records to ensure workers are receiving proper and necessary medical care and to ensure providers' compliance with the department's medical aid rules, fee schedules, and policies. A records review may be the basis for corrective action against the provider.

(2) The department may review records before, during, or after delivery of health services. Records reviews may be

for cause or at random and may include the utilization of statistical sampling methodologies and projections based upon sample findings. Records reviews may be conducted at or away from the provider's places of business, at the department's discretion.

(3) The department will give ten working days' written notification to any provider that the provider's patient and billing related records will be reviewed by an auditor at the provider's place(s) of business to determine compliance with medical aid rules and standards.

(4) The department may request legible copies of providers' records. Providers shall furnish copies of the requested records within thirty calendar days of receipt of the request.

(5) The department will not remove original records from provider's premises.

(6) For information regarding the formal appeals process refer to chapter 51.52 RCW.

[Statutory Authority: RCW 51.04.020. 03-21-069, § 296-20-02010, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-02010, filed 2/2/90, effective 3/5/90; 86-20-074 (Order 86-36), § 296-20-02010, filed 10/1/86, effective 11/1/86.]

WAC 296-20-02015 Interest on excess payments. (1) When a provider of health services receives a payment to which that provider is not entitled, the provider must repay the excess payment, plus accrued interest, without regard to whether the excess payment occurred due to provider or department error or oversight, except as provided in subsection (2) of this section.

(2) When a provider:

(a) Accepts in good faith a determination by the department that a worker is eligible for benefits under Title 51 RCW;

(b) Provides, bills, and receives payment for services to that worker and the department later determines that the worker was ineligible for services during that period no interest will begin to accrue until notification is received by the provider that the worker was ineligible.

(3) Interest accrues on excess payments at the rate of one percent per month or portion of a month beginning on the thirty-first day after payment was made. Where partial repayment of an excess payment is made, interest accrues on the remaining balance.

(4) The department reserves the option of either requesting the provider to remit the amount of the excess payment and accrued interest to the department or offsetting excess payments and accrued interest against future payments due to the provider.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-20-074 (Order 86-36), § 296-20-02015, filed 10/1/86, effective 11/1/86.]

WAC 296-20-022 Payment of out-of-state providers. (1) **How will health care providers outside of Washington state be paid?** All health care service providers, regardless of their geographic location, will be paid according to the fee schedule rules, rates, coverage and payment policies as published in the Washington state *Medical Aid Rules and Fee Schedules* and/or provider bulletins.

(2) **Can an injured worker be charged for services?** In all cases, the department's maximum allowed fees and payment levels are the maximum payable. If a provider's charge exceeds the maximum amount payable under the department's *Medical Aid Rules and Fee Schedules*, the provider must not charge the injured worker for the difference. A provider violating this provision may be held ineligible to treat injured workers as provided by department rules and may be subject to other applicable penalties.

Exception: When a provider treats an injured worker for condition(s) unrelated to the worker's accepted industrial injury or illness, the provider may bill the worker or other insurers for the unrelated services only.

(3) **What services will be paid to providers outside of Washington?** Only those diagnostic and treatment services authorized under the state of Washington medical aid rules, fee schedules, payment policies, or medical coverage decisions may be authorized or paid by the department or self-insurer. As determined by the department of labor and industries, the scope of practice of providers outside the state of Washington may be recognized for payment purposes. However, in all cases WAC 296-20-03002 (Treatment not authorized) shall apply. Specifically, services not authorized under Washington workers compensation rules, fee schedules, payment policies, or medical coverage decisions will not be paid, even if permitted under the workers compensation program in the provider's state or country of business. When in doubt, the provider should verify coverage of a service with the department or self-insurer.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-09-078, § 296-20-022, filed 4/18/00, effective 7/1/00. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-022, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-022, filed 11/30/87, effective 1/1/88; 87-03-004 (Order 86-45), § 296-20-022, filed 1/8/87.]

WAC 296-20-023 Third-party settlement—Excess recoveries. (1) In cases where a third-party settlement has been made resulting in an excess recovery subject to offset from the worker's future benefits or compensation due, the department or self-insurer is not liable for payment for services rendered by providers.

(2) The worker should be treated and billed in accordance with the department's medical aid rules and maximum fee schedules. When bills are processed against the amount of the excess recovery, the department will notify the provider on the remittance advice.

(3) The department or self-insurer will resume financial responsibility to or on behalf of the worker when the amount of such excess has been reduced to zero.

[Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. 93-23-060, § 296-20-023, filed 11/15/93, effective 1/1/94. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-023, filed 2/28/86, effective 4/1/86.]

WAC 296-20-024 Utilization management. The department, as a trustee of the medical aid fund, has a duty to supervise the provision of proper and necessary medical care that is delivered promptly, efficiently, and economically. Toward this end, the department will institute programs of utilization management. These programs are designed to monitor and control the proper and necessary use and cost of, health care services. These programs include, but are not limited to, managed care contracting, prior authorization for services, and alternative reimbursement systems.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-024, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-024, filed 11/30/87, effective 1/1/88.]

WAC 296-20-025 Initiating treatment and submitting a claim for benefits. (1) Worker's responsibility: The worker must notify the provider when the worker has reason to believe his/her injury or illness is work related. If treatment beyond the initial office or emergency room visit is needed, the worker must seek treatment from a network provider.

(2) Provider's responsibility: The provider must notify the worker if he/she identifies an injury, illness, or condition which he/she has reason to believe is work related.

Once such determination is made by either the worker or the attending provider, a report of the injury or illness must be filed with the department or self-insurer.

Failure to comply with this responsibility can result in penalties as outlined in RCW 51.48.060.

(3) Additional provider responsibilities: The provider must ascertain whether he/she is the first attending provider and give emergency treatment.

The first attending provider must immediately complete and forward a report of the injury or illness to the department or self-insurer and instruct and assist the injured worker in completing his/her portion of the report of the injury or illness. In filing a claim, the following information is necessary so there is no delay in adjudication of the claim or payment of compensation.

(a) Complete history of the work related accident or exposure.

(b) Complete listing of positive physical findings.

(c) Specific diagnosis with ICD-9-CM, or most current version as updated, code(s) and narrative definition relating to the injury.

(d) Type of treatment rendered.

(e) Known medical, emotional or social conditions which may influence recovery or cause complications.

(f) Estimate time-loss due to the injury or illness.

(4) Initial office and emergency room visit services may be performed by a network or nonnetwork provider. Services that are bundled with those performed during the initial visit (as defined in WAC 296-20-01002), with no additional payment being due, are part of the initial visit.

(5) When the worker needs treatment beyond the initial office or emergency room visit, the network provider continues with necessary treatment in accordance with medical aid rules. If the provider is not enrolled in the provider network and the injured worker requires additional treatment, the provider will either:

(a) Apply for the provider network (if eligible) at the time he/she files the worker's report of accident; or

(b) Refer the injured worker to a network provider of the worker's choice.

(6) If the provider is *not* the original attending provider, he/she should question the injured worker to determine whether a report of accident has been filed for the injury or condition. If no report of accident has been filed, it should be completed immediately and forwarded to the department or self-insurer, as the case may be, with information as to the name and address of original provider if known, so that he/she may be contacted for information if necessary. A worker must complete a request for transfer as outlined in WAC 296-20-065 if a report of accident has previously been filed and the provider is not enrolled in the provider network or the worker and provider agree that a change in attending provider is desirable.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-06-066, § 296-20-025, filed 3/6/12, effective 4/6/12. Statutory Authority: RCW 51.04.020, 51.04.030, and Title 51 RCW. 08-24-047, § 296-20-025, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-025, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-025, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-025, filed 6/1/71; Order 70-12, § 296-20-025, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-025, filed 11/27/68, effective 1/1/69.]

MEDICAL COVERAGE DECISIONS

WAC 296-20-02700 What is a medical coverage decision? A medical coverage decision is a general policy decision by the director or the director's designee to include or exclude a specific health care service or supply as a covered benefit. These decisions are made to insure quality of care and prompt treatment of workers. Medical coverage decisions include, but are not limited to, decisions on health care services and supplies rendered for the purpose of diagnosis, treatment or prognosis, such as:

- Ancillary services including, but not limited to, home health care services, ambulatory services, specific rehabilitative modalities;
- Devices;
- Diagnostic tests;
- Drugs, biologics, and other therapeutic modalities;
- Durable medical equipment;
- Procedures;
- Prognostic tests; and
- Supplies.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02700, filed 12/7/99, effective 1/8/00.]

WAC 296-20-02701 Who makes medical coverage decisions? The director or the director's designee makes medical coverage decisions.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02701, filed 12/7/99, effective 1/8/00.]

WAC 296-20-02702 Who uses medical coverage decisions? Self-insured employers and state fund claim managers use medical coverage decisions to help them make claim-specific decisions. For example, the director or director's designee may find that a particular medical device is effective in treating a specific category of injuries. The medical coverage decision might be that that device is a covered benefit for that category of injuries. The self-insured employer or state fund claim manager would make a claim-specific decision to pay or deny payment for that device based on a number of factors, one of which is whether the accepted condition on that claim matches the approved category of injuries in the medical coverage decision.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02702, filed 12/7/99, effective 1/8/00.]

WAC 296-20-02703 How can I determine if a specific health care service or supply is the subject of a medical coverage decision? (1) The *Medical Aid Rules*, fee schedules, and provider bulletins and updates specify covered and noncovered services and supplies.

(2) For additional information on existing medical coverage decisions or if you have a question about a new and emerging technology, device, or off-label use of a drug, contact the office of the medical director at:

Department of Labor and Industries
Office of the Medical Director
P.O. Box 44321
Olympia, WA 98504-4321

(3) For questions about what will be authorized on a specific claim, contact the self-insured employer or state fund claim manager.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02703, filed 12/7/99, effective 1/8/00.]

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

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

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

(2) Scientific evidence.

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

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

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

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

(3) National and community-based opinion.

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

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

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

• The industrial insurance medical advisory committee;
• The industrial insurance chiropractic advisory committee.
• The Washington state pharmacy and therapeutics committee.
• The Washington state health technology assessment clinical committee.

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

(5) Experience of the department and other entities.

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

(6) Regulatory status.

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

• The federal food and drug administration's (FDA) regulation of drugs and medical devices (21 U.S.C. 301 et seq. and 21 C.F.R. Chapter 1, Subchapters C, D, & H consistent with the purposes of this chapter, and as now or hereafter amended); and
• The Washington state department of health's regulation of scope of practice and standards of practice for licensed health care professionals regulated under Title 18 RCW.

[Statutory Authority: 2007 c 282, RCW 51.04.02 [51.04.020], 51.04.030. 08-02-020, § 296-20-02704, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-02704, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02704, filed 12/7/99, effective 1/8/00.]

WAC 296-20-02705 What are treatment and diagnostic guidelines and how are they related to medical coverage decisions? (1) Treatment and diagnostic guidelines are developed by the department for the diagnosis or treatment of accepted conditions. These guidelines are developed to give

providers a range of the many treatment or diagnostic options available for a particular medical condition. Treatment and diagnostic guidelines are a combination of the best available scientific evidence and a consensus of expert opinion.

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

• The industrial insurance medical advisory committee;

• The industrial insurance chiropractic advisory committee.

• The Washington state pharmacy and therapeutics committee.

• The Washington state health technology assessment clinical committee.

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

(4) Network providers are required to follow the department's evidence-based coverage decisions, treatment guidelines, and policies.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-23-020, § 296-20-02705, filed 11/13/12, effective 12/14/12. Statutory Authority: 2007 c 282, RCW 51.04.02 [51.04.020], 51.04.030. 08-02-020, § 296-20-02705, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-02705, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02705, filed 12/7/99, effective 1/8/00.]

WAC 296-20-02850 When may the department cover controversial, obsolete, investigational or experimental treatment? (1) The department or self-insurer will not authorize nor pay for treatment measures of a controversial, obsolete, investigational or experimental nature. (See WAC 296-20-03002.) Under certain conditions, the director or the director's designee may determine that such treatment is appropriate. In making such a decision, the director or director's designee will consider factors including, but not limited to, the following:

(a) Scientific studies investigating the safety and efficacy of the treatment are incomplete, or if completed, have conflicting conclusions, and:

• Preliminary data indicate the treatment or diagnostic procedure or device has improved net health and functional outcomes; and

• No alternative treatment or diagnostic is available; or

(b) The treatment or diagnostic procedure or device is prescribed as part of:

• A controlled, clinical trial that has been reviewed and approved by an institutional review board that was established in accordance with the federal Department of Health and Human Services (DHHS) regulations (45 C.F.R. Part 46 consistent with the purposes of this chapter, and as now or hereafter amended); and

• For medical devices not yet cleared for marketing, the clinical evaluation has an approved investigational device exemption (IDE) in accordance with the federal Food and Drug Administration (FDA) regulations (21 C.F.R. Parts 50, 56, and 812 consistent with the purposes of this chapter, and as now or hereafter amended); and

• For drugs not yet cleared for marketing, the clinical evaluation has been approved in accordance with the federal Food and Drug Administration (FDA) regulations (21 C.F.R. Part 312 consistent with the purposes of this chapter, and as now or hereafter amended); or

(c) The usually indicated procedure or diagnostic test would likely be harmful for the patient because of other unrelated conditions.

(2) The health care provider must submit a written request and obtain approval from the department or self-insurer, prior to using a controversial, obsolete, investigational, or experimental treatment. The written requests must contain a description of the treatment, the reason for the request, potential risks and expected benefits, length of care and estimated cost of treatment.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-037, § 296-20-02850, filed 12/7/99, effective 1/8/00.]

TREATMENT AUTHORIZATION REQUIREMENTS

WAC 296-20-030 Treatment not requiring authorization for accepted conditions. (1) A maximum of twenty office calls for the treatment of the industrial condition, during the first sixty days, following injury. Subsequent office calls must be authorized. Reports of treatment rendered must be filed at sixty 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 physical therapy treatments as provided by chapters 296-21, 296-23, and 296-23A WAC, upon consultation by the attending doctor or under his 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 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.

[Statutory Authority: RCW 70.14.110, 51.04.020, and 51.04.030. 12-12-059, § 296-20-030, filed 6/5/12, effective 7/6/12. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-030, filed 12/7/99, effective 1/20/00. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-030, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-030, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4),

51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-030, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-030, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-030, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-030, filed 11/28/75, effective 1/1/76; Order 74-7, § 296-20-030, filed 1/30/74; Order 71-6, § 296-20-030, filed 6/1/71; Order 70-12, § 296-20-030, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-030, filed 11/27/68, effective 1/1/69.]

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; ICD-9-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 visits or sixty 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 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. The attending doctor must submit justification for an additional three injections if indicated with a maximum of six injections to be authorized for any one patient.

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 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 can be performed in other than a hospital inpatient setting. Where a worker has a medical condition which necessitates a hospital admission, prior approval of the department or self-insurer must be obtained.

[Statutory Authority: RCW 70.14.110, 51.04.020, and 51.04.030. 12-12-059, § 296-20-03001, filed 6/5/12, effective 7/6/12. Statutory Authority: RCW 51.04.020, 51.04.030, and Title 51 RCW. 08-24-047, § 296-20-03001, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.060, 51.32.072, and 7.68.070. 01-18-041, § 296-20-03001, filed 8/29/01, effective 10/1/01. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-03001, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-03001, filed 2/2/90, effective 3/5/90; 86-20-074 (Order 86-36), § 296-20-03001, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-03001, filed 2/28/86, effective 4/1/86; 83-16-066 (Order 83-23), § 296-20-03001, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-03001, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-03001, filed 12/23/80, effective 3/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-03001, filed 11/30/79, effective 1/1/80; Order 76-34, § 296-20-03001, filed 11/24/76, effective 1/1/77.]

WAC 296-20-03002 Treatment not authorized. The department or self-insurer will not allow nor pay for following treatment:

(1) Use of diapulse, thermatic (standard model only), spectrowave and superpulse machines on workers entitled to benefits under the Industrial Insurance Act.

(2) Iontophoresis; prolotherapy; acupuncture; injections of colchicine; injections of fibrosing or sclerosing agents; and injections of substances other than anesthetic or contrast into the subarachnoid space (intra-thecal injections).

(3) Treatment to improve or maintain general health (i.e., prescriptions and/or injection of vitamins or referrals to special programs such as health spas, swim programs, exercise programs, athletic-fitness clubs, diet programs, social counseling).

(4) Continued treatment beyond stabilization of the industrial condition(s), i.e., maintenance care, except where necessary to monitor prescription of medication necessary to maintain stabilization i.e., anti-convulsive, anti-spasmodic, etc.

(5) After consultation and advice to the department or self-insurer, any treatment measure deemed to be dangerous or inappropriate for the injured worker in question.

(6) Treatment measures of an unusual, controversial, obsolete, or experimental nature (see WAC 296-20-045). Under certain conditions, treatment in this category may be approved by the department or self-insurer. Approval must be obtained prior to treatment. Requests must contain a description of the treatment, reason for the request with benefits and results expected.

(7) Therapeutic medial branch block injections, therapeutic intradiscal injections, and therapeutic facet injections of the spine.

(8) Transcutaneous, interferential, and percutaneous nerve stimulators used in the home setting, and all associated supplies and equipment.

[Statutory Authority: RCW 70.14.110, 51.04.020, and 51.04.030. 12-12-059, § 296-20-03002, filed 6/5/12, effective 7/6/12. Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-03002, filed 9/30/09, effective 11/1/09. Statutory Authority: RCW 51.04.020, 51.04.030. 06-15-110, § 296-20-03002, filed 7/18/06, effective 8/18/06. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-03002, filed 2/28/86, effective 4/1/86; 83-16-066 (Order 83-23), § 296-20-03002, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-03002, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-03002, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-03002, filed 11/24/76, effective 1/1/77.]

WAC 296-20-03004 Chemonucleolysis. Chymopapain injections may be authorized in the treatment of lumbar disc disease under the following limitations and criteria:

(1) Only physicians (a) who routinely care for patients with herniated lumbar intervertebral discs, (b) who are qualified by training and experience to diagnose lumbar disc disease and to perform laminectomy, discectomy or other spinal procedures, (c) who have received specialized training in chemonucleolysis, may administer the procedure for industrial injured workers covered under state industrial insurance fund or self-insurance.

(2) Preadministration work-up shall include but is not limited to (a) a concurring opinion from a physician familiar with the procedure and qualified by training and experience to diagnose and treat lumbar disc disease, (b) diagnostic studies indicative of level of disc herniation i.e., myelogram, a high resolution CT scan, discogram, etc., (c) other diagnostic studies including sedimentation rate (anaphylaxis has occurred primarily in females with sedimentation rates in excess of 20 mm per hour) as indicated for the individual patient.

(3) Procedure will be authorized (a) one time only in the treatment life of any given patient, (b) maximum of two levels per patient (Generally only one level will be authorized. Indications for a second level are infrequent. However, authorization may be granted if diagnostic studies and/or concurring opinion so indicates.), (c) only for patients who have had no previous lumbar surgery at that level.

(4) Procedure must be carried out in hospital setting under radiographic or fluoroscopic control, with a permanent X-ray record maintained.

(5) **Prior authorization from the department or the self-insurer must be obtained before procedure is scheduled.**

(6) These rules were formulated based upon the recommendations of the Federal Food and Drug Administration, the drug manufacturer, and the industrial insurance committee of the Washington state medical association.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 83-16-066 (Order 83-23), § 296-20-03004, filed 8/2/83.]

MEDICATION RULES

WAC 296-20-03005 Inoculation or immunological treatment for exposure to infectious occupational disease. Authorization for inoculation or other immunological treatment for occupational disease shall be given only in cases in which a work related activity has resulted in probable exposure of the worker to a potential infectious occupational disease. In no case shall such inoculation or immunological treatment be authorized until such time as a work related activity has resulted in such probable exposure. Inoculation or other treatment required as a condition for employment or otherwise obtained prior to the worker's performing a work related activity resulting in probable exposure to an occupational disease shall not be authorized. For purposes of this section, probable exposure is an incident which gives rise to a clear and immediate likelihood of contracting an occupational disease process.

[Statutory Authority: RCW 51.04.020(4), 51.04.030 and 51.36.010. 86-18-025 (Order 86-34), § 296-20-03005, filed 8/27/86, effective 11/1/86.]

WAC 296-20-03010 What are the general principles the department uses to determine coverage on drugs and medications? The department or self-insurer pays for drugs that are deemed proper and necessary to treat the industrial injury or occupational disease accepted under the claim. In general, the department will consider coverage for all FDA approved drugs for stated indications. The department or self-insurer may pay for prescriptions for off label indications when used within current medical standards and prescribed in compliance with published contraindications, precautions and warnings.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03010, filed 12/7/99, effective 1/20/00.]

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

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

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

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

tor/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks or the nonendorsing practitioner has received prior authorization from the department to fill the prescription as written, in which case the pharmacist shall dispense the prescribed nonpreferred drug.

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

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

[Statutory Authority: RCW 51.04.020, 51.04.030. 07-17-167, § 296-20-03011, filed 8/22/07, effective 9/22/07. Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-03011, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03011, filed 12/7/99, effective 1/20/00.]

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

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

• **Allowed**

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

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

• **Prior authorization required**

Drugs used routinely to treat conditions not normally accepted as work related injuries, drugs which are used to treat unrelated conditions retarding recovery from the accepted condition on the claim, and drugs for which less expensive alternatives exist. For example: All drugs to treat hypertension require prior authorization because hypertension is not normally an accepted industrial condition. In addition, nonendorsing practitioners must obtain prior authorization for a nonpreferred drug when the category of drugs has a preferred drug.

• **Denied**

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

Example: Most hormones, most nutritional supplements.

[Statutory Authority: RCW 51.04.020, 70.14.050. 04-08-040, § 296-20-03012, filed 3/30/04, effective 5/1/04. Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03012, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03013 Will the department or self-insurer pay for a denied outpatient drug in special circumstances? Some of the drugs that are routinely denied may be covered in special circumstances. Requests for coverage under special circumstances require authorization prior to treatment. Examples of drugs that may be covered in special circumstances include:

• Drugs and medications to treat unrelated conditions when retarding recovery;

• Special treatments for unique catastrophic injuries.

The department may require written documentation to support the request.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03013, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03014 Which drugs have specific limitations? (1) **Injectables.** Prescriptions for injectable opioids or other analgesics, sedatives, antihistamines, tranquilizers, psychotropics, vitamins, minerals, food supplements, and hormones are not covered.

Exceptions: The department or self-insurer covers injectable medications under the following circumstances.

(a) Indicated injectable drugs for the following:

• Inpatients; or

• During emergency treatment of a life-threatening condition/injury; or

• During outpatient treatment of severe soft tissue injuries, burns or fractures when needed for dressing or cast changes; or

• During the perioperative period and the postoperative period, not to exceed forty-eight hours from the time of discharge.

(b) Prescriptions of injectable insulin, heparin, antimigraine medications, or impotency treatment, when proper and necessary.

(2) **Noninjectable scheduled drugs administered by other than the oral route.** Nonoral routes of administration of scheduled drugs that result in systemic availability of the drug equivalent to injectable routes will also not be covered.

(3) **Sedative-hypnotics.** During the chronic stage of an industrial injury or occupational disease, payment for scheduled sedatives and hypnotics will not be authorized.

(4) **Benzodiazepines.** Payment for prescriptions for benzodiazepines are limited to the following types of patients:

• Hospitalized patients;

• Claimants with an accepted psychiatric disorder for which benzodiazepines are indicated;

• Claimants with an unrelated psychiatric disorder that is retarding recovery but which the department or self-insurer has temporarily authorized treatment (see WAC 296-20-055) and for which benzodiazepines are indicated; and

• Other outpatients for not more than thirty days for the life of the claim.

(5) **Cancer.** When cancer or any other end-stage disease is an accepted condition, the department or self-insurer may authorize payment for any indicated scheduled drug and by any indicated route of administration.

(6) **Spinal cord injuries.** When a spinal cord injury is an accepted condition, the department or self-insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Note: See the department formulary for specific limitations and prior authorization requirements of other drugs.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03014, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03015 What steps may the department or self-insurer take when concerned about the amount or appropriateness of drugs and medications prescribed to the injured worker? (1) The department or self-insurer may take any or all of the following steps when concerned about the amount or appropriateness of drugs the patient is receiving:

• Notify the attending physician of concerns regarding the medications such as drug interactions, adverse reactions, prescriptions by other providers;

• Require that the attending physician send a treatment plan addressing the drug concerns;

• Request a consultation from an appropriate specialist;

• Request that the attending physician consider reducing the prescription, and provide information on chemical dependency programs;

• Limit payment for drugs on a claim to one prescribing doctor.

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

(3) Physician failure to reduce or terminate prescription of controlled substances, habit forming or addicting medications, or dependency inducing medications, after department or self-insurer request to do so for an injured worker may result in a transfer of the worker to another physician of the worker's choice. (See WAC 296-20-065.)

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

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03015, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03016 Is detoxification and/or chemical dependency treatment covered? The department or self-insurer may pay for detoxification and/or chemical dependency treatment in the following circumstances:

• The injured worker becomes dependent or toxic on medication prescribed for an accepted condition on the claim; or

• The injured worker becomes dependent or toxic due to medications prescribed for a condition retarding recovery of the accepted condition on the claim; or

• The injured worker is dependent or toxic due to medications for an unrelated condition, but that dependency or toxicity is retarding recovery of the accepted condition.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03016, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03017 What information is needed for prescriptions and the physician's record? Prescriptions must include the department authorized provider number for the prescribing physician and the physician's signature. The physician's record must contain the name and reason for the medication, the dosage, quantity prescribed and/or dispensed, the route of administration, the frequency, the starting and stopping dates, the expected outcome of treatment, and any adverse effects that occur. Please refer to WAC 296-20-03021 and 296-20-03022 for additional documentation requirements when treating chronic, noncancer pain.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03017, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03018 What inpatient drugs are covered? In general, the department or self-insured employer pays for most drugs in an inpatient hospital setting. Please see WAC 296-20-075, Hospitalization.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03018, filed 12/7/99, effective 1/20/00.]

OPIOIDS FOR NONCANCER PAIN

WAC 296-20-03019 Under what conditions will the department or self-insurer pay for oral opioid treatment for chronic, noncancer pain? Chronic, noncancer pain may develop after an acute injury episode. It is defined as pain that typically persists beyond two to four months following the injury.

The department or self-insurer may pay for oral opioids for the treatment of chronic, noncancer pain caused by an accepted condition when that treatment is proper and necessary. See WAC 296-20-01002 for the definition of "proper and necessary" health care services.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03019, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03020 What are the authorization requirements for treatment of chronic, noncancer pain with opioids? No later than thirty days after the attending physician begins treating the worker with opioids for chronic, noncancer pain, the attending physician must submit a written report to the department or self-insurer in order for the department or self-insurer to pay for such treatment. The written report must include the following:

• A treatment plan with time-limited goals;

• A consideration of relevant prior medical history;

• A summary of conservative care rendered to the worker that focused on reactivation and return to work;

• A statement on why prior or alternative conservative measures may have failed or are not appropriate as sole treatment;

• A summary of any consultations that have been obtained, particularly those that have addressed factors that may be barriers to recovery;

• A statement that the attending physician has conducted appropriate screening for factors that may significantly increase the risk of abuse or adverse outcomes (e.g., a history of alcohol or other substance abuse); and

• An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement must be renewed every six months. The treatment agreement must outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in pain and function, and the worker's responsibilities.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03020, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03021 What documentation is required to be submitted for continued coverage of opioids to treat chronic, noncancer pain? In addition to the general documentation required by the department or self-insurer, the attending physician must submit the following information at least every sixty days when treating with opioids:

• Documentation of drug screenings, consultations, and all other treatment trials;

• Documentation of outcomes and responses, including pain intensity and functional levels; and

• Any modifications to the treatment plan.

The physician must use a form developed by the department, or a substantially equivalent form, to document the patient's improvement in pain intensity and functional levels. This form may be included as part of a sixty-day report.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03021, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03022 How long will the department or self-insurer continue to pay for opioids to treat chronic, noncancer pain? The department or self-insurer will continue to pay for treatment with opioids so long as the physician documents:

• Substantial reduction of the patient's pain intensity; and

• Continuing substantial improvement in the patient's function.

Once the worker's condition has reached maximum medical improvement, further treatment with opioids is not payable. Opioid treatment for chronic, noncancer pain past the first three months of such treatment without documentation of substantial improvement is presumed to be not proper and necessary.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03022, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03023 When may the department or self-insurer deny payment of opioid medications used to treat chronic, noncancer pain? Payment for opioid medications may be denied in any of the following circumstances:

• Absent or inadequate documentation;

• Noncompliance with the treatment plan;

• Pain and functional status have not substantially improved after three months of opioid treatment; or

• Evidence of misuse or abuse of the opioid medication or other drugs, or noncompliance with the attending physician's request for a drug screen.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03023, filed 12/7/99, effective 1/20/00.]

WAC 296-20-03024 Will the department or self-insurer pay for nonopioid medications for the treatment of chronic, noncancer pain? The department or self-insurer may pay for nonopioid medication for the treatment of chronic, noncancer pain when it is proper and necessary.

For example, some drugs such as anti-convulsants, antidepressants, and others have been demonstrated to be useful in the treatment of chronic pain and may be approved when proper and necessary.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 00-01-040, § 296-20-03024, filed 12/7/99, effective 1/20/00.]

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

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-035, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.040.030 [51.04.030]. 87-08-004 (Order 87-09), § 296-20-035, filed 3/20/87. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-035, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-035, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-035, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-035, filed 6/1/71; Order 70-12, § 296-20-035, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-035, filed 11/27/68, effective 1/1/69.]

WAC 296-20-045 Consultation requirements. In the event of complication, controversy, or dispute over the treatment aspects of any claim, the department or self-insurer will not authorize treatment until the attending doctor has arranged a consultation with a qualified doctor with experience and expertise on the subject, and the department or self-insurer has received notification of the findings and recommendations of the consultant.

This consultation must be arranged in accordance with WAC 296-20-051.

Consultations are also required in the following situations:

(1) All nonemergent major surgery on a patient with serious medical, emotional or social problems which are likely to complicate recovery.

(2) All procedures of a controversial nature or type not in common use for the specific condition.

(3) Surgical cases where there are complications or unfavorable circumstances such as age, preexisting conditions or interference with occupational requirements, etc.

(4) If the attending doctor, the department, self-insurer, or authorized department representative requests a consultation.

(5) Conservative care, (e.g., nonsurgical cases) extending past one hundred twenty days following initial visit. Such consultation may be with a chiropractic or a medical or osteopathic consultant.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-045, filed 2/2/90, effective 3/5/90. Statutory Authority: RCW 51.04.-020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-045, filed 12/23/80, effective 3/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-045, filed 11/30/79, effective 1/1/80; Order 71-6, § 296-20-045, filed 6/1/71; Order 70-12, § 296-20-045, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-045, filed 11/27/68, effective 1/1/69.]

WAC 296-20-051 Consultations. In cases presenting diagnostic or therapeutic problems to the attending doctor, consultation with a specialist will be allowed without prior authorization. The consultant must submit his findings and recommendations immediately to the attending doctor and the department or self-insurer. Refer to chapter 296-20 WAC and department policy for reporting requirements.

Whenever possible, the referring doctor should make his X rays and records available to the consultant to avoid unnecessary duplication. The department's consultation referral form may be used to convey information to the consultant. Consultants may proceed with indicated and reasonable X rays or laboratory work and reasonable diagnostic studies as permitted within their scope of practice.

Consultations will be held with a specialist within a reasonable geographic area. Whenever possible, consultation should be made with a doctor outside the referring doctor's office or partnership.

The attending doctor will not arrange a consultation if he has received notification that a special or commission examination is being arranged by the department or self-insurer. If he has had recent consultation and is notified that the department or self-insurer is arranging an examination, he must immediately advise the department or self-insurer of the consultation.

The consultation fee will be paid only if a consultation report is complete and contains all pathological findings as well as all pertinent negative or normal findings. The report must be received in the department within fifteen days from the date of the consultation. No fee is paid to the consultant if the worker fails the appointment.

The consultant may not order, prescribe, or provide treatment without the approval of the attending doctor and the injured worker. No transfer will be made to the consultant without the prior approval of the attending doctor and the injured worker.

Consultation services will not be reimbursed for workers who are currently, or have been under the physician's care within the last three years. Such services should be billed as follow up visits, as listed in the fee schedules.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-051, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-051, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-051, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-051, filed 6/1/71; Order 70-12, § 296-20-051, filed 12/1/70, effective 1/1/71. Formerly WAC 296-20-070.]

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 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 was receiving treatment prior to his industrial injury or occupational disease, which is not retarding recovery of his 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.

[Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-055, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-055, filed 6/1/71; Order 70-12, § 296-20-055, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-055, filed 11/27/68, effective 1/1/69.]

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

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Report of Industrial Injury 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, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.
Sixty Day (narrative) **Purpose:** Support and document the need for continued care when conservative (nonsurgical) treatment is to continue beyond sixty days	Every sixty days when only conservative (nonsurgical) care has been provided.	(1) The **conditions diagnosed,** including ICD-9-CM codes and the subjective complaints and objective findings.	Providers may submit legible comprehensive chart notes in lieu of sixty day reports **PROVIDED** the chart notes include all the information required as noted in the "What Information Should Be Included?" column.
		(2) The **relationship of diagnoses,** if any, to the industrial injury or exposure.	**However,** office notes are not acceptable in lieu of requested narrative reports and providers may not bill for the report if chart notes are submitted in place of the report.
		(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. (4) **Current medications,** including dosage and amount prescribed. With repeated prescriptions, include the plan and need for continuing medication. (5) If the worker has not returned to work, **indicate whether a vocational assessment will be necessary** to evaluate the worker's ability to return to work and why. (6) If the worker has not returned to work, a **doctor's estimate of physical capacities** should be included. (7) **Response to any specific questions** asked by the insurer or vocational counselor.	Please see WAC 296-20-03021 and 296-20-03022 for documentation requirements for those workers receiving opioids to treat chronic non-cancer pain. Providers must **include** their **name, address and date** on all chart notes submitted.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Special Reports/Follow-up Reports (narrative)	As soon as possible following request by the department/insurer.	**Response to any specific questions** asked by the insurer or vocational counselor.	"Special reports" are payable only when requested by the insurer.
Consultation Examination Reports (narrative)	At one hundred twenty days if only conservative (nonsurgical) care has been provided.	(1) Detailed history.	If the injured/ill worker had been seen by the consulting doctor within the past three years for the same condition, the consultation will be considered a follow-up office visit, not consultation.
Purpose: Obtain an objective evaluation of the need for ongoing conservative medical management of the worker. The attending or treating provider may choose the consultant.		(2) **Comparative history** between the history provided by the attending or treating provider and injured worker. (3) Detailed physical examination. (4) **Condition(s) diagnosed** including ICD-9-CM codes, subjective complaints and objective findings. (5) Outline of **proposed treatment program:** Its length, components, expected prognosis including when treatment should be concluded and condition(s) stable. (6) **Expected degree of recovery** from the industrial condition. (7) **Probability of returning to regular work** or modified work and an **estimated** return to work **date.** (8) **Probability,** if any, of **permanent partial disability** resulting from the industrial condition. (9) A doctor's **estimate of physical capacities** should be included if the worker has not returned to work. (10) **Reports** of necessary, reasonable **X ray** and **laboratory** studies to establish or confirm diagnosis when indicated.	A copy of the consultation report must be submitted to both the attending or treating provider and the department/insurer.
Attending Provider Review of IME Report (form)	As soon as possible following request by the department/insurer.	Agreement or disagreement with IME findings. If you disagree, provide objective/subjective findings to support your opinion.	Payable only to the attending provider upon request of the department/insurer. PAs can concur with treatment recommendations but not PPD ratings.

Report	*Due/Needed by Insurer*	*What Information Should Be Included In the Report?*	*Special Notes*
Purpose: Obtain the attending provider's opinion about the accuracy of the diagnoses and information provided based on the IME.			
Loss of Earning Power (form) **Purpose:** Certify the loss of earning power is due to the industrial injury/occupational disease.	As soon as possible after receipt of the form.	See form	Payable only to the attending or treating provider.
Application to Reopen Claim Due to Worsening of Condition (form) **Purpose:** Document worsening of the accepted condition and need to reopen claim for additional treatment.	Immediately following identification of worsening after a claim has been closed for sixty days. **Crime Victims:** Following identification of worsening after a claim has been closed for ninety days.	See form	Only MD, DO, DC, ND, DPM, DDS, ARNP, PA, and OD may sign and be paid for completion of this form.

What documentation is required for initial and follow up visits?

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

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

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

Provider	Chart Notes	Reports
Audiology	X	X
Biofeedback	X	X
Dietician		X
Drug & Alcohol Treatment	X	X
Free Standing Surgery	X	X
Free Standing Emergency Room	X	X
Head Injury Program	X	X
Home Health Care		X
Infusion Treatment, Professional Services		X
Hospitals	X	X
Laboratories		X
Licensed Massage Therapy	X	X
Medical Transportation		X
Nurse Case Managers		X
Nursing Home	X	X
Occupational Therapist	X	X
Optometrist	X	X
Pain Clinics	X	X
Panel Examinations		X
Physical Therapist	X	X
Prosthetist/Orthotist	X	X
Radiology		X
Skilled Nursing Facility	X	X
Speech Therapist	X	X

[Statutory Authority: 2007 c 263, RCW 51.04.020 and 51.04.030. 08-04-095, § 296-20-06101, filed 2/5/08, effective 2/22/08. Statutory Authority: 2004 c 65 and 2004 c 163. 04-22-085, § 296-20-06101, filed 11/2/04, effective 12/15/04. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.-060. 00-01-190, § 296-20-06101, filed 12/22/99, effective 1/24/00. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-06101, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-06101, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-06101, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-06101, filed 12/23/80, effective 3/1/81; Order 74-39, § 296-20-06101, filed 11/22/74, effective 1/1/75.]

WAC 296-20-065 Transfer of providers. For services or provider types where the department has established the provider network, the injured worker must select an attending provider from the provider network for all care beyond the initial visit. If the initial office or emergency room visit was completed with a nonnetwork provider and additional treatment is needed, the worker must transfer care to a network provider and promptly inform the department or self-insurer.

All transfers from one network provider to another must be approved by the department or self-insurer. Normally transfers will be allowed only after the worker has been under the care of the attending provider for sufficient time for the provider to: Complete necessary diagnostic studies, establish an appropriate treatment regimen, and evaluate the efficacy of the therapeutic program.

Under RCW 51.36.010 the worker is entitled to free choice of treating provider. Except as provided under subsections (1) through (7) of this section, no reasonable request for transfer to a network provider will be denied. The worker must be advised when and why a transfer is denied.

When a transfer is approved, the new attending provider must be provided with a copy of the worker's treatment record by the previous attending provider. X rays in the possession of the previous attending provider must be immediately forwarded to the new attending provider for his or her retention as long as the worker remains under his or her care. Copies of X rays and other records may be provided in lieu of originals.

The department or self-insurer reserves the right to require a worker to select another provider or specialist for treatment, under the following conditions:

(1) When more conveniently located providers, qualified to provide the necessary treatment, are available.

(2) When the attending provider fails to cooperate in observance and compliance with the department rules.

(3) In time loss cases where reasonable progress towards return to work is not shown.

(4) Cases requiring specialized treatment, which the attending provider is not qualified to render, or is outside the scope of the attending provider's license to practice.

(5) Where the department or self-insurer finds a transfer of provider to be appropriate and has requested the worker to transfer in accordance with this rule, the department or self-insurer may select a new attending provider if the worker unreasonably refuses or delays in selecting another attending provider.

(6) In cases where the attending provider is not qualified to treat each of several accepted conditions. This does not preclude concurrent care where indicated. See WAC 296-20-071.

(7) No transfer will be approved to a consultant or special examiner without the approval of the attending provider and the worker.

Transfers will be authorized for the foregoing reasons or where the department or self-insurer in its discretion finds that a transfer is in the best interest of returning the worker to a productive role in society.

When a worker's care is transferred to another provider each provider must submit a separate bill to the department or self-insurer for their portion of the care. Payment will be made at rates determined by department policy.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-06-066, § 296-20-065, filed 3/6/12, effective 4/6/12. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-065, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-065, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-065, filed 12/23/80, effective 3/1/81; Order 77-27, § 296-20-065, filed 11/30/77, effective 1/1/78; Emergency Order 77-26, § 296-20-065, filed 12/1/77; Emergency Order 77-16, § 296-20-065, filed 9/6/77; Order 75-39, § 296-20-065, filed 11/28/75, effective 1/1/76; Order 74-7, § 296-20-065, filed 1/30/74; Order 71-6, § 296-20-065, filed 6/1/71; Order 70-12, § 296-20-065, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-065, filed 11/27/68, effective 1/1/69.]

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 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.

[Statutory Authority: RCW 51.04.020, 51.04.030. 09-14-104, § 296-20-071, filed 6/30/09, effective 7/31/09. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-071, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-071, filed 12/23/80, effective 3/1/81; Order 75-39, § 296-20-071, filed 11/28/75, effective 1/1/76; Order 70-12, § 296-20-071, filed 12/1/70, effective 1/1/71. Formerly WAC 296-20-060.]

WAC 296-20-075 Hospitalization. (1) Hospitalization will be paid for proper and necessary medical treatment of the accepted condition(s). The department may develop and implement utilization management criteria which will be used to review inpatient hospital admissions. Reimbursement for hospitalization is limited to proper and necessary care for an accepted condition. Failure to comply with these criteria may result in delayed or reduced reimbursement to the provider as allowed under chapter 51.48 RCW. Ward or semi-private accommodations will be paid, unless the worker's condition requires special care.

(2) Discharge from the hospital shall be at the earliest date possible consistent with proper health care. If additional treatment is needed, discharge planning must include referral to a network provider. If transfer to a convalescent center or nursing home is indicated, prior arrangements should be made with the department or self-insurer. See WAC 296-20-091 for further information. The department may designate those diagnostic and surgical procedures which will be reimbursed only if performed in an outpatient setting. When procedures so designated must be performed in an inpatient setting for reasons of medical necessity, prior authorization must be obtained.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-06-066, § 296-20-075, filed 3/6/12, effective 4/6/12. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-20-075, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-20-075, filed 11/30/87, effective 1/1/88; 86-20-074 (Order 86-36), § 296-20-075, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-075, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120 (3). 81-01-100 (Order 80-29), § 296-20-075, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-075, filed 6/1/71; Order 70-12, § 296-20-075, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-075, filed 11/27/68, effective 1/1/69.]

WAC 296-20-081 Unrelated concurrent nonemergent surgery. Elective surgery for an unrelated condition is not normally permitted during hospitalization for an industrial condition. Under some circumstances unrelated elective surgery may be permitted through prior agreement and approval by the department provided the unrelated surgery is not more extensive than the procedure for the industrial condition. The requesting doctor must submit a written request and identify which services are needed due to the industrial

injury and which are needed due to unrelated conditions, along with an estimate of what effect, if any, the unrelated surgery will have on the accepted conditions and recovery time from surgery.

[Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-081, filed 12/23/80, effective 3/1/81; Order 70-12, § 296-20-081, filed 12/1/70, effective 1/1/71. Formerly WAC 296-20-095.]

WAC 296-20-091 Home nursing. A worker temporarily totally disabled or permanently totally disabled may either temporarily or permanently require home nursing care. A physician's request and prior department authorization are required for home nursing care.

Home health, hospice, and home care agency providers shall be licensed.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.060, 51.32.072, and 7.68.070. 01-18-041, § 296-20-091, filed 8/29/01, effective 10/1/01. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-05-041, § 296-20-091, filed 2/13/92, effective 3/15/92. Statutory Authority: RCW 51.04.-020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-091, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-091, filed 6/1/71; Order 70-12, § 296-20-091, filed 12/1/70, effective 1/1/71. Formerly WAC 296-20-080.]

WAC 296-20-097 Reopenings. When a claim has been closed by the department or self-insurer by written order and notice for sixty days, submission of a formal "application to reopen claim for aggravation of condition" form # F242-079-000 is necessary. The department or self-insurer is responsible for customary charges for examinations, diagnostic studies, and determining whether or not time-loss is payable regardless of the final action taken on the reopening application. Reopening applications should be submitted immediately. When reopening is granted, the department or self-insurer can pay time loss and treatment benefits only for a period not to exceed sixty days *prior* to date the application is received by the department or self-insurer. Necessary treatment should not be deferred pending a department or self-insurer adjudication decision. However, should reopening be denied treatment costs become the financial responsibility of the worker.

[Statutory Authority: RCW 51.04.020, 51.04.030, and Title 51 RCW. 08-24-047, § 296-20-097, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 51.32.190 and 51.32.210. 90-22-054, § 296-20-097, filed 11/5/90, effective 12/6/90. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-097, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-097, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-097, filed 6/1/71; Order 70-12, § 296-20-095 (codified as WAC 296-20-097), filed 12/1/70, effective 1/1/71. Formerly WAC 296-20-090.]

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 or injured worker. When this occurs the attending doctor should submit immediately in writing his request for reconsideration of the adjudication action, supported by an outline of:

(1) The claimant'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 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 or the injured worker within sixty days of the date of the action or order.

[Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-09701, filed 12/23/80, effective 3/1/81.]

WAC 296-20-100 Eye glasses and refractions. The department or self-insurer will be responsible one time for replacement of glasses or contact lenses only to the extent of the cost of restoring damaged item to its condition at the time of the accident. This benefit applies only if the worker was wearing the glasses or contact lens when the industrial accident occurred.

If glasses are repairable and a worker determines that he/she prefers a replacement, the department or self-insurer is responsible only for the cost of the repairs and the worker is responsible for the difference between repair and replacement costs.

Refraction to replace a broken or lost lens is only payable when it is substantiated that the prescription was not available from the broken lens or any other source. If the prescription is available, and the patient needs a new refraction, he is responsible for the costs of such exam.

If a refractive error is the result of the industrial injury or occupational disease condition, refraction and glasses or contact lenses will be authorized and paid by the department or self-insurer.

When broken or lost glasses or contact lenses are the only injury or condition suffered, the doctor's portion of the report of accident can be completed by an optometrist or other vendor furnishing the replacement. A report of accident must be received by the department or self-insurer in order to adjudicate the claim.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-100, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-100, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-100, filed 6/1/71; Order 70-12, § 296-20-100, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-100, filed 11/27/68, effective 1/1/69.]

WAC 296-20-110 Dental. Only dentists, oral surgeons or dental specialists licensed in the state in which they practice are eligible to treat workers entitled to benefits under the industrial insurance law.

If only a dental injury is involved, the doctor's portion of the report of accident must be completed by the dentist to whom the worker first reports. See WAC 296-20-025 for further information.

If the accident report has been submitted by another doctor, the dentist's report should be made by letter. In addition to the information required under WAC 296-20-025, the dentist should outline the extent of the dental injury and the treatment program necessary to repair damage due to the injury. Dental X rays should be retained by the attending dentist for a period of not less than ten years. The department or self-insurer does not require submission of the actual films except upon specific request.

The department or self-insurer is responsible only for repair or replacement of teeth injured or dentures broken as a result of an industrial accident. Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker. It is the responsibility of the dentist to advise the worker accordingly.

In cases presenting complication, controversy, or diagnostic or therapeutic problems, consultation by another dentist may be requested to support authorization for restorative repairs.

Bills covering the cost of dentures should be submitted for the denture only and should not include the cost for subsequent relining. If relining becomes necessary, authorization for relining must be obtained in advance from the department or self-insurer.

Bills must be submitted to the department or self-insurer within one year from the date the service is rendered. Bills must itemize the service rendered, including the current HCPCS Level II codes, the materials used and the injured tooth number(s). See WAC 296-20-125 and department policy for further billing rules.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 94-14-044, § 296-20-110, filed 6/29/94, effective 7/30/94; 93-16-072, § 296-20-110, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-110, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-110, filed 12/23/80, effective 3/1/81; Order 70-12, § 296-20-110, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-110, filed 11/27/68, effective 1/1/69.]

WAC 296-20-1101 Hearing aids and masking devices. The department or self-insurer is responsible for replacement or repair of hearing aids damaged or lost due to an industrial accident only to the extent of restoring the damaged item to its condition at time of the accident. If the hearing aid is repairable and the worker determines he prefers replacement, the department or self-insurer is responsible only to the extent of the cost to repair the original and the worker is responsible for the difference between repair and replacement costs.

When the department or self-insurer has accepted a hearing loss condition either as a result of industrial injury or occupational exposure, the department or self-insurer will furnish a hearing aid (hearing aids when bilateral loss is present) when prescribed or recommended by a physician.

The department or self-insurer will bear the cost of repairs or replacement due to normal wear and the cost of battery replacement for the life of the hearing aid.

If the worker has been issued a linear analog hearing aid and it becomes inoperable or if the worker is unable to hear, the department or self-insurer will replace the linear analog hearing aid with a nonlinear digital or nonlinear analog hearing aid in accordance with existing medical aid rules and fee schedules and at no cost to the worker even if the linear analog hearing aid is repairable.

In cases of accepted tinnitus, the department or self-insurer may provide masking devices under the same provisions as outlined for hearing aids due to hearing loss.

Provision of masking devices and hearing aids require prior authorization.

[Statutory Authority: RCW 51.04.020, 51.36.080, 7.68.030, 7.68.080. 08-05-093, § 296-20-1101, filed 2/15/08, effective 3/22/08. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-1101, filed 12/23/80, effective 3/1/81.]

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 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 estimate of how long the item will be needed.

The prescribing doctor 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 attending doctor. If such items are furnished by the attending doctor, the department or self-insurer will reimburse the doctor his 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.

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 depart-

ment or self-insurer may pay for rental fees of oxygen equipment beyond its purchase price.

[Statutory Authority: RCW 51.04.020 and 51.04.030. 05-23-143, § 296-20-1102, filed 11/22/05, effective 1/3/06. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-1102, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-22-052 (Order 87-22), § 296-20-1102, filed 11/2/87; 86-06-032 (Order 86-19), § 296-20-1102, filed 2/28/86, effective 4/1/86; 83-16-066 (Order 83-23), § 296-20-1102, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-1102, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-1102, filed 12/23/80, effective 3/1/81.]

WAC 296-20-1103 Travel expense. The department or self-insurer will reimburse travel expense incurred by workers for the following reasons:

(1) Examinations at department's or self-insurer's request;

(2) Vocational services at department's or self-insurer's request;

(3) Fitting of prosthetic device; and

(4) Upon *prior authorization* for treatment or vocational retraining when worker must travel more than fifteen miles one-way from the worker's home to the nearest point of adequate treatment or vocational retraining. Travel expense *is not* payable when adequate treatment is available within fifteen miles of injured worker's home, yet the injured worker prefers to report to an attending provider outside the worker's home area.

Under subsections (3) and (4) of this section, when travel expense is authorized the first fifteen miles one-way are not payable. The first and last fifteen miles are not payable on an authorized round trip.

Travel expenses will be reimbursed at the current department rate.

Receipts are required for all expenses except parking expenses under ten dollars.

Claims for reimbursement of travel expenses must be received by the department or self-insurer within one year after the date expenses are incurred. Refer to WAC 296-20-125 and to department policy for additional rules.

[Statutory Authority: RCW 51.04.020, 51.04.030. 10-15-105, § 296-20-1103, filed 7/20/10, effective 9/1/10. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-1103, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020. 91-12-010, § 296-20-1103, filed 5/30/91, effective 7/1/91. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 83-16-066 (Order 83-23), § 296-20-1103, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-1103, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-1103, filed 12/23/80, effective 3/1/81.]

WAC 296-20-120 Procedures not listed in this schedule. Procedures not specifically listed will be given values comparable to those of the listed procedures of closest similarity. Refer to chapter 296-20 WAC (including the definition section) and the fee schedules for required billing documentation.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-120, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-120, filed 12/23/80, effective 3/1/81; Order 71-6, § 296-20-120, filed 6/1/71; Order 70-12, § 296-20-120, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-120, filed 11/27/68, effective 1/1/69.]

WAC 296-20-12050 Special programs. (1) The department or self-insurer may from time to time enter into special agreements for services provided by, or under the direction of, licensed providers authorized to bill the department. Special agreements are for services other than routine services covered under the fee schedule, and may include multidisciplinary or interdisciplinary programs such as pain management, work hardening, and physical conditioning.

(2) The department shall establish payment rates for special agreements, and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements and such other criteria as will ensure injured workers receive good quality and effective services at a prudent cost.

(3) Special agreements shall be purchased at the discretion of the department or self-insurer. The department may terminate special programs from the industrial insurance program upon thirty days notice to the provider.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-24-050 (Order 87-23), § 296-20-12050, filed 11/30/87, effective 1/1/88.]

STRUCTURED INTENSIVE MULTIDISCIPLINARY PROGRAM (SIMP) FOR CHRONIC NONCANCER PAIN

WAC 296-20-12055 Structured intensive multidisciplinary program (SIMP) for chronic noncancer pain. (1) Injured workers eligible for benefits under Title 51 RCW may be evaluated for and enrolled in a comprehensive treatment program for chronic noncancer pain if it meets the definition of a structured, intensive, multidisciplinary program (SIMP). The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic noncancer pain.

(2) Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12055, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12060 SIMP requirements for lumbar fusion and artificial disc replacement candidates. Special conditions and requirements apply to workers who are considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease (referred to as lumbar surgery candidates as defined in WAC 296-20-12065). Lumbar surgery candidates must successfully complete a SIMP to obtain authorization for a lumbar fusion or a lumbar intervertebral artificial disc replacement. Refer to WAC 296-20-12095 for referral and prior authorization information.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12060, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12065 SIMP definitions. The definitions in this section refer to terms used in WAC 296-20-12055 through 296-20-12095.

(1) **SIMP** means a chronic pain management program with the following four components:

Structured means care is delivered through regular scheduled modules of assessment, education, treatment, and

follow up evaluation where workers interact directly with licensed health care practitioners. Workers follow a treatment plan designed specifically to meet their needs.

Intensive means the treatment phase is delivered on a daily basis, six to eight hours per day, five days per week, for up to four consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs.

Multidisciplinary (interdisciplinary) means that structured care is delivered and directed by licensed health care professionals with expertise in pain management in at least the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the workers' needs and covered benefits.

Program means an interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of health care systems and services.

(2) **Uncomplicated degenerative disc disease (UDDD)** means chronic low back pain of discogenic origin without objective clinical evidence of any of the following conditions:

• Radiculopathy;

• Functional neurologic deficits;

• Spondylolisthesis (> grade 1);

• Isthmic spondylolysis;

• Primary neurogenic claudication associated with stenosis;

• Fracture, tumor, infection, inflammatory disease; or

• Degenerative disease associated with significant deformity.

(3) **Lumbar surgery candidate** means an injured worker who is considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease.

(4) **Important associated conditions** means medical or psychological conditions (often referred to as comorbid conditions) that hinder functional recovery from chronic pain.

(5) **Treatment plan** means an individualized plan of action and care developed by licensed health care professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the treatment phase. It is established during the evaluation phase and may be revised during the treatment phase.

(6) **Valid tests and instruments** mean those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12065, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12070 SIMP evaluation phase. See WAC 296-20-12095 SIMP referral and prior authorization requirements, for information about how and when each phase may be prior authorized by the claim manager.

Evaluation phase:

The Evaluation phase occurs before the treatment phase and includes treatment plan development and a report. Only one evaluation is allowed per authorization but it can be conducted over one to two days. The evaluation phase includes all of the following components:

(1) A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pretreatment evaluation that are allowed by the commission on accreditation of rehabilitation facilities (CARF);

(2) Review of medical records and reports, including diagnostic tests and previous efforts at pain management;

(3) Assessment of any important associated conditions that may hinder recovery (e.g., opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease). If such conditions exist, see WAC 296-20-12095 SIMP referral and prior authorization requirements;

(4) Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs;

(5) Psychological and social assessment by a licensed clinical psychologist using valid tests and instruments;

(6) Identification of the worker's family and support resources;

(7) Identification of the worker's reasons and motivation for participation and improvement;

(8) Identification of factors that may affect participation in the program;

(9) Assessment of pain and function using valid tests and instruments; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:

• Activities of daily living (ADLs);

• Range of motion (ROM);

• Strength;

• Stamina;

• Capacity for and interest in returning to work.

(10) If the claim manager has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity;

(11) A summary report of the evaluation and a preliminary recommended treatment plan. If there are any barriers preventing the worker from moving on to the treatment phase, the report should explain the circumstances;

(12) For lumbar surgery candidates, the report should address their expectation and interest in having surgery.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12070, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12075 SIMP treatment phase. Treatment phase services may be provided for up to twenty consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts six to eight hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and

may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

(1) Graded exercise: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence;

(2) Cognitive behavioral therapy: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist or psychiatric advanced registered nurse practitioner;

(3) Coordination of health services: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the treatment plan;

• For lumbar surgery candidates, communication and consultation with the spine surgeon is recommended;

(4) Education and skill development on the factors that contribute to pain, responses to pain, and effective pain management;

• For lumbar surgery candidates, this includes provision and review of a patient education aid, provided by the insurer, describing the risks associated with lumbar fusion;

(5) Tracking of pain and function: Individual medical assessment of pain and function levels using valid tests and instruments;

(6) Ongoing assessment of important associated conditions, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment;

(7) Performance of real or simulated work or daily functional tasks;

(8) SIMP vocational services may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the return to work action plan when a vocational referral has been made;

(9) A discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the treatment phase;

(10) A report at the conclusion of the treatment phase that addresses all the following questions:

• To what extent did the worker meet his or her treatment goals?

• What changes, if any, have occurred in the worker's medical and psycho-social conditions, including dependence on opioids and other medications?

• What changes, if any, have occurred in the worker's pain level and functional capacity as measured by valid tests and instruments?

• What changes, if any, have occurred in the worker's ability to manage pain?

• What is the status of the worker's readiness to return to work or daily activities?

• What is the status of progress in achieving the goals listed in the return to work action plan, if applicable?

• How much and what kind of follow up care does the worker need?

• For lumbar surgery candidates, what is the worker's current expectation and interest in having surgery?

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12075, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12080 SIMP follow-up phase. (1) So long as the claim remains open, a follow-up phase may occur within six months after the treatment phase has concluded. This phase is not a substitute for and cannot serve as an extended treatment phase. The goals of the follow-up phase are to:

(a) Improve and reinforce the pain management gains made during the treatment phase;

(b) Help the worker integrate the knowledge and skills gained during the treatment phase into his or her job, daily activities, and family and community life;

(c) Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results;

(d) Address the goals listed in the return to work action plan if one was developed.

(2) Site of the follow-up phase. The activities of the follow-up phase may occur at the original multidisciplinary clinic (clinic-based) or at the worker's home, workplace, or health care provider office (community-based). This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow-up care at the clinic to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to health care resources.

(3) Face-to-face vs. nonface-to-face services: Follow-up services are payable as "face-to-face" and "nonface-to-face" services. Face-to-face services are when the provider interacts directly with the worker, the worker's family, employer, or other health care providers. Nonface-to-face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other health care providers for the purpose of coordinating care in the worker's home community. Both are subject to the following limits:

(a) Face-to-face services: Up to twenty-four hours are allowed with a maximum of four hours per day.

(b) Nonface-to-face services: Up to forty hours are allowed.

(4) Reporting requirements.

(a) If a worker has been receiving follow-up services, a summary report must be submitted to the insurer that provides the following information:

• The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems;

• What was done during the follow-up phase;

• What resulted from the follow-up care; and

• Measures of pain and function using valid tests and instruments.

(b) This summary report must be submitted at the following intervals:

• For nonlumbar surgery candidates: At one and three months.

• For lumbar surgery candidates (regardless of whether they had lumbar surgery after successfully completing SIMP treatment): At one, three, and six months.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12080, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12085 Requirements the SIMP provider must meet. Refer to department policy on comprehensive treatment for chronic noncancer pain for requirements the SIMP provider must meet.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12085, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12090 Requirements the worker must meet for a SIMP. An injured worker must make a good faith effort to participate and comply with the treatment plan prescribed for him or her by the SIMP provider. To successfully complete a SIMP, the worker must meet all the requirements in this section. The worker must:

(1) Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her treatment plan;

(2) Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her treatment plan;

(3) Agree to be evaluated and comply with treatment prescribed for any important associated conditions that hinder progress or recovery (e.g., opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease);

(4) Attend each day and each session that is part of his or her treatment plan. Sessions may be made up if, in the opinion of the provider, they do not interfere with the worker's progress toward treatment plan goals;

(5) Cooperate and comply with his or her treatment plan;

(6) Not pose a threat or risk to himself or herself, to staff, or to others;

(7) Review and sign a participation agreement with the provider;

(8) Participate with coordination efforts at the end of the treatment phase to help him or her transition back to his or her home, community, and workplace.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12090, filed 9/30/09, effective 11/1/09.]

WAC 296-20-12095 SIMP referral and prior authorization requirements. (1) All SIMP services require:

- Prior authorization by the claim manager; and
- A referral from the worker's attending provider.

An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider.

(2) When the attending provider refers a worker to a chronic pain management program (i.e., a SIMP), the claim manager may authorize an evaluation if the worker has had unresolved chronic pain for longer than three months despite conservative care and has one or more of the following conditions:

(a) Is unable to return to work due to the chronic pain;

(b) Has returned to work but needs help with chronic pain management;

(c) Has significant pain medication dependence, tolerance, abuse, or addiction;

(d) Is a lumbar surgery candidate. It is recommended that lumbar surgery candidates be evaluated by a SIMP provider prior to requesting surgery.

(3) Prior authorization for the evaluation phase occurs first and includes only one evaluation. Once authorized, the SIMP provider verifies the worker meets the requirements set forth in WAC 296-20-12090 and can fully participate in the program. If the worker:

(a) Meets the requirements and the SIMP provider recommends the worker move on to the treatment phase, the SIMP provider must provide the insurer with a report and treatment plan as described under the evaluation phase.

(b) Does not meet the requirements, the SIMP provider must provide the insurer with a report explaining what requirements are not met and the goals the worker must meet before he or she can return and participate in the program. If the worker is found to have important associated conditions during the evaluation phase that prevent him or her from participating in the treatment phase, the SIMP provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

(4) The treatment phase must be prior authorized separately from the evaluation phase. Treatment phase authorization includes authorization for the follow up phase.

(5) SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

(6) If a lumbar surgery candidate previously participated in a SIMP as a lumbar surgery candidate but did not successfully complete treatment, one additional SIMP may be authorized only if:

(a) The worker obtains an additional surgical recommendation noting clinical changes one year or more after the date first referred to a SIMP; or

(b) The reason the worker did not participate fully or successfully complete a SIMP the first time was because of important associated conditions that are now fully resolved.

(7) If a lumbar surgery candidate successfully completed a SIMP and did not have surgery, and in the future becomes a lumbar surgery candidate again, another SIMP may be authorized but is not required.

(8) If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the claim manager may authorize resuming or restarting the SIMP if recommended by the SIMP provider.

(9) If a SIMP provider plans to travel to the worker's community to deliver face-to-face services, mileage may be reimbursed, but only if it is authorized prior to travel. Lodging or meals (per diem expenses) are not reimbursable. Actual travel time is not included in the twenty-four-hour limit as stated in WAC 296-20-12080. When requesting prior authorization for mileage, the SIMP provider must explain the reason for the visit and how it will benefit the worker.

[Statutory Authority: RCW 70.14.120, 51.04.020, 51.04.030. 09-20-040, § 296-20-12095, filed 9/30/09, effective 11/1/09.]

WAC 296-20-121 X rays. Recognizing the greatest need for access to X rays lies with the attending doctor, 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 retain X rays for a period of not less than ten years. In transfer cases, the X rays in the possession of the current attending doctor must be made available to the new attending doctor.

When requesting consultation, the attending doctor should make any X rays in his 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 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.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-121, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-121, filed 11/30/81, effective 1/1/82; 81-01-100 (Order 80-29), § 296-20-121, filed 12/23/80, effective 3/1/81; Order 77-27, § 296-20-121, filed 11/30/77, effective 1/1/78; Emergency Order 77-26, § 296-20-121, filed 12/1/77; Emergency Order 77-16, § 296-20-121, filed 9/6/77; Order 74-39, § 296-20-121, filed 11/22/74, effective 1/1/75; Order 74-7, § 296-20-121, filed 1/30/74.]

WAC 296-20-124 Rejected and closed claims. (1) No payment will be made for treatment or medication on rejected claims except:

(a) Services which were carried out at the specific request of the department or the self-insurer; or

(b) Examination or diagnostic services which served as a basis for the adjudication decision; or

(c) Initial prescription drugs prescribed during the initial visit for state fund claims.

(2) No payment will be made for services rendered after the date of claim closure. Following the date of the order and notice of claim closure, the department or self-insurer will be responsible only for those services specifically requested or those examinations, and diagnostic services necessary to complete and file a reopening application.

(3) Periodic medical surveillance examinations will be covered by the department or self-insurer for workers with closed claims for asbestos-related disease, to include chest X-ray abnormalities, without the necessity of filing a reopening application when such examinations are recommended by accepted medical protocol.

(4) Replacement of prosthetics, orthotics, and special equipment can be provided on closed claims after prior authorization. See WAC 296-20-1102 for further information.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 2007 c 134. 08-02-021, § 296-20-124, filed 12/21/07, effective 1/21/08. Statutory Authority: Chapters 34.04 [34.05], 51.04, 51.32 and 51.36 RCW. 90-04-007, § 296-20-124, filed 1/26/90, effective 2/26/90. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-124, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-124, filed 11/24/76, effective 1/1/77.]

WAC 296-20-12401 Application process for providers outside the scope of the provider network. For providers or services not subject to the health care provider network requirements, including treatment at the initial office or emergency room visit, a provider must obtain a provider account number from the department.

(1) **How can a provider obtain a provider account number from the department?** In order to receive a provider account number from the department, a provider must:

- Complete a provider application;
- Sign a provider agreement;
- Provide a copy of any practice or other license held;
- Complete, sign and return a Form W-9; and
- Meet the department's provider eligibility requirements as cited in the department's rules.

Notes: A provider account number is required to receive payment from the department, but is not a guarantee of payment for services.
Self-insured employers may have additional requirements for provider status.

(2) **Provider account status definitions.**

- Active - Account information is current and provider is eligible to receive payment.
- Inactive - Account is not eligible to receive payment based on action by the department or at provider request. These accounts can be reactivated.
- Terminated - Account is not eligible to receive payment based on action by the department or at provider request. These accounts can not be reactivated.

(3) **When may the department inactivate a provider account?** The department may inactivate a provider account when:

- There has been no billing activity on the account for eighteen months; or
- The provider requests inactivation; or
- Provider communications are returned due to address changes; or
- The department changes the provider application or application procedures; or
- Provider does not comply with department request to update information.

(4) **When may the department terminate a provider account?** The department may terminate a provider account when:

- The provider is found ineligible to treat per department rules; or
- The provider requests termination; or
- The provider dies or is no longer in active business status.

(5) **How can a provider reactivate a provider account?** To reactivate a provider account, the provider may call or write the department. The department may require the

provider to update the provider application and/or agreement or complete other needed forms prior to reactivation. Account reactivation is subject to department review.

If a provider account has been terminated, a new provider application will be required.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. 12-06-066, § 296-20-12401, filed 3/6/12, effective 4/6/12. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-09-078, § 296-20-12401, filed 4/18/00, effective 7/1/00.]

BILLING

WAC 296-20-125 Billing procedures. All services rendered must be in accordance with the medical aid rules, fee schedules, and department policy. The department or self-insurer may reject bills for services rendered in violation of these rules. Workers may not be billed for services rendered in violation of these rules.

(1) Bills must be itemized on department or self-insurer forms or other forms which have been approved by the department or self-insurer. Bills may also be transmitted electronically using department file format specifications. Providers using any of the electronic transfer options must follow department instructions for electronic billing. Physicians, osteopaths, advanced registered nurse practitioners, chiropractors, naturopaths, podiatrists, psychologists, and registered physical therapists use the current national standard Health Insurance Claim Form (as defined by the National Uniform Claim Committee) with the bar code placed 2/10 of an inch from the top and 1 1/2 inches from the left side of the form. Hospitals use the current National Uniform Billing Form (as defined by the National Uniform Billing Committee) for institution services and the current national standard Health Insurance Claim Form (as defined by the National Uniform Claim Committee) with the bar code placed 2/10 of an inch from the top and 1 1/2 inches from the left side of the form for professional services. Hospitals should refer to chapter 296-23A WAC for billing rules pertaining to institution, or facilities, charges. Pharmacies use the department's statement for pharmacy services. Dentists, equipment suppliers, transportation services, vocational services, and massage therapists use the department's statement for miscellaneous services. When billing the department for home health services, providers should use the "statement for home nursing services." Providers may obtain billing forms from the department's local service locations.

(2) Bills must specify the date and type of service, the appropriate procedure code, the condition treated, and the charges for each service.

(3) Bills submitted to the department must be completed to include the following:

(a) Worker's name and address;

(b) Worker's claim number;

(c) Date of injury;

(d) Referring doctor's name and L & I provider account number;

(e) Area of body treated, including ICD-9-CM code(s), identification of right or left, as appropriate;

(f) Dates of service;

(g) Place of service;

(h) Type of service;

(i) Appropriate procedure code, hospital revenue code, or national drug code;

(j) Description of service;

(k) Charge;

(l) Units of service;

(m) Tooth number(s);

(n) Total bill charge;

(o) The name and address of the practitioner rendering the services and the provider account number assigned by the department;

(p) Date of billing;

(q) Submission of supporting documentation required under subsection (6) of this section.

(4) Responsibility for the completeness and accuracy of the description of services and charges billed rests with the practitioner rendering the service, regardless of who actually completes the bill form;

(5) Vendors are urged to bill on a monthly basis. Bills must be received within one year of the date of service to be considered for payment.

(6) The following supporting documentation is required when billing for services:

(a) Laboratory and pathology reports;

(b) X-ray findings;

(c) Operative reports;

(d) Office notes;

(e) Consultation reports;

(f) Special diagnostic study reports;

(g) For BR procedures - See chapter 296-20 WAC for requirements; and

(h) Special or closing exam reports.

(7) The claim number must be placed on each bill and on each page of reports and other correspondence in the upper right-hand corner.

(8) The following considerations apply to rebills.

(a) If you do not receive payment or notification from the department within one hundred twenty days, services may be rebilled.

(b) Rebills must be submitted for services denied if a claim is closed or rejected and subsequently reopened or allowed. In these instances, the rebills must be received within one year of the date the final order is issued which subsequently reopens or allows the claim.

(c) Rebills should be identical to the original bill: Same charges, codes, and billing date.

(d) In cases where vendors rebill, please indicate "REBILL" on the bill.

(9) The department or self-insurer will adjust payment of charges when appropriate. The department or self-insurer must provide the health care provider or supplier with a written explanation as to why a billing or line item of a bill was adjusted at the time the adjustment is made. A written explanation is not required if the adjustment was made solely to conform with the maximum allowable fees as set by the department. Any inquiries regarding adjustment of charges must be received in the required format within ninety days from the date of payment to be considered. Refer to the medical aid rules for additional information.

[Statutory Authority: RCW 51.04.020, 51.36.080, 7.68.030, 7.68.080. 07-08-088, § 296-20-125, filed 4/3/07, effective 5/23/07. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-125, filed

8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-16-004 (Order 87-18), § 296-20-125, filed 7/23/87; 86-20-074 (Order 86-36), § 296-20-125, filed 10/1/86, effective 11/1/86; 86-06-032 (Order 86-19), § 296-20-125, filed 2/28/86, effective 4/1/86; 83-16-066 (Order 83-23), § 296-20-125, filed 8/2/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-125, filed 12/23/80, effective 3/1/81; Order 77-27, § 296-20-125, filed 11/30/77, effective 1/1/78; Emergency Order 77-26, § 296-20-125, filed 12/1/77; Emergency Order 77-16, § 296-20-125, filed 9/6/77; Order 75-39, § 296-20-125, filed 11/28/75, effective 1/1/76; Order 74-39, § 296-20-125, filed 11/22/74, effective 1/1/75; Order 74-7, § 296-20-125, filed 1/30/74; Order 71-6, § 296-20-125, filed 6/1/71; Order 70-12, § 296-20-125, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-125, filed 11/27/68, effective 1/1/69.]

WAC 296-20-12501 Physician assistant billing procedure. Billing for physician assistant services will be paid at ninety percent of the value listed in the fee schedules. Payment will be made directly to the supervising physician.

(1) Bills must be itemized on department or self-insurer forms, as the case may be, specifying: The date, type of service and the charges for each service.

(2) The bill form must be completed in detail to include the claim number. All bills must be submitted under the physician assistant's account number. Bills will be accepted when signed by other than the practitioner rendering services. When bills are prepared by someone else, the responsibility for the completeness and accuracy of the description of services and charges rests with the supervising physician.

(3) For a bill to be considered for payment, it must be received in the department or by the self-insurer within one year from the date each specific treatment and/or service was rendered or performed. Whenever possible, bills should be submitted monthly.

(4) Bills cannot be paid for services rendered while a claim is closed.

(5) The department or self-insurer may deny payment of bills for services rendered in violation of the medical aid rules or department policy. Workers may not be billed for services rendered in violation of these rules.

[Statutory Authority: RCW 51.04.020. 03-21-069, § 296-20-12501, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-12501, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-12501, filed 11/30/79, effective 1/1/80.]

WAC 296-20-132 Determination of conversion factor adjustments. Adjustments to the conversion factors for providers and services covered by the fee schedules and by department policy may occur annually following prior public hearings.

Such adjustments will be based on the estimated increase/decrease in the state's average wage for the current year and on other factors as determined by department policy. The following calendar year's estimate, of the average state wage will be adjusted to reflect the actual increase/decrease in the state's average wage for the preceding year.

The total percentage change for any one calendar year for the conversion factors may not exceed the total of the estimated increase/decrease in the current year, plus or minus the actual adjustment for the preceding calendar year.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 96-10-086, § 296-20-132, filed 5/1/96, effective 7/1/96. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-132, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 88-24-011 (Order 88-28), § 296-20-132, filed 12/1/88, effective 1/1/89; 82-24-050 (Order 82-39), § 296-20-132, filed 11/29/82, effective 1/1/84.]

WAC 296-20-135 Conversion factors. (1) Conversion factors are used to calculate payment levels for services reimbursed under the Washington resource based relative value scale (RBRVS), and for anesthesia services payable with base and time units.

(2) **Washington RBRVS** services have a conversion factor of $55.34. The fee schedules list the reimbursement levels for these services.

(3) **Anesthesia services** that are paid with base and time units have a conversion factor of $3.22 per minute, which is equivalent to $48.30 per 15 minutes. The base units and payment policies can be found in the fee schedules.

[Statutory Authority: RCW 51.04.020(1) and 51.04.030. 12-11-107, § 296-20-135, filed 5/22/12, effective 7/1/12; 11-12-019, § 296-20-135, filed 5/24/11, effective 7/1/11; 10-10-107, § 296-20-135, filed 5/4/10, effective 7/1/10; 08-09-121, § 296-20-135, filed 4/22/08, effective 7/1/08; 07-10-082, § 296-20-135, filed 5/1/07, effective 7/1/07; 06-09-071, § 296-20-135, filed 4/18/06, effective 7/1/06; 05-09-062, § 296-20-135, filed 4/19/05, effective 7/1/05; 04-09-100, § 296-20-135, filed 4/20/04, effective 7/1/04; 03-14-043, § 296-20-135, filed 6/24/03, effective 8/1/03; 02-10-129, § 296-20-135, filed 5/1/02, effective 7/1/02; 01-10-026, § 296-20-135, filed 4/24/01, effective 7/1/01; 00-09-077, § 296-20-135, filed 4/18/00, effective 7/1/00. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 99-10-043, § 296-20-135, filed 4/30/99, effective 7/1/99; 98-09-125, § 296-20-135, filed 4/22/98, effective 7/1/98; 97-10-017, § 296-20-135, filed 4/28/97, effective 7/1/97. Statutory Authority: RCW 51.04.020 and 51.04.030. 96-19-060. §296-20-135, filed 9/16/96, effective 10/17/96; 96-10-086, § 296-20-135, filed 5/1/96, effective 7/1/96; 95-17-001 § 296-20-135, filed 8/2/95, effective 10/1/95; 95-05-072, § 296-20-135, filed 2/15/95, effective 3/18/95. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 94-02-045 and 94-03-008, § 296-20-135, filed 12/30/93 and 1/6/94, effective 3/1/94; 93-16-072, § 296-20-135, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 91-02-063, § 296-20-135, filed 12/28/90, effective 1/28/91; 88-24-011 (Order 88-28), § 296-20-135, filed 12/1/88, effective 1/1/89; 87-03-004 (Order 86-45), § 296-20-135, filed 1/8/87; 83-24-016 (Order 83-35), § 296-20-135, filed 11/30/83, effective 1/1/84; 82-24-050 (Order 82-39), § 296-20-135, filed 11/29/82, effective 7/1/83. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-24-041 (Order 81-28), § 296-20-135, filed 11/30/81, effective 1/1/82; 80-18-033 (Order 80-24), § 296-20-135, filed 12/1/80, effective 1/1/81. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-135, filed 11/30/79, effective 1/1/80; Order 77-27, § 296-20-135, filed 11/30/77, effective 1/1/78; Order 76-34, § 296-20-135, filed 11/24/76, effective 1/1/77; Order 75-39, § 296-20-135, filed 11/28/75, effective 1/1/76; Order 74-7, § 296-20-135, filed 1/30/74; Order 71-6, § 296-20-135, filed 6/1/71; Order 68-7, § 296-20-135, filed 11/27/68, effective 1/1/69.]

WAC 296-20-170 Pharmacy—Acceptance of rules and fees. (1) Acceptance and filling of a prescription for a worker entitled to benefits under the industrial insurance law, constitutes acceptance of the department's rules and fees.

(2) When there is questionable eligibility, (i.e., no claim number, prescription is for medication other than usually prescribed for industrial injury; or pharmacist has reason to believe claim is closed or rejected), the pharmacist may require the worker to pay for the prescription.

(a) The pharmacist must furnish the worker with a signed receipt and a nonnegotiable copy of the prescription including national drug code and quantity or a completed department pharmacy bill form signed in the appropriate areas verifying worker has paid for the prescribed item(s) in order for the worker to bill the department or self-insurer for reimbursement.

(b) The worker may not be charged more than the amount allowable by the department or self-insurer.

(c) The worker must submit such reimbursement request within one year of the date of service.

See WAC 296-20-020 for details on providing a refund.

(3) Pharmacies may bill the department for initial prescription drugs prior to claim acceptance upon the presentation to the pharmacy of a state fund identification card or a copy of the *Report of Industrial Injury or Occupational Disease*.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 2007 c 134. 08-02-021, § 296-20-170, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020. 03-21-069, § 296-20-170, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-170, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-170, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 80-18-033 (Order 80-24), § 296-20-170, filed 12/1/80, effective 1/1/81; Order 76-34, § 296-20-170, filed 11/24/76, effective 1/1/77.]

WAC 296-20-17001 Allowance and payment for medication. (1) The department or self-insurer will pay for medications or supplies dispensed for the treatment of conditions resulting from an industrial injury and/or conditions which are retarding the recovery from the industrial injury, for which the department or self-insurer has accepted temporary responsibility.

(2) Approved generic are to be substituted for brand name pharmaceuticals in all cases unless the worker's condition will not tolerate a generic preparation and the prescribing physician indicates no substitution is permitted. A list of approved generics and their base cost will be published periodically by the department.

(3) Items not normally paid include: Syringes, injectables, heating pads, vibrators, personal appliances, oral nutritional supplements, anorexiants, and medications normally prescribed for systemic conditions. These items may be authorized to certain individuals in unusual circumstances; prior approval from the department or self-insurer is mandatory.

(4) Rental or purchase of medical equipment must be prior authorized by the department or self-insurer.

(5) No payment will be made for medication dispensed after the date of the order and notice of claim closure or rejection or for conditions unrelated to the industrial injury or occupational disease except for initial prescription drugs prescribed during the initial visit for state fund claims.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 2007 c 134. 08-02-021, § 296-20-17001, filed 12/21/07, effective 1/21/08. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-17001, filed 2/28/86, effective 4/1/86; 83-24-016 (Order 83-35), § 296-20-17001, filed 11/30/83, effective 1/1/84. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 80-18-033 (Order 80-24), § 296-20-17001, filed 12/1/80, effective 1/1/81; Order 76-34, § 296-20-17001, filed 11/24/76, effective 1/1/77.]

WAC 296-20-17002 Billing. In addition to the billing procedures described in WAC 296-20-125 and in department policy the current national drug code number for each prescribed drug, followed by the average wholesale price to the pharmacy must be entered on each prescription. The department's statement for pharmacy services must be used when billing the department for NDC medications and supplies. The department's statement for miscellaneous services must be used when billing the department for non-NDC medications and supplies. In addition, the claimant's name, claim number, date of injury, prescribing doctor's name and department of labor and industries provider number; and the assigned department provider number for the pharmacy must be on the bill. Bills for medication not containing this information will be returned to the pharmacy. Billing must be made within one year of the date of service. It is requested bills be presented on a monthly basis.

When billing the department for compound prescriptions, providers must use the "Statement for Compound Prescriptions."

[Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-20-17002, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 86-06-032 (Order 86-19), § 296-20-17002, filed 2/28/86, effective 4/1/86; 83-24-016 (Order 83-35), § 296-20-17002, filed 11/30/83, effective 1/1/84. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 80-18-033 (Order 80-24), § 296-20-17002, filed 12/1/80, effective 1/1/81; Order 76-34, § 296-20-17002, filed 11/24/76, effective 1/1/77.]

WAC 296-20-17004 Billing and payment for initial prescription drugs. (1) Pharmacies may bill the department for initial prescription drugs prior to claim acceptance upon the presentation to the pharmacy of a state fund identification card or a copy of the *Report of Industrial Injury or Occupational Disease* with a valid claim number.

(2) The department will pay pharmacies or reimburse the worker for initial prescription drugs prescribed during the initial visit except when the prescription is:

(a) A second or subsequent filling of the initial prescription drugs prescribed for the same industrial injury or occupational disease prior to claim acceptance; or

(b) Associated with a self-insurer claim.

(3) Payment for initial prescription drugs shall be in accordance with the department's fee schedule including, but not limited to screening for drug utilization review (DUR) criteria, the preferred drug list (PDL) provision and formulary status.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 2007 c 134. 08-02-021, § 296-20-17004, filed 12/21/07, effective 1/21/08.]

IMPAIRMENT RATING

WAC 296-20-19000 What is a permanent partial disability award? Permanent partial disability is any anatomic or functional abnormality or loss after maximum medical improvement (MMI) has been achieved. At MMI, the worker's condition is determined to be stable or nonprogressive at the time the evaluation is made. A permanent partial disability award is a monetary award designed to compensate the worker for the amputation or loss of function of a body part or organ system. Impairment is evaluated without reference to the nature of the injury or the treatment given. To ensure uniformity, consistency and fairness in rating permanent partial disability, it is essential that injured workers with comparable anatomic abnormalities and functional loss receive comparable disability awards. As such, the amount of the permanent partial disability award is not dependent upon or influenced by the economic impact of the occupational

injury or disease on an individual worker. Rather, Washington's Industrial Insurance Act requires that permanent partial disability be established primarily by objective physical or clinical findings establishing a loss of function. Mental health impairments are evaluated under WAC 296-20-330 and 296-20-340.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-19000, filed 10/22/02, effective 12/1/02.]

WAC 296-20-19010 Are there different types of permanent partial disabilities? Under Title 51 RCW, there are two types of permanent partial disabilities.

(1) Specified disabilities are listed in RCW 51.32.080 (1)(a). They are limited to amputation or loss of function of extremities, loss of hearing or loss of vision.

(2) Unspecified disabilities include, but are not limited to, internal injuries, back injuries, mental health conditions, respiratory disorders, and other disorders affecting the internal organs.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-19010, filed 10/22/02, effective 12/1/02.]

WAC 296-20-19020 How is it determined which impairment rating system is to be used to rate specified and unspecified disabilities? (1) Specified disabilities are rated in one of two ways:

(a) Impairment due to amputation, total loss of hearing, and total loss of vision are rated according to RCW 51.32.-080;

(b) Impairment for the loss of function of extremities, as well as partial loss of hearing or vision, is rated using a nationally recognized impairment rating guide unless otherwise precluded by department rule.

(2) Unspecified disabilities are rated in accordance with WAC 296-20-200 through 296-20-660.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-19020, filed 10/22/02, effective 12/1/02.]

WAC 296-20-19030 To what extent is pain considered in an award for permanent partial disability? The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA guides.

For example:

• Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA guides. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of AMA *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-19030, filed 10/22/02, effective 12/1/02.]

WAC 296-20-200 General information for impairment rating examinations by attending doctors, 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 catego-

ries 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.

[Statutory Authority: RCW 51.32.055, 51.32.112, 51.32.114, 51.36.060, and 51.36.070. 04-04-029, § 296-20-200, filed 1/27/04, effective 3/1/04. Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.112, 51.32.114 and 51.36.015. 97-09-036, § 296-20-200, filed 4/14/97 effective 5/15/97. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 91-07-008, § 296-20-200, filed 3/8/91, effective 5/1/91; Order 74-32, § 296-20-200, filed 6/21/74, effective 10/1/74.]

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

(1) Impairment rating examinations shall be performed only by doctors currently licensed in 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.

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

(a) Statement that the patient 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 and consultants to be familiar with the contents of the *Medical Examiner Handbook* section on how to rate impairment.

(4) Attending doctors 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 calendar days of the examination date, or within fourteen 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.

[Statutory Authority: RCW 51.32.055, 51.32.112, 51.32.114, 51.36.060, and 51.36.070. 04-04-029, § 296-20-2010, 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 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
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

Rating System	Used for These Conditions	Form of the Rating
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

[Statutory Authority: RCW 51.32.055, 51.32.112, 51.32.114, 51.36.060, and 51.36.070. 04-04-029, § 296-20-2015, 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 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, any other provider involved in the worker's care, or any other personnel employed by the attending doctor 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.

[Statutory Authority: RCW 51.32.055, 51.32.112, 51.32.114, 51.36.060, and 51.36.070. 04-04-029, § 296-20-2025, 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 or a consultant? The use of recording equipment of any kind by the worker or accompanying person is not allowed.

[Statutory Authority: RCW 51.32.055, 51.32.112, 51.32.114, 51.36.060, and 51.36.070. 04-04-029, § 296-20-2030, filed 1/27/04, effective 3/1/04.]

WAC 296-20-220 Special rules for evaluation of permanent bodily impairment. (1) Evaluations of permanent bodily impairment using categories require uniformity in procedure and terminology. The following rules have been enacted to produce this uniformity and shall apply to all evaluations of permanent impairment of an unspecified nature.

(a) Gradations of relative severity shall be expressed by the words "minimal," "mild," "moderate" and "marked" in an ascending scale. "Minimal" shall describe deviations from normal responses which are not medically significant. "Mild," "moderate" and "marked" shall describe ranges of medically significant deviations from normal responses. "Mild" shall describe the least severe third. "Moderate" shall describe the middle third. "Marked" shall describe the most severe third.

(b) "Permanent" describes those conditions which are fixed, lasting and stable, and from which within the limits of medical probability, further recovery is not expected.

(c) "Impairment" means a loss of physical or mental function.

(d) "Total bodily impairment," as used in these rules, is the loss of physical or mental function which is essentially complete short of death.

(e) The examiner shall not assign a percentage figure for permanent bodily impairment described in the categories established herein.

(f) The method of evaluating impairment levels is by selection of the appropriate level of impairment. These descriptive levels are called "categories." Assessments of the level of impairment are to be made by comparing the condition of the injured workman with the conditions described in the categories and selecting the most appropriate category.

These rules and categories for various bodily areas and systems provide a comprehensive system for the measurement of disabling conditions which are not already provided for in the list of specified permanent partial disabilities in RCW 51.32.080(1). Disabilities resulting from loss of central visual acuity, loss of an eye by enucleation, loss of hearing, amputation or loss of function of the extremities will continue to be evaluated as elsewhere provided in RCW 51.32.-080.

The categories have been classified in percentages in reasonable proportion to total bodily impairment for the purpose of determining the proper award. Provision has been made for correctly weighing the overall impairment due to particular injuries or occupational disease in cases in which there are preexisting impairments.

(g) The categories of the various bodily areas and systems are listed in the order of increasing impairment except as otherwise specified. Where several categories are given for the evaluation of the extent of permanent bodily impairment, the impairments in the higher numbered categories, unless otherwise specified, include the impairments in the lesser numbered categories. No category for a condition due to an injury shall be selected unless that condition is permanent as defined by these rules.

The examiner shall select the one category which most accurately indicates the overall degree of permanent impairment unless otherwise instructed. Where there is language in more than one category which may appear applicable, the category which most accurately reflects the overall impairment shall be selected.

The categories include appropriate subjective complaints in an ascending scale in keeping with the severity of objective findings, thus a higher or lower category is not to be

selected purely on the basis of unusually great or minor complaints.

(h) When the examination discloses a preexisting permanent bodily impairment in the area of the injury, the examiner shall report the findings and any category of impairment appropriate to the worker's condition prior to the industrial injury in addition to the findings and the categories appropriate to the worker's condition after the injury.

(i) Objective physical or clinical findings are those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examiners.

(j) Subjective complaints or symptoms are those perceived only by the senses and feelings of the person being examined which cannot be independently proved or established.

(k) Muscle spasm as used in these rules is an involuntary contraction of a muscle or group of muscles of a more than momentary nature.

(l) An involuntary action is one performed independently of the will.

(m) These special rules for evaluation of permanent bodily impairment shall apply to all examinations for the evaluation of impairment, in accordance with RCW 51.32.-080, for the body areas or systems covered by or enumerated in WAC 296-20-230 through 296-20-660.

(n) The rules for evaluation of each body area or system are an integral part of the categories for that body area or system.

(o) In cases of injury or occupational disease of bodily areas and/or systems which are not included in these categories or rules and which do not involve loss of hearing, loss of central visual acuity, loss of an eye by enucleation or loss of the extremities or use thereof, examiners shall determine the impairment of such bodily areas and/or systems in terms of percentage of total bodily impairment.

(p) The words used in the categories of impairments, in the rules for evaluation of specific impairments, the general rules, and the special rules shall be deemed, unless the context indicates the contrary, to have their general and accepted medical meanings.

(q) The rating of impairment due to total joint replacement shall be in accordance with the limitation of motion guidelines as set forth in the "Guides to the Evaluation of Permanent Impairment" of American Medical Association, with department of labor and industries acknowledgement of responsibility for failure of prostheses beyond the seven year limitation.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.112, 51.32.114 and 51.36.015. 97-09-036, § 296-20-220, filed 4/14/97 effective 5/15/97. Statutory Authority: RCW 51.04.030 and 51.16.035. 79-12-086 (Order 79-18), § 296-20-220, filed 11/30/79, effective 1/1/80; Order 74-32, § 296-20-220, filed 6/21/74, effective 10/1/74.]

WAC 296-20-230 Cervical and cervico-dorsal impairments. (1) Rules for evaluation of cervical and cervico-dorsal impairments are as follows:

(a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selecting the appropriate category, only insofar as productive of cervical or cervico-dorsal impairment.

(b) Gradations of clinical findings of cervico-dorsal impairments in terms of "mild," "moderate" or "marked" shall be based on objective medical tests.

(c) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree in the neck or extremities.

(d) Bladder and/or bowel sphincter impairments deriving from cervical and cervico-dorsal impairment shall be evaluated separately.

(e) Neck as used in these rules and categories shall include the cervical and adjacent areas.

[Order 74-32, § 296-20-230, filed 6/21/74, effective 10/1/74.]

WAC 296-20-240 Categories of permanent cervical and cervico-dorsal impairments. (1) No objective clinical findings are present. Subjective complaints may be present or absent.

(2) Mild cervico-dorsal impairment, with objective clinical findings of such impairment with neck rigidity substantiated by X-ray findings of loss of anterior curve, without significant objective neurological findings.

This and subsequent categories include the presence or absence of pain locally and/or radiating into an extremity or extremities. This and subsequent categories also include the presence or absence of reflex and/or sensory losses. This and subsequent categories also include objectively demonstrable herniation of a cervical intervertebral disc with or without discectomy and/or fusion, if present.

(3) Mild cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by X-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective findings of mild nerve root involvement.

This and subsequent categories include the presence or absence of any other neurological deficits not otherwise specified in these categories with the exception of bladder and/or bowel sphincter impairments.

(4) Moderate cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by X-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of moderate nerve root involvement with weakness and numbness in one or both upper extremities.

(5) Marked cervico-dorsal impairment, with marked objective clinical findings of such impairment, with neck rigidity substantiated by X-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of marked nerve root involvement with weakness and numbness in one or both upper extremities.

[Order 74-32, § 296-20-240, filed 6/21/74, effective 10/1/74.]

WAC 296-20-250 Impairments of the dorsal area. (1) Rules for evaluation of permanent dorsal area impairments are as follows:

(a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation

devices or other physical finding shall be considered, in selection of the appropriate category, only insofar as productive of dorsal area impairment.

(b) Gradations of clinical findings of dorsal impairments in terms of "mild," "moderate" or "marked" shall be based on objective medical tests.

(c) Categories 2 and 3 include the presence of complaints of whatever degree.

(d) Bladder and/or bowel sphincter impairments deriving from impairments of the dorsal area shall be evaluated separately.

(e) Impairments which also involve the cervical or lumbar areas shall be evaluated only under the cervical and cervico-dorsal or dorsolumbar and lumbosacral categories.

[Order 74-32, § 296-20-250, filed 6/21/74, effective 10/1/74.]

WAC 296-20-260 Categories of permanent dorsal area impairments. (1) No objective clinical findings are present. Subjective complaints may be present or absent.

(2) Mild or moderate dorsal impairment, with objective clinical findings of such impairment, without significant objective neurological findings, with or without X-ray changes of narrowed intervertebral disc spaces and/or osteoarthritic lipping of intervertebral margins. Includes the presence or absence of reflex and/or sensory losses.

This and the subsequent category include the presence or absence of pain, locally or radiating from the dorsal area.

(3) Marked dorsal impairment, with marked objective clinical findings, with marked X-ray findings of narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective neurological deficits, complaints and/or findings, deriving from dorsal impairment.

[Order 74-32, § 296-20-260, filed 6/21/74, effective 10/1/74.]

WAC 296-20-270 Dorso-lumbar and lumbosacral impairments. (1) Rules for evaluation of permanent dorso-lumbar and lumbosacral impairments are as follows:

(a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selecting the appropriate category, only insofar as productive of low back impairment.

(b) Gradations of clinical findings of low back impairments in terms of "mild," "moderate" or "marked" shall be based on objective medical tests.

(c) All of the low back categories include the presence of complaints of whatever degree.

(d) Any and all neurological deficits, complaints, and/or findings in other bodily areas or systems which are the result of dorso-lumbar and lumbosacral impairments, except for objectively demonstrated bladder and/or bowel sphincter impairments, shall be evaluated by the descriptions contained in the categories of dorso-lumbar and lumbosacral impairments.

(e) Bladder and/or bowel sphincter impairments deriving from dorso-lumbar and lumbosacral impairments shall be evaluated separately.

(f) Low back as used in these rules and categories includes the lumbar and adjacent areas.

[Order 74-32, § 296-20-270, filed 6/21/74, effective 10/1/74.]

WAC 296-20-280 Categories of permanent dorso-lumbar and lumbosacral impairments. (1) No objective clinical findings. Subjective complaints and/or sensory losses may be present or absent.

(2) Mild low back impairment, with mild intermittent objective clinical findings of such impairment but no significant X-ray findings and no significant objective motor loss. Subjective complaints and/or sensory losses may be present.

(3) Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment but without significant X-ray findings or significant objective motor loss.

This and subsequent categories include: The presence or absence of reflex and/or sensory losses; the presence or absence of pain locally and/or radiating into an extremity or extremities; the presence or absence of a laminectomy or discectomy with normally expected residuals.

(4) Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment, with mild but significant X-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

This and subsequent categories include the presence or absence of a surgical fusion with normally expected residuals.

(5) Moderate low back impairment, with moderate continuous or marked intermittent objective clinical findings of such impairment, with moderate X-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

(6) Marked low back impairment, with marked intermittent objective clinical findings of such impairment, with moderate or marked X-ray findings and with moderate motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

(7) Marked low back impairment, with marked continuous objective clinical findings of such impairment, with marked X-ray findings and with marked motor loss objectively demonstrated by marked atrophy and weakness of a specific muscle or muscle group.

(8) Essentially total loss of low back functions, with marked X-ray findings and with marked motor loss objectively demonstrated by marked atrophy and weakness of a muscle group or groups.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 83-16-066 (Order 83-23), § 296-20-280, filed 8/2/83; Order 74-32, § 296-20-280, filed 6/21/74, effective 10/1/74.]

WAC 296-20-290 Impairments of the pelvis. (1) Rules for impairment of the pelvis:

(a) All of these categories include the presence of complaints of whatever degree.

(b) Categories 2, 5, 6 and 7 describe separate entities and more than one may be selected when appropriate. Category 9 includes the findings described in Category 3, and Category 8 includes the findings described in Category 4.

[Order 74-32, § 296-20-290, filed 6/21/74, effective 10/1/74.]

WAC 296-20-300 Categories of permanent impairments of the pelvis. (1) Healed pelvic fractures without displacement, without residuals; healed fractures with displacement without residuals, of: Single ramus, bilateral rami, ilium, innominate or coccyx; or healed fracture of single rami with displacement with deformity and residuals.

(2) Healed fractures with displacement with deformity and residuals of ilium.

(3) Healed fractures of symphysis pubis, without separation with displacement without residuals.

(4) Healed fractures of sacrum with displacement without residuals.

(5) Healed fracture of bilateral rami with displacement with deformity and residuals.

(6) Excision or nonunion of fractures of coccyx.

(7) Healed fractures of innominate, displaced one inch or more, with deformity and residuals.

(8) Healed fractures of sacrum extending into sacroiliac joint with deformity and residuals.

(9) Healed fractures of symphysis, displaced or separated, with deformity and residuals.

[Order 74-32, § 296-20-300, filed 6/21/74, effective 10/1/74.]

WAC 296-20-310 Convulsive neurological impairments. (1) Rules for evaluation of convulsive neurological impairments:

(a) The description of Categories 2, 3 and 4 include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-310, filed 6/21/74, effective 10/1/74.]

WAC 296-20-320 Categories of permanent convulsive neurological impairments. (1) No electroencephalogram findings of convulsive neurological disorder. Subjective complaints may be present or absent.

(2) Electroencephalogram findings of convulsive neurological disorder, but on appropriate medication there are no seizures.

(3) Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year either one through four major seizures or one through twelve minor seizures.

(4) Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year either more than four major seizures or more than twelve minor seizures.

[Order 74-32, § 296-20-320, filed 6/21/74, effective 10/1/74.]

WAC 296-20-330 Impairments of mental health. (1) Rules for evaluation of permanent impairment of mental health:

(a) Mental illness means malfunction of the psychic apparatus that significantly interferes with ordinary living.

(b) Each person has a pattern of adjustment to life. The pattern of adjustment before the industrial injury or occupational disease serves as a base line for all assessments of whether there has been a permanent impairment due to the industrial injury or occupational disease.

(c) To determine the preinjury pattern of adjustment, all evaluations of mental health shall contain a complete preinjury history including, but not necessarily limited to: Family background and the relationships with parents or other nurturing figures; extent of education and reaction to it; military experience, if any; problems with civil authorities; any history of prolonged illness, and difficulty with recovery; any history of drug abuse or alcoholism; employment history, the extent of and reaction to responsibility, and relationships with others at work; capacity to make and retain friends; relationships with spouses and children; nature of daily activities, including recreation and hobbies; and lastly, some summary statement about the sources of the patient's self-esteem and sense of identity. Both strengths and vulnerabilities of the person shall be included.

(d) Differences in adjustment patterns before and after the industrial injury or occupational disease shall be described, and the report shall contain the examining physician's opinion as to whether any differences: (1) Are the result of the industrial injury or occupational disease and its sequelae, in the sense they would not have occurred had there not been the industrial injury or occupational disease; (2) are permanent or temporary; (3) are more than the normal, self-correcting and expectable response to the stress of the industrial injury or occupational disease; (4) constitute an impairment psychosocially or physiologically; and (5) are susceptible to treatment, and, if so, what kind. The presence of any unrelated or coincidental mental impairment shall always be mentioned.

(e) All reports of mental health evaluations shall use the diagnostic terminology listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

(f) No classification of impairment shall be made for complaints where the quality of daily life does not differ substantially from the preinjury pattern. A patient not currently employed may not engage in the same activities as when working, but the level and variety of his activities and zest for them shall distinguish the purely situational difference from cases of regression and withdrawal. In cases where some loss of use of body member is claimed, no category or impairment shall be assigned unless there are objective findings of physiologic regression or consistent evidence of altered adaptability.

(g) The physician shall identify the schizoid, antisocial, inadequate, sociopathic, passive, hysterical, paranoid, or dependent personality types. Patients with these longstanding character disorders may show problem behavior that seems more related to current stress than it is, sometimes unconsciously insinuating themselves into difficult situations of which they then complain. Emotional reactions to an injury and subsequent events must be carefully evaluated in these patients. It must be medically probable that such reactions are permanent before a category of impairment can be attributed to the injury; temporary reactions or preexisting psychopathology must be differentiated.

[Order 74-32, § 296-20-330, filed 6/21/74, effective 10/1/74.]

WAC 296-20-340 Categories for evaluation of permanent impairments of mental health. (1) Nervousness, irritability, worry or lack of motivation following an injury and commensurate with it and/or other situational responses

to injury that do not alter significantly the life adjustment of the patient may be present.

(2) Any and all permanent worsenings of preexisting personality traits or character disorders where aggravation of preexisting personality trait or character disorder is the major diagnosis; mild loss of insight, mildly deficient judgment, or rare difficulty in controlling behavior, anxiety with feelings of tension that occasionally limit activity; lack of energy or mild apathy with malaise; brief phobic reactions under usually avoidable conditions; mildly unusual and overly rigid responses that cause mild disturbance in personal or social adjustment; rare and usually self-limiting psycho-physiological reactions; episodic hysterical or conversion reactions with occasional self-limiting losses of physical functions; a history of misinterpreted conversations or events, which is not a preoccupation; is aware of being absentminded, forgetful, thinking slowly occasionally or recognizes some unusual thoughts; mild behavior deviations not particularly disturbing to others; shows mild over-activity or depression; personal appearance is mildly unkempt. Despite such features, productive activity is possible most of the time. If organicity is present, some difficulty may exist with orientation; language skills, comprehension, memory; judgment; capacity to make decisions; insight; or unusual social behavior; but the patient is able to carry out usual work day activities unassisted.

(3) Episodic loss of self-control with risk of causing damage to the community or self; moments of morbid apprehension; periodic depression that disturbs sleep and eating habits or causes loss of interest in usual daily activities but self-care is not a problem; fear-motivated behavior causing mild interference with daily life, frequent emotogenic organ dysfunctions requiring treatment; obsessive-compulsive reactions which limit usual activity; periodic losses of physical function from hysterical or conversion reactions; disturbed perception in that patient does not always distinguish daydreams from reality; recognizes his fantasies about power and money are unusual and tends to keep them secret; thought disturbances cause patient to fear the presence of serious mental trouble; deviant social behavior can be controlled on request; exhibits periodic lack of appropriate emotional control; mild disturbance from organic brain disease such that a few work day activities require supervision.

(4) Very poor judgment, marked apprehension with startle reactions, foreboding leading to indecision, fear of being alone and/or insomnia; some psychomotor retardation or suicidal preoccupation; fear-motivated behavior causing moderate interference with daily life; frequently recurrent and disruptive organ dysfunction with pathology of organ or tissues; obsessive-compulsive reactions causing inability to work with others or adapt; episodic losses of physical function from hysterical or conversion reactions lasting longer than several weeks; misperceptions including sense of persecution or grandiosity which may cause domineering, irritable or suspicious behavior; thought disturbance causing memory loss that interferes with work or recreation; periods of confusion or vivid daydreams that cause withdrawal or reverie; deviations in social behavior which cause concern to others; lack of emotional control that is a nuisance to family and associates; moderate disturbance from organic brain disease such as to require a moderate amount of supervision and direction of work day activities.

(5) Marked apprehension so as to interfere with memory and concentration and/or to disturb markedly personal relationships; depression causing marked loss of interest in daily activities, loss of weight, unkempt appearance, marked psycho-motor retardation, suicidal preoccupation or attempts, or marked agitation as well as depression; marked phobic reactions with bizarre and disruptive behavior; psychophysiological reactions resulting in lasting organ or tissue damage; obsessive-compulsive reactions that preclude patient's usual activity; frequent or persistent loss of function from conversion or hysterical reactions with regressive tissue or organ change; defects in perception including frank illusions or hallucinations occupying much of the patient's time; behavior deviations so marked as to interfere seriously with the physical or mental well-being or activities of others; lack of emotional control including marked irritability or overactivity.

[Order 74-32, § 296-20-340, filed 6/21/74, effective 10/1/74.]

WAC 296-20-350 Cardiac impairments. (1) Rule for evaluation of permanent cardiac impairments:

(a) Classification of impairment using the following categories shall be based upon a carefully obtained history, thorough physical examination and the use of appropriate laboratory aids.

[Order 74-32, § 296-20-350, filed 6/21/74, effective 10/1/74.]

WAC 296-20-360 Categories of permanent cardiac impairments. (1) No objective findings are present. Subjective complaints may be present or absent.

(2) Objective findings of mild organic heart disease but no signs of congestive heart failure. No medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress.

(3) Objective findings of mild organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort, or marked emotional stress but not by usual daily activities.

(4) Objective findings of moderate organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress but not by usual daily activities.

(5) Objective findings of marked organic heart disease with minimal signs of congestive heart failure with therapy. Medically appropriate symptoms produced by usual daily activities.

(6) Objective findings of marked organic heart disease with mild to moderate signs of congestive heart failure despite therapy. Medically appropriate symptoms produced by usual daily activities.

[Order 74-32, § 296-20-360, filed 6/21/74, effective 10/1/74.]

WAC 296-20-370 Respiratory impairments. (1) Rules for evaluation of permanent respiratory impairments:

(a) Definitions.

(i) "FEV1" means the forced expiratory volume in 1 second as measured by a spirometric test performed as described in the most current *American Thoracic Society Statement on Standardization of Spirometry*, and using equipment, meth-

ods of calibration, and techniques that meet American Thoracic Society (ATS) criteria including reproducibility. The measurement used must be taken from a spirogram which is technically acceptable and represents the patient's best effort. The measurement is to be expressed as both an absolute value and as a percentage of the predicted value. The predicted values are those listed in the most current edition of the *American Medical Association (AMA) Guidelines* for rating permanent respiratory impairment.

(ii) "FVC" means the forced vital capacity as measured by a spirometric test in accordance with criteria described in (a)(i) of this subsection.

(iii) "FEV1/FVC" is a ratio calculated based on the ATS Guides criteria as described in the most current *American Thoracic Society Statement on Standardization of Spirometry*.

(iv) "Significant improvement" means a fifteen percent or greater improvement in FEV1 (volume) after a post-bronchodilator pulmonary function test.

(v) "DLCO" means the diffusion capacity of carbon monoxide as measured by a test based on predicted values demonstrated to be appropriate to the techniques and equipment of the laboratory performing the test according to current ATS standards. DLCO may be considered for impairment rating only if accompanied by evidence of impaired gas exchange based on exercise testing.

(vi) "VO2 Max" means the directly measured oxygen consumption at maximum exercise capacity of an individual as measured by exercise testing and oxygen consumption expressed in ml/kilo/min corrected for lean bodyweight. Estimated values from treadmill or other exercise tests without direct measurement are not acceptable. The factor limiting the exercise must be identified.

(vii) "Preexisting impairment" shall be reported as described in WAC 296-20-220 (1)(h).

(viii) "Coexisting" is a disease or injury not due to or causally related to the work-related condition that impacts the overall respiratory disability.

(ix) "Apportionment" is an estimate of the degree of impairment due to the occupational injury/exposure when preexisting or coexisting conditions are present.

(x) "Dyspnea" is the subjective complaint of shortness of breath. Dyspnea alone must not be used to determine the level of respiratory impairment. Dyspnea unexplained by objective signs of impairment or spirometry requires more extensive testing (i.e., VO2 Max).

(xi) Copies of the *American Thoracic Society Statement on Standardization of Spirometry* and ATS standards for measuring D_{LCO} can be obtained by ordering *Pulmonary Function Testing* from The American Thoracic Society, 1740 Broadway, New York, NY 10019-4374, Attn: ATS Statements. Copies of this document are available for review in the section of the office of the medical director, department of labor and industries, Tumwater building.

These standards are also available through the following references: "American Thoracic Society Committee on Proficiency Standards for Pulmonary Function Laboratories: Standardization of spirometry-1987 update." *Am Rev Respir Dis* 1987; 136:1285-1298. "American Thoracic Society D_{LCO} Standardization Conference: Single breath carbon monoxide diffusing capacity (transfer factor): Recommendations for a standard technique." *Am Rev Respir Dis* 1987; 136:1299-1307.

(b) Evaluation procedures. Each report of examination must include the following, at a minimum:

(i) Identification data: Worker's name, claim number, gender, age, and race.

(ii) Detailed occupational history: Job titles of all jobs held since employment began. A detailed description of typical job duties, protective equipment worn, engineering controls present (e.g., ventilation) as well as the specific exposures and intensity (frequency and duration) of exposures. More detail is required for jobs involving potential exposure to known respiratory hazards.

(iii) History of the present illness: Chief complaint and description of all respiratory symptoms present (e.g., wheezing, cough, phlegm, chest pain, paroxysmal nocturnal dyspnea, dyspnea at rest and on exertion) as well as the approximate date of onset, and duration of each symptom, and aggravating and relieving factors.

(iv) Past medical history: Past history of childhood or adult respiratory illness, hay fever, asthma, bronchitis, chest injury, chest surgery, respiratory infections, cardiac problems, hospitalizations for chest or breathing problems and current medications.

(v) Lifestyle and environmental exposures: Descriptive history of exposures clinically related to respiratory disease including, but not limited to, tobacco use with type and years smoked. Use of wood as a primary heat source at home or hobbies that involve potential exposure to known respiratory tract hazards, and other environmental exposures.

(vi) Family history: Family history of respiratory or cardiac disease.

(vii) Physical examination findings: Vital signs including a measured height without shoes, weight, and blood pressure. Chest exam shall include a description of the shape, breathing, breath sounds, cardiac exam, and condition of extremities (e.g., cyanosis, clubbing, or edema).

(viii) Diagnostic tests: A chest X ray shall be obtained in all cases. When available, the X ray should be obtained using International Labor Organization (ILO) standard techniques and interpreted using the ILO classification system. The presence or absence of pleural thickening or interstitial abnormalities shall be noted. Pulmonary function reports including a description of equipment used, method of calibration, and the predicted values used. A hard copy of all pulmonary function tracings must be available for review. The report must contain at a minimum FEV1 and FVC and a narrative summary of an interpretation of the test results and their validity.

(ix) The rating of respiratory impairment. The rating of respiratory impairment shall be based on the pulmonary function test most appropriate to the respiratory condition. A prebronchodilator and postbronchodilator test must be performed on and results reported for all patients with demonstrated airway obstruction. The largest FEV1 or FVC, on either the prebronchodilator or postbronchodilator trial must be used for rating the impairment. If the FEV1 and FEV1/FVC result in different categories of impairment, the value resulting in a higher category of impairment will be used.

(x) The rating of persisting variable respiratory impairment with abnormal baseline function. If resting FEV1 is "abnormal" (below eighty percent predicted) and shows sig-

nificant bronchodilator improvement (a greater than or equal to fifteen percent improvement in FEV1) one category of impairment must be added to the given category rating, but only when the work-related disease being rated is obstructive in nature. If there is substantial variability from test to test (and good effort), the severity of impairment may be rated, using the best fit into the category system, as described in WAC 296-20-380.

(xi) The rating of persisting variable respiratory impairment with normal baseline spirometry. Variable respiratory impairment due to allergic or irritative disorder of the respiratory tract, such as bronchial asthma or reactive airway disease, caused or permanently aggravated by factors in the work place, shall be evaluated by detailed narrative report, including the casual relationship to work factors, a discussion of the relative importance of nonwork related cofactors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. When tests of ventilatory function, done when the patient is in clinical steady state, are normal (one second forced expiratory volume eighty percent or greater of predicted), an appropriate provocative bronchial challenge test (i.e., methacholine or histamine) shall be done to demonstrate the presence of unusual respiratory sensitivity.

(xii) At the time of the rating, the patient shall be off theophylline for at least twenty-four hours, beta agonists for at least twelve hours, and oral and/or inhaled steroids or cromolyn for at least two weeks, in order to determine severity of air-flow obstruction, unattenuated by therapy. If withdrawal of medication would produce a hazardous or life threatening condition, then the impairment cannot be rated at this time, and the physician must provide a statement describing the patient's condition and the effect of medication withdrawal.

(xiii) The method for standardizing provocative bronchial challenge testing, using either histamine or methacholine, shall be used. The test drug may be given either by continuous tidal volume inhalation of known concentrations, using an updraft nebulizer, for two minutes, or by the technique of intermittent deep breaths of increasing test drug strengths either via a Rosenthal dosimeter or updraft nebulizer, and the results shall be expressed either as the mg/ml concentration of test drug, or the cumulative breath units (1 breath of a 1 mg/ml solution equals one breath unit) which result in a prompt and sustained (at least three minute) fall in the FEV1, greater than twenty percent below baseline FEV1. Medications that can blunt the effect of bronchoprovocation testing shall be withheld prior to testing. Once testing is complete, the results shall be expressed in terms of normal, mild, moderate, or marked bronchial reactivity, as described in WAC 296-20-385.

If multiple bronchoprovocative inhalation challenge tests have been done, the examining physician shall select the one category (normal, mild, moderate, or marked) which most accurately indicates the overall degree of permanent impairment at the time of rating.

If the results of serial pulmonary function testing are extremely variable and the clinical course and use of medication also indicate major impairment, then the physician must make a statement in the formulation and medical evaluation containing, at a minimum: Diagnosis and whether work related or nonwork related; nature and frequency of treatment; stability of condition and work limitations; impairment.

(xiv) Further treatment needs. In all cases, the examining physician shall indicate whether further treatment is indicated and the nature, type, frequency, and duration of treatment recommended.

[Statutory Authority: RCW 51.04.020(4), 51.04.030 and 51.32.080(2). 94-03-073, § 296-20-370, filed 1/17/94, effective 3/1/94. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 82-24-050 (Order 82-39), § 296-20-370, filed 11/29/82, effective 1/1/83; Order 74-32, § 296-20-370, filed 6/21/74, effective 10/1/74.]

WAC 296-20-380 Categories of permanent respiratory impairments. (1) The FVC and FEV1 are greater than or equal to eighty percent of predicted normal for the person's age, gender, and height. The FEV1/FVC ratio is greater than or equal to .70. Subjective complaints may be present or absent. If exercise testing is done, the maximum oxygen consumption is greater than 25cc/kilo/min.

(2) The FVC or FEV1 is from seventy to seventy-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60 - .69. If exercise testing is done, the maximum oxygen consumption is 22.5-25cc/kilo/min.

(3) The FVC or FEV1 is from sixty to sixty-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60 - .69. If exercise testing is done, the maximum oxygen consumption is 20-22.4cc/kilo/min.

(4) The FVC or FEV1 is from fifty-one to fifty-nine percent of predicted. The FEV1/FVC ratio is .51 - .59. If exercise testing is done, the maximum oxygen consumption is 17.5-19.9cc/kilo/min.

(5) FVC from fifty-one to fifty-nine percent of predicted, or the FEV1 from forty-one to fifty percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .41 - .50. If exercise testing is done, the maximum oxygen consumption is 15-17.4cc/kilo/min.

(6) The FVC is equal to or less than fifty percent of predicted or the FEV1 is equal to or less than forty percent of predicted. The FEV1/FVC ratio is equal to or less than .40. If exercise testing is done, the maximum oxygen consumption is less than 15cc/kilo/min.

[Statutory Authority: RCW 51.04.020(4), 51.04.030 and 51.32.080(2). 94-03-073, § 296-20-380, filed 1/17/94, effective 3/1/94. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 82-24-050 (Order 82-39), § 296-20-380, filed 11/29/82, effective 1/1/83; Order 74-32, § 296-20-380, filed 6/21/74, effective 10/1/74.]

WAC 296-20-385 Categories of persisting variable respiratory impairment with normal baseline spirometry. (1) "Normal" bronchial reactivity is demonstrated by an insignificant (less than twenty percent) fall from baseline FEV1 at test doses of histamine or methacholine, up to 16 mg/ml (continuous inhalation method) or up to 160 breath units (cumulative, repeated deep breath technique).

(2) "Mild" bronchial hyperactivity (BHR) is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 2.1-16 mg/ml, or 21-160 breath units.

(3) "Moderate" BHR is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 0.26-2 mg/ml, or 2.6-20 breath units.

(4) "Marked" BHR is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses equal to or less than .25 mg/ml, or 2.5 breath units.

[Statutory Authority: RCW 51.04.020(4), 51.04.030 and 51.32.080(2). 94-03-073, § 296-20-385, filed 1/17/94, effective 3/1/94.]

WAC 296-20-390 Air passage impairments. (1) Rule for evaluation of permanent air passage impairments:

(a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-390, filed 6/21/74, effective 10/1/74.]

WAC 296-20-400 Categories of permanent air passage impairments. (1) No objective findings are present. Subjective complaints may be present or absent.

(2) Objective findings of one or more of the following air passage defects: Partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally. No dyspnea caused by the air passage defect even on activity requiring prolonged exertion or intensive effort.

(3) Objective findings of one or more of the following air passage defects: Partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

(4) Objective findings of one or more of the following air passage defects: Partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, with permanent tracheostomy or stoma, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

(5) Objective findings of one or more of the following air passage defects: Partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by moderate exertion.

(6) Objective findings of one or more of the following air passage defects: Partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by mild exertion.

[Statutory Authority: RCW 51.04.020(4) and 51.04.030. 83-16-066 (Order 83-23), § 296-20-400, filed 8/2/83; Order 74-32, § 296-20-400, filed 6/21/74, effective 10/1/74.]

WAC 296-20-410 Nasal septum impairments. (1) Rules for evaluation of permanent air passage impairments due to nasal septum perforation.

(a) These categories, if appropriate, are to be used in addition to the categories of permanent air passage impairment.

(b) Categories 1 and 2 include complaints of whatever degree.

[Order 74-32, § 296-20-410, filed 6/21/74, effective 10/1/74.]

WAC 296-20-420 Categories of permanent air passage impairment due to nasal septum perforations. (1) Perforation or perforations posterior to the cartilaginous septum.

(2) Perforation or perforations through or anterior to the cartilaginous septum.

[Order 74-32, § 296-20-420, filed 6/21/74, effective 10/1/74.]

WAC 296-20-430 Loss of taste and smell. (1) Rule for evaluation of permanent loss of taste and smell.

(a) If the person being examined can detect any odor or taste, even though it cannot be named, no category shall be assigned.

[Order 74-32, § 296-20-430, filed 6/21/74, effective 10/1/74.]

WAC 296-20-440 Categories of permanent loss of taste and smell. (1) Loss of sense of taste.

(2) Loss of sense of smell.

[Order 74-32, § 296-20-440, filed 6/21/74, effective 10/1/74.]

WAC 296-20-450 Speech impairments. (1) Rules for evaluation of permanent speech impairments.

(a) The physician making an examination for evaluation of permanent speech impairment should have normal hearing and the examination should be conducted in a reasonably quiet office which approximates the noise level conditions of everyday living.

(b) Selection of the appropriate category of permanent speech impairment shall be based on direct observation of the speech of the person being examined, including, but not limited to: Response to interview, oral reading, and counting aloud. The observation shall be made with the physician about eight feet from the person being examined both when he faces the physician and with his back to the physician.

[Order 74-32, § 296-20-450, filed 6/21/74, effective 10/1/74.]

WAC 296-20-460 Categories of permanent speech impairments. (1) No objective findings of significant speech impairment are present. Subjective complaints may be present or absent.

(2) Can produce speech of sufficient audibility, intelligibility and functional efficiency for most everyday needs, although this may require effort and occasionally exceed capacity; listeners may occasionally ask for repetition and it may be difficult to produce some elements of speech, and there may be slow speaking and hesitation.

(3) Can produce speech of sufficient audibility, intelligibility and functional efficiency for many everyday needs, is usually heard under average conditions but may have difficulty in automobiles, busses, trains, or enclosed areas; can give name, address, and be understood by a stranger, but may have numerous inaccuracies and have difficulty articulating; speech may be interrupted, hesitant or slow.

(4) Can produce speech of sufficient audibility, intelligibility and functional efficiency for some everyday needs such as close conversation, conversation with family and friends, but has considerable difficulty in noisy places; voice tires rapidly and tends to become inaudible in a few seconds, strangers may find patient difficult to understand; patient may be asked to repeat often, and often can only sustain consecutive speech for brief periods.

(5) Can produce speech of sufficient audibility, intelligibility and functional efficiency for few everyday needs; can barely be heard by a close listener or over the telephone; may be able to whisper audibly but has no voice; can produce some speech elements; may have approximation of a few words such as names of family members which are, however, unintelligible out of context; cannot maintain uninterrupted speech flow, speech is labored, and its rate is impractically slow.

(6) Is unable to produce speech of sufficient audibility, intelligibility and functional efficiency for any everyday needs.

[Order 74-32, § 296-20-460, filed 6/21/74, effective 10/1/74.]

WAC 296-20-470 Skin impairments. (1) Rules for evaluation of permanent skin impairments.

(a) Evaluation of permanent impairment of the skin shall be based upon actual loss of function and cosmetic factors shall not be considered.

(b) Categories 2, 3, 4, 5 and 6 include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-470, filed 6/21/74, effective 10/1/74.]

WAC 296-20-480 Categories of permanent skin impairments. (1) Objective findings of skin disorder may be present or absent but there is no or minimal limitation in daily activities. Subjective complaints may be present or absent.

(2) Objective findings of skin disorder are present and there is discomfort and minimal limitation in the performance of daily activities.

(3) Objective findings of skin disorder are present and there is limitation in some daily activities, including avoidance of and protective measures against certain chemical or physical agents. Intermittent symptomatic treatment is required.

(4) Objective findings of skin disorder are present and there is limitation in many daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

(5) Objective findings of skin disorder are present and there is limitation in most daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

(6) Objective findings of skin disorder are present and there is limitation in all daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

[Order 74-32, § 296-20-480, filed 6/21/74, effective 10/1/74.]

WAC 296-20-490 Impairment of the upper digestive tract, stomach, esophagus or pancreas. (1) Rule for evaluation of permanent impairments of the upper digestive tract, stomach, esophagus or pancreas.

(a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

[Order 74-32, § 296-20-490, filed 6/21/74, effective 10/1/74.]

WAC 296-20-500 Categories of permanent impairments of the upper digestive tract, stomach, esophagus or pancreas. (1) No objective findings are present. Subjective complaints may be present or absent.

(2) There are objective findings of digestive tract impairment but no anatomic loss or alteration, continuous treatment is not required and weight can be maintained at the medically appropriate level.

(3) There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs control symptoms, signs and/or nutritional state, and weight can be maintained at at least 90 percent of medically appropriate level.

(4) There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not completely control symptoms, signs and/or nutritional state. Weight can be maintained at 80-90 percent of medically appropriate level.

(5) There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not control symptoms, signs and/or nutritional state. Weight cannot be maintained as high as 80 percent of medically appropriate level.

[Order 74-32, § 296-20-500, filed 6/21/74, effective 10/1/74.]

WAC 296-20-510 Lower digestive tract impairments. (1) Rule for evaluation of permanent lower digestive tract impairments.

(a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-510, filed 6/21/74, effective 10/1/74.]

WAC 296-20-520 Categories of permanent lower digestive tract impairments. (1) No objective findings of impairment of lower digestive tract. Subjective complaints may be present or absent.

(2) The objective findings of lower digestive tract impairment are infrequent and of brief duration, and there is limitation of activities, but special diet or medication is not required, and there are neither systemic manifestations nor impairment of nutrition.

(3) There are objective findings of lower digestive tract impairment or anatomic loss or alteration and mild gastrointestinal symptoms with occasional disturbance of bowel function, accompanied by moderate pain and minimal restriction of diet; mild symptomatic therapy may be necessary; no impairment of nutrition.

(4) There are moderate to marked intermittent bowel disturbances with continual or periodic pain; there is restriction of activities and diet during exacerbations, there are constitutional manifestations such as fever, anemia or weight loss. Includes but is not limited to any permanent ileostomy or colostomy.

[Order 74-32, § 296-20-520, filed 6/21/74, effective 10/1/74.]

WAC 296-20-530 Impairment of anal function. (1) Rule for evaluation of permanent impairment of anal function.

(a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-530, filed 6/21/74, effective 10/1/74.]

WAC 296-20-540 Categories of permanent impairments of anal function. (1) No objective findings of impairment of anal function. Subjective complaints may be present or absent.

(2) There are objective findings of mild organic disease, anatomic loss or alteration with loss of anal function and mild incontinence involving gas and/or liquid stool.

(3) There are objective findings of moderate anal disease, anatomic loss or alteration with loss of anal function and moderate incontinence requiring continual care.

(4) There are objective findings of marked anal disease, anatomic loss, alteration and/or complete fecal incontinence.

[Order 74-32, § 296-20-540, filed 6/21/74, effective 10/1/74.]

WAC 296-20-550 Liver and biliary tract impairments. (1) Rule for evaluation of permanent liver and biliary tract impairments.

(a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

[Order 74-32, § 296-20-550, filed 6/21/74, effective 10/1/74.]

WAC 296-20-560 Categories of permanent liver and biliary tract impairments. (1) There are no objective findings of impairment of the liver or biliary tract. Subjective complaints may be present or absent.

(2) There are objective findings on biochemical studies of minimal impairment of liver function with or without symptoms, or there are occasional episodes of loss of function of the biliary tract, but nutrition and strength are good.

(3) There are objective findings on biochemical studies of mild impairment of liver function without symptoms, or there is recurrent biliary tract impairment, but no ascites, jaundice or bleeding esophageal varices and nutrition and strength are good.

(4) There are objective findings on biochemical studies of moderate impairment of liver function with jaundice, ascites, bleeding esophageal varices or gastric varices and nutrition and strength may be affected; or there is irreparable obstruction of the common bile duct with recurrent cholangitis.

(5) There are objective findings on biochemical studies of marked impairment of liver function and nutritional state is poor; or persistent jaundice, bleeding esophageal varices or gastric varices.

[Order 74-32, § 296-20-560, filed 6/21/74, effective 10/1/74.]

WAC 296-20-570 Impairments of the spleen, loss of one kidney, and surgical removal of the bladder with urinary diversion. (1) Rule for evaluation of permanent impairments of the spleen, loss of one kidney, and surgical removal of bladder with urinary diversion.

(a) Categories 1, 2 and 3 include complaints of whatever degree.

[Order 74-32, § 296-20-570, filed 6/21/74, effective 10/1/74.]

WAC 296-20-580 Categories of permanent impairment of the spleen, loss of one kidney, and surgical removal of bladder with urinary diversion. (1) Loss of spleen by splenectomy after age eight.

(2) Loss of one kidney by surgery or complete loss of function of one kidney.

(3) Surgical removal of bladder with urinary diversion.

[Order 74-32, § 296-20-580, filed 6/21/74, effective 10/1/74.]

WAC 296-20-590 Impairment of upper urinary tract. (1) Rule for evaluation of permanent impairment of upper urinary tract.

(a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever nature.

[Order 74-32, § 296-20-590, filed 6/21/74, effective 10/1/74.]

WAC 296-20-600 Categories of permanent impairments of upper urinary tract. (1) No objective findings of impairment of upper urinary tract. Subjective complaints may be present or absent.

(2) Loss of upper urinary function as evidenced by creatinine clearance of 75 to 90 liters/24 hr. (52 to 62.5 ml/min) and PSP excretion of 15 percent to 20 percent in 15 minutes; or if there are intermittent objective findings of upper urinary tract disease or dysfunction not requiring continuous treatment or surveillance.

(3) Loss of upper urinary tract function as evidenced by creatinine clearance of 60 to 75 liters/24 hr. (42 to 52 ml/min) and PSP excretion of 10 percent to 15 percent in 15 minutes; or although function is greater than these levels, there are objective findings of upper urinary tract disease or dysfunction requiring continuous surveillance and frequent symptomatic treatment.

(4) Loss of upper urinary tract function as evidenced by creatinine clearance of 40 to 60 liters/24 hr. (28 to 42 ml/min) and PSP excretion of 5 percent to 10 percent in 15 minutes; or although function is greater than these levels, there are objective findings of mild or moderate upper urinary tract disease or dysfunction which can be only partially controlled.

(5) Loss of upper urinary tract function as evidenced by creatinine clearance below 40 liters/24 hr. (28 ml/min) and PSP excretion below 5 percent in 15 minutes; or although function is greater than these levels there are objective findings of severe upper urinary tract disease or dysfunction which persists despite continuous treatment.

[Order 74-32, § 296-20-600, filed 6/21/74, effective 10/1/74.]

WAC 296-20-610 Additional permanent impairments of upper urinary tract due to surgical diversion. (1) Rule for evaluation of additional permanent impairments of upper urinary tract due to surgical diversion.

(a) These categories include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-610, filed 6/21/74, effective 10/1/74.]

WAC 296-20-620 Categories of additional permanent impairments of upper urinary tract due to surgical diversion. (1) Uretero-intestinal diversion or cutaneous ureterostomy without intubation.

(2) Nephrostomy or intubated ureterostomy.

[Order 74-32, § 296-20-620, filed 6/21/74, effective 10/1/74.]

WAC 296-20-630 Impairment of bladder function. (1) Rules for evaluation of permanent impairment of bladder function.

(a) In making examinations for evaluation of impairments of bladder function, physicians shall use objective techniques including, but not limited to, cystoscopy, cystography, voiding cystourethrography, cystometry, uroflometry, urinalysis and urine culture.

(b) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

[Order 74-32, § 296-20-630, filed 6/21/74, effective 10/1/74.]

WAC 296-20-640 Categories of permanent impairments of bladder function. (1) No objective findings are present. Subjective complaints may be present or absent.

(2) Objective findings of bladder dysfunction, intermittent treatment required, but there is no dysfunction between such intermittent attacks.

(3) Objective findings of bladder dysfunction, continuous treatment required or there is good bladder reflex activity but no voluntary control.

(4) Objective findings of bladder dysfunction, there is poor reflex activity with intermittent dribbling and no voluntary control.

(5) Objective findings of bladder dysfunction, there is no reflex or voluntary control and there is continuous dribbling.

[Order 74-32, § 296-20-640, filed 6/21/74, effective 10/1/74.]

WAC 296-20-650 Anatomical or functional loss of testes. (1) Rule for evaluation of permanent anatomical or functional loss of testes.

(a) Categories 2, 3, 4 and 5 include the presence of whatever complaints.

[Order 74-32, § 296-20-650, filed 6/21/74, effective 10/1/74.]

WAC 296-20-660 Categories of permanent anatomical or functional loss of testes. (1) No objective findings. Subjective complaints may be present or absent.

(2) Anatomical or functional loss of one testicle.

(3) Anatomical or functional loss of both testes after the age of 65.

(4) Anatomical or functional loss of both testes between the ages of 40 and 65.

(5) Anatomical or functional loss of both testes before the age of 40.

[Order 74-32, § 296-20-660, filed 6/21/74, effective 10/1/74.]

WAC 296-20-670 Disability. (1) The rules for determining disability are as follows:

(a) The determination of the percentage of disability in terms of total bodily impairment for any category is solely an administrative function and shall be done only in accordance with the tables of disability listed in WAC 296-20-680 and 296-20-690, or as otherwise provided in this chapter.

(b) When the industrial injury or occupational disease has caused further impairment to a bodily area where permanent bodily impairment existed prior to the industrial injury or occupational disease, the department shall award the percentage difference between the disability for the category of impairment which preexisted the industrial injury or occupational disease and the disability for the category of permanent impairment existing after the industrial injury or occupational disease.

(c) Neither the combined values chart provided in the guides to the evaluation of permanent impairment nor any other formula for the combination of the disabilities to different body areas or organ systems used in any other nationally recognized guide for determining bodily impairments shall be applied in computing the amount of disabilities to be awarded under these rules.

(d) Except as otherwise specifically provided, a percentage of total bodily impairment in one body area or system shall not be added to or combined with a percentage of total bodily impairment from another body area or system; the percentages for each body area or system shall be stated separately.

[Order 74-32, § 296-20-670, filed 6/21/74, effective 10/1/74.]

WAC 296-20-680 Classification of disabilities in proportion to total bodily impairment.

(1) Permanent Cervical and Cervico-Dorsal Impairments

Category	1	0%
	2	10%
	3	20%
	4	25%
	5	35%

(2) Permanent Dorsal Region Impairments

Category	1	0%
	2	10%
	3	20%

(3) Permanent Dorso-Lumbar and Lumbosacral Impairments

Category	1	0%
	2	5%
	3	10%
	4	15%
	5	25%
	6	40%
	7	60%
	8	75%

(4) Permanent Impairments of the Pelvis

Category	1	0%
	2	2%
	3	5%
	4	5%
	5	5%
	6	5%
	7	10%
	8	10%
	9	15%

(5) Permanent Convulsive Neurologic Impairments

Category	1	0%
	2	10%
	3	35%
	4	60%

(6) Permanent Mental Health Impairments

Category	1	0%
	2	10%
	3	25%
	4	45%
	5	70%

(7) Permanent Cardiac Impairments

Category	1	0%
	2	10%
	3	20%
	4	35%
	5	50%
	6	65%

(8) Permanent Respiratory Impairments

Category	1	0%
	2	15%
	3	25%
	4	40%
	5	65%
	6	75%

(9) Permanent Variable Respiratory Impairment with Normal Baseline Spirometry

Category	1	0%
	2	5%
	3	10%
	4	15%

(10) Permanent Air Passage Impairments

Category	1	0%
	2	5%
	3	15%
	4	25%
	5	35%
	6	60%

(11) Permanent Air Passage Impairments Due to Nasal Septum Perforations

Category	1	0%
	2	2%

(12) Permanent Loss of Taste and Smell

Category	1	3%
	2	3%

(13) Permanent Speech Impairments

Category	1	0%
	2	5%
	3	10%
	4	20%
	5	30%
	6	35%

(14) Permanent Skin Impairments

Category	1	0%
	2	5%
	3	10%
	4	25%
	5	40%
	6	60%

(15) Permanent Impairments of Upper Digestive Tract, Stomach, Esophagus or Pancreas

Category	1	0%
	2	5%
	3	10%
	4	35%
	5	60%

(16) Permanent Impairments of Lower Digestive Tract

Category	1	0%
	2	5%
	3	15%
	4	30%

(17) Permanent Impairments of Anal Function

Category	1	0%
	2	5%
	3	15%
	4	25%

(18) Permanent Impairments of Liver and Biliary Tract

Category	1	0%
	2	5%
	3	20%
	4	40%
	5	60%

(19) Permanent Impairments of the Spleen, Loss of One Kidney, and Surgical Removal of Bladder with Urinary Diversion

Category	1	15%
	2	10%
	3	20%

(20) Permanent Impairments of Upper Urinary Tract

Category	1	0%
	2	10%
	3	25%
	4	45%
	5	65%

(21) Additional Permanent Impairments of Upper Urinary Tract Due to Surgical Diversion

Category	1	10%
	2	15%

(22) Permanent Impairments of Bladder Function

Category	1	0%
	2	10%
	3	20%
	4	30%
	5	50%

(23) Permanent Anatomical or Functional Loss of Testes

Category	1	0%
	2	5%
	3	10%
	4	25%
	5	35%

[Statutory Authority: RCW 51.04.020(4), 51.04.030 and 51.32.080(2). 94-03-073, § 296-20-680, filed 1/17/94, effective 3/1/94. Statutory Authority: Chapters 34.04 [34.05], 51.04, 51.32 and 51.36 RCW. 90-04-007, § 296-20-680, filed 1/26/90, effective 2/26/90. Statutory Authority: RCW 51.04.020(4), 51.04.030, and 51.16.120(3). 81-01-100 (Order 80-29), § 296-20-680, filed 12/23/80, effective 3/1/81; Order 74-32, § 296-20-680, filed 6/21/74, effective 10/1/74.]

WAC 296-20-690 Permanent impairments of the cervico-dorsal (WAC 296-20-240) and lumbosacral regions (WAC 296-20-280) jointly.

(1) Permanent Cervical and Cervicodorsal Impairment Category 1 Plus Permanent Dorsolumbar and Lumbosacral Impairment

Category	1	0%
	2	5%

	3	10%
	4	15%
	5	25%
	6	40%
	7	60%
	8	75%

(2) Cervical-Cervicodorsal Category 2 Plus Dorsolumbar-Lumbosacral

Category	1	10%
	2	15%
	3	20%
	4	25%
	5	35%
	6	50%
	7	70%
	8	75%

(3) Cervical Cervicodorsal Category 3 Plus Dorsolumbar-Lumbosacral

Category	1	20%
	2	25%
	3	30%
	4	35%
	5	45%
	6	55%
	7	70%
	8	75%

(4) Cervical-Cervicodorsal Category 4 Plus Dorsolumbar-Lumbosacral

Category	1	25%
	2	30%
	3	35%
	4	40%
	5	45%
	6	55%
	7	70%
	8	80%

(5) Cervical-Cervicodorsal Category 5 Plus Dorsolumbar-Lumbosacral

Category	1	35%
	2	40%
	3	45%
	4	50%
	5	55%
	6	65%
	7	70%
	8	80%

[Order 74-32, § 296-20-690, filed 6/21/74, effective 10/1/74.]