

**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~~) the current federally adopted ICD-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~~) the current federally adopted ICD-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+)) (1) Health Care Common Procedure Coding System Level I and II Codes, descriptions and modifiers that describe medical and other services, supplies and materials.

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

((+c+)) (3) 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+)) (4) Billing instructions or policies relating to the submission of bills by providers and the payment of bills by the department or self-insurer.

((+e+)) (5) Average wholesale price (AWP), baseline price (BLP), and policies related to the purchase of medications.

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

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

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

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

**Initial visit:** The first visit to a health care provider during which the *Report of Industrial 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 necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

**Refill:** The continuation of therapy with the same drug (including the renewal of a previous prescription or adjustments in dosage) when a prescription is for an antipsychotic, antidepressant, chemotherapy, antiretroviral or immunosuppressive drug, 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.

AMENDATORY SECTION (Amending WSR 12-06-066, filed 3/6/12, effective 4/6/12)

**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-in-

surer 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,~~) the current federally adopted ICD-CM 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.

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

**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~~) the current federally adopted ICD-CM codes; their relationship, if any, to the industrial injury/exposure; an outline of the proposed treatment program, its length and components, procedure codes, and expected prognosis; and an estimate of when treatment would be concluded and condition stable.

(1) Office calls in excess of the first twenty 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 mal-function 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.

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

<i>Report</i>	<i>Due/Needed by Insurer</i>	<i>What Information Should Be Included In the Report?</i>	<i>Special Notes</i>
<b>Report of Industrial Injury or Occupational Disease</b> (form)  <b>Self-Insurance: Provider's Initial Report</b> (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.
<b>Sixty Day</b> (narrative) <b>Purpose:</b> 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 <b>conditions diagnosed</b> , including ((ICD-9-CM)) <u>the current federally adopted ICD-CM</u> codes and the subjective complaints and objective findings.	Providers may submit legible comprehensive chart notes in lieu of sixty day reports <b>PROVIDED</b> the chart notes include all the information required as noted in the "What Information Should Be Included?" column.
		(2) The <b>relationship of diagnoses</b> , if any, to the industrial injury or exposure.	<b>However</b> , 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 <b>proposed treatment program</b> , its length, components and expected prognosis including an <b>estimate of when treatment should be concluded</b> and condition(s) stable. An <b>estimated return to work date</b> and the <b>probability</b> , if any, of <b>permanent partial disability</b> resulting from the industrial condition.	
		(4) <b>Current medications</b> , including dosage and amount prescribed. With repeated prescriptions, include the plan and need for continuing medication.	Providers must <b>include their name, address and date</b> on all chart notes submitted.

<i>Report</i>	<i>Due/Needed by Insurer</i>	<i>What Information Should Be Included In the Report?</i>	<i>Special Notes</i>
		(5) If the worker has not returned to work, <b>indicate whether a vocational assessment will be necessary</b> to evaluate the worker's ability to return to work and why.	
		(6) If the worker has not returned to work, a <b>doctor's estimate of physical capacities</b> should be included.	
		(7) <b>Response to any specific questions</b> asked by the insurer or vocational counselor.	
<b>Opioid Authorization Requirement</b>	Opioids in subacute phase - Six weeks from the date of injury or surgery.  Opioids in chronic phase - Twelve weeks from the date of injury or surgery.  Opioids for ongoing chronic therapy - Every ninety days.	Please see WAC 296-20-03056 through 296-20-03059 for documentation requirements for those workers receiving opioids.	
<b>Special Reports/Follow-up Reports</b> (narrative)	As soon as possible following request by the department/insurer.	<b>Response to any specific questions</b> asked by the insurer or vocational counselor.	"Special reports" are payable only when requested by the insurer.
<b>Consultation Examination Reports</b> (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.
<b>Purpose:</b> Obtain an objective evaluation of the need for ongoing conservative medical management of the worker.		(2) <b>Comparative history</b> between the history provided by the attending or treating provider and injured worker.	
		(3) Detailed physical examination.	
The attending or treating provider may choose the consultant.		(4) <b>Condition(s) diagnosed</b> including ( <del>ICD-9-CM</del> ) <u>the current federally adopted ICD-CM</u> codes, subjective complaints and objective findings.	A copy of the consultation report must be submitted to both the attending or treating provider and the department/insurer.
		(5) Outline of <b>proposed treatment program:</b> Its length, components, expected prognosis including when treatment should be concluded and condition(s) stable.	

<i>Report</i>	<i>Due/Needed by Insurer</i>	<i>What Information Should Be Included In the Report?</i>	<i>Special Notes</i>
		(6) <b>Expected degree of recovery</b> from the industrial condition.	
		(7) <b>Probability of returning to regular work</b> or modified work and an <b>estimated</b> return to work <b>date</b> .	
		(8) <b>Probability</b> , if any, of <b>permanent partial disability</b> resulting from the industrial condition.	
		(9) A doctor's <b>estimate of physical capacities</b> should be included if the worker has not returned to work.	
		(10) <b>Reports</b> of necessary, reasonable <b>X ray</b> and <b>laboratory</b> studies to establish or confirm diagnosis when indicated.	
<b>Attending Provider Review of IME Report</b> (form)  <b>Purpose:</b> Obtain the attending provider's opinion about the accuracy of the diagnoses and information provided based on the IME.	As soon as possible following request by the department/insurer.	Agreement or disagreement with IME findings. If you disagree, provide objective/subjective findings to support your opinion.	Payable only to the attending provider upon request of the department/insurer. PAs can concur with treatment recommendations but not PPD ratings.
<b>Loss of Earning Power</b> (form)  <b>Purpose:</b> 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.
<b>Application to Reopen Claim Due to Worsening of Condition</b> (form)  <b>Purpose:</b> 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.  <b>Crime Victims:</b> 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:

<b>Provider</b>	<b>Chart Notes</b>	<b>Reports</b>
Audiology	X	X
Biofeedback	X	X

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

AMENDATORY SECTION (Amending WSR 07-08-088, filed 4/3/07, effective 5/23/07)

**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 In-

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~~) the current federally adopted ICD-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.