Washington State Department of
Labor & Industries

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Attending Doctor's Handbook

For Doctors and Office Staff

A Look Inside

PUBLICATION F252-004-000 [10-2012]

Quick Tips for Providers

When you treat patients covered by State Fund or Self-Insured workers' compensation

For more information, see the "Quick Reference Guide to L&I Services" at the back of this book or the sections in this handbook referenced below. **Note:** The quick reference guide includes URLs to areas of L&I's website that cover information specifically for providers.

Report of Accident

- Must be submitted within 5 days; 2 days is the best practice.
- Include the provider number on the initial Report of Accident. **See Section 2, Pages 6-21**.

When Documentation is Due

Report Types:	**Due:**
Initial Report of Injury	Within 5 days of 1st visit
Office/Chart/Progress Reports. **See Page 24**.	Every 30-60 days
Supplemental Reports	ASAP upon request
Consultation Reports	At 120 days
IME Reports	When authorized
Extended Service Report	When service is billed

Chart/Progress Notes

Use the SOAPER format for all doctor's office/ chart/progress notes and 60-day narrative reports to reduce the number of phone calls and letters from the claim managers:

- **S** The worker's subjective complaints
- **O** The doctor's objective findings
- **A** The doctor's assessment
- **P** The doctor's treatment plan (This should include what you tell the worker regarding expectations for recovery, medication side effects, etc.)

In workers' compensation, claim managers have unique needs for work status information. To meet this need, we suggest adding an "ER" to the SOAP contents:

- **E** Employment issues. Has the worker been released for or returned to work? When is release anticipated?
- **R** Restrictions to recovery. Describe the physical limitations, both temporary and permanent, that prevent return to work. What other limitations, including unrelated conditions are preventing return to work? Can the worker perform modified work or different duties while recovering? Is there a need for return-to-work assistance? (Use the *Activity Prescription* form when appropriate.)

For more information, see Section 3B, page 24-25.

Correspondence

We need your help! To get your documents to the right file, write the worker's claim number and name in the upper righthand corner of every page of all correspondence. Please submit only on 8.5 x 11 size white paper to assure quality electronic imaging. **See Appendix I, Page 84**.

Transfer of Attending Doctor

If you accept a new patient formerly treated by a different doctor for a work-related condition, ask the worker to request transfer of care:

- Online at **www.TransferCare.Lni.wa.gov** or
- By submitting a "Case Transfer" card or note to the claim manager at the following address.

Department of Labor & Industries
P.O. Box 44291
Olympia, WA 98504-4291

See Section 3F, Page 29.

Helping Your Patient Return to Work and Preventing Long-Term Disability (LTD)

Minor strains and sprains too often lead to permanent, total disability. Disability may be prevented by taking measures *soon after the injury*, such as job modification, case management, and light-duty work addressing risk factors for LTD. Strong communication among you, your patient, your patient's employer and others is key. Many resources are available.

For more information, see Section 1C, Page 4; Section 2E, Page 8; Section 2F, Page 8; and Section 2H, Page 16.

Treatment Limits

By law, workers' compensation claims are closed when a patient's condition reaches Maximum Medical Improvement (MMI) and it has been determined that a patient is able to work in any occupation.

- MMI is defined as a level of recovery to a point where the injury or illness will not improve with continued care. A patient may still have subjective complaints and objective findings that fluctuate over time.
- Workers' compensation in Washington cannot pay for palliative or maintenance care. Workers' compensation laws in Washington only permit curative and rehabilitative care necessary for an injured worker to reach MMI status.
- In some cases permanent partial disability awards (settlements) may be made to the worker.

See Section 3J, Page 30, and Section 5, Page 46.

Find it fast! *Photocopy this page and the "Quick Reference Guide to L&I Services" at the back of this book and keep them in a convenient location.*

About the October 2012 Update Edition to the *Attending Doctor's Handbook*

This October 2012 update edition of the *Attending Doctor's Handbook* contains selected updates to the March 2005 edition. New or updated information is located inside the front and back covers of the book and in the center "insert." **Pages i through 90 have not changed**.

We've also included the **Updates and Additions** table below to introduce topics not covered in Pages i through 90 or to call out changes to existing sections. Until L&I publishes a completely new edition of this handbook, you will find the original content and the Updates and Additions table, together with links to online resources, make this document a useful reference tool for your practice.

We also want to draw your attention to two significant developments:

1. Please take a look at the **Workers' Compensation Reforms** insert in the center of this book. Among the reforms is the new Medical Provider Network, which we invite Washington's attending health-care providers to join. This is an open network—L&I will accept all qualified providers who meet network requirements. Details are in the insert.

2. Continuing Education (CE) Credits associated with this publication have changed. **Please disregard all references to CMEs in Pages i through 90**. However, readers who successfully complete the online ADH CE activity receive a certificate for 3 hours of Category 2. For more information, go to **www.CMECredits.Lni.wa.gov**.

Updates and Additions to the *Attending Doctor's Handbook*, October 2012

Section	Page	Title	Comments
2	6 & 18	Claim Filing	The Occupational Health Best Practice is to submit the report of accident within two days. "FileFast" allows workers and medical providers to file the *Report of Accident* online at **www.FileFast.Lni.wa.gov**. Workers without computer access can file by phone at 1-877-561-FILE (3453). Employers statewide can file online at **www.EmployerROA.Lni.wa.gov**. The *Report of Accident* was revised to allow more space for ICD codes and address Medical Provider Network requirements. Ordering information: **www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599**. To transfer care to a different provider, workers should go to **www.TransferCare.Lni.wa.gov** to submit their request or they should use the Case Transfer Card available at **www.Lni.wa.gov/FormPub/Detail.asp?DocID=1618**.
	11	Special Return to Work Resources	The 2012 edition of the *Attending Provider's Return to Work Desk Reference* is available at **www.Lni.wa.gov/FormPub/Detail.asp?DocID=1492**. Readers who pass the online CME Activity receive 3 hours of Category 1 CME credit. Go to **www.CMECredits.Lni.wa.gov** to learn more. Contact local L&I service locations to obtain ergonomic and job modification assessments, early return to work, and risk management assistance. Office locations and phone numbers are listed at **www.Offices.Lni.wa.gov**.

(Continued on Page C)

Updates and Additions to the *Attending Doctor's Handbook*, October 2012

Section	Page	Title	Comments
2	17	Physician and Chiropractic Consultants	Pain management specialists are available at L&I for State Fund claims to provide second opinions at the attending doctor's request on how to manage workers with pain issues or who take high doses of opioids. These consultants will review claims and call the attending doctor to confer on treatment options. Locate chiropractic consultants in Washington at **www.FindADoc.Lni.wa.gov**. Click on "Search for L&I providers" and then choose "advanced search." Fill in "located near." Then, under "provider types and specialties," select chiropractor in the first box and "chiropractic consultant" in the second box.
	20	The State Fund: Communicating with the Department	Send secure messages to the claim manager through L&I's online Claim & Account Center. Join or login at **www.ClaimInfo.Lni.wa.gov** to review the status of a claim or bill, and see medical records. L&I pays for good communication. Remember these billing codes are available to you: **Telephone Calls** 99941-9443 Physicians only 98966-98968 Non-physician **Secure messages through L&I's online Claim & Account Center** 99444-99443 Physicians only 98969 Non-physician
	22	Communicating with a Self-Insured Employer	To locate the contact information for a self-insured employer or their third party administrator, go here: **www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList**.
3	25	Reports	The *Supplemental Medical Report* and four other forms were replaced by the *Activity Prescription Form*. See **www.Lni.wa.gov/ClaimsIns/Providers/Claims/ActivityRx** for when to use it, how to complete it, and billing codes.
	25	Authorization for Services	Authorization requirements have changed for advanced imaging and other services, see **www.Lni.wa.gov/ClaimsIns/Providers/AuthRef/GetAuth.asp**.
	28	Pain Management	L&I adopted opioid dosing guidelines developed by agency medical directors. Four hours of Category 1 CME credit are available for successful completion of the online CME activity. Go to: **www.agencymeddirectors.wa.gov/opioiddosing.asp**. This website also includes an opioid dosing calculator you can download, use from the website or access from a mobile device: **www.agencymeddirectors.wa.gov/mobile.html**.
	31	Pensions	See "Structured Settlement" in the Workers' Compensation Reforms insert in the middle of this book.
4	33	Medical and Surgical Guidelines	Current guidelines are online at: **www.TreatmentGuidelines.Lni.wa.gov**.

(Continued on Page D at back of book)

CONTENTS

INTRODUCTION

For most injured workers, doctors are key players in the workers' compensation system. In addition to your primary responsibility of providing quality medical care, the system also relies on you to give injured workers guidance and information about workers' compensation and to help your patients return to work, perhaps even during recovery. Please talk to them about workers' compensation and return-to-work efforts. The guidance and information you provide may help them return to their jobs earlier, resulting in better economic outcomes for workers and their families.

This handbook will help you meet these responsibilities. It is a general guide for attending doctors: licensed practitioners of medicine, osteopathic medicine and surgery, chiropractic, dentistry, podiatry, optometry and naturopathy who treat injured workers.

It is packed with information and telephone numbers of resources available to assist you and the injured workers you treat. It contains an index and telephone listings. It is not a legal interpretation of complex law, but rather an easy-to-understand explanation of current requirements under Washington State's industrial insurance (workers' compensation) program, and your role as the treating provider.

The information is current as of June 2004. There were many contributors to this handbook including (but not limited to): Hal Stockbridge, MD, MPH; Gary Franklin, MD, MPH; John Holland, MD, MPH, and Joanne McDaniel, MA, OTR/L.

Please let us know how we can make this guide more helpful to you. We welcome and encourage your questions, comments, and suggestions. Please contact:

Associate Medical Director for Industrial Insurance
Office of the Medical Director
P.O. Box 44321
Olympia, WA 98504-4321

360-902-5022

Additional copies of this handbook may be obtained by contacting the nearest L&I service location. A list of locations and telephone numbers is on page 66.

ACOEM approval date: March 15, 2005
Expiration date: March 14, 2008

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

CME Self-Assessment Test

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the Joint Sponsorship of the American College of Occupational and Environmental Medicine and Washington State Department of Labor and Industries.

The American College of Occupational and Environmental Medicine is accredited by the ACCME to provide continuing medical education for physicians.

ACOEM designates this educational activity for a maximum of 3 category 1 hours toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credits that he/she actually spent in the activity.

The estimated time for reading this handbook and completing the self-assessment test is three hours. After reading these materials and taking the Self-Assessment Test, you should be able to:

- Describe measures to prevent or address some of the major occupational conditions encountered in this country, including long-term disability (LTD), cumulative trauma disorders, chemically related illness, and musculoskeletal injuries.
- Describe diagnostic and treatment guidelines developed by the medical community to improve the quality of care delivered to patients with occupational injuries and illnesses.
- Describe resources (job modifications, occupational therapists, industrial hygienists, medical consultants, etc.) that may be available to the doctor, the patient, or the employer to aid recovery and speed return to work after an injury or illness.
- Describe the roles and responsibilities of treating (attending) physicians and consulting doctors.
- Define terms commonly used in workers' compensation, including "fixed and stable," "MMI," "impairment," "disability," "work-relatedness," "medically necessary" and "more-probable-than-not".
- Discuss the processes for evaluating and rating permanent impairment.
- Describe the basic concepts and features of Washington State's industrial insurance laws, rules, and policies.

SECTION

1

Fundamentals of Workers' Compensation

A. Overview of Workers' Compensation in Washington State

The state workers' compensation program works to secure prompt medical care, return-to-work options and financial security for injured workers as they heal, while controlling employer and employee costs. The Department of Labor and Industries (the department, or L&I) focuses its efforts on preventing workplace accidents and injuries, helping injured workers return to work and preventing long-term disability. (See Preventing Long-Term Disability, page 4, and Helping Patients Return to Work, page 8.) This is the best way to contain costs for everyone involved with the workers' compensation system in Washington, especially labor and management, the true "owners" of the system.

A Historical Perspective

Washington enacted industrial insurance laws in 1911, as a step designed to protect workers and employers.

The turn of the century brought new industries with new and more frequent injuries to workers. Employers were faced with lengthy and costly legal suits resulting from these work-related injuries, while workers, forced to prove an employer's liability, often were left jobless and destitute.

Industrial insurance's "no-fault" insurance program tried to take the uncertainty out of this situation for both the employer and the worker. Neither the worker nor the employer had to accept blame for the incident. Employers could not be sued because of a workplace injury. Workers were guaranteed medical benefits and compensation to offset lost wages while they recovered.

Washington was the first state to make workers' compensation mandatory. The program has grown through the century but has stayed fundamentally the same. In 1937, the law began covering occupational diseases. In 1971, the Legislature expanded coverage to all classifications of employment in the state, not just the most hazardous.

The department today:

Washington's Department of Labor and Industries is one of the largest and oldest providers of workers' compensation in the United States. The department administers the state's workers' compensation system through the State Fund, which covers more than 151,000 employers and 1.7 million workers. Another 400 large employers, that employ the remaining third of the state's workforce, self-insure. Labor and Industries and self-insurance are the only two options for workers' compensation coverage that are available in Washington.

Most Washington workers are guaranteed workers' compensation coverage. (A small percentage of workers are not covered by either the State Fund or a self-insured employer. Federal employees and workers covered under the Longshore and Harbor Workers Act are examples.) About 180,000 claims are filed with the department each year. The department accepts about 85 percent as valid.

Premiums and benefits

The State Fund functions as an insurance company and is almost wholly funded by the premiums businesses and their workers pay. Washington is unique in that employers and workers share the costs, with employers paying about 70 percent, employees 30 percent. Each claim filed for a work-related injury affects the amount the employer and employees pay into the State Fund and, therefore, the cost of doing business.

Workplace safety and health

In addition to paying benefits for injured workers, the department is actively involved in keeping workplaces safe. The WISHA services division regularly inspects businesses for hazards and investigates accidents that have resulted in death and severe injury. When appropriate, the department levies fines and, when necessary, can shut down a business that the agency determines is operating in a manner that threatens the health and safety of employees. One branch of the WISHA services division conducts research on workplace safety, regularly identifying the most hazardous jobs and industries. Often, the department works with employers to lessen the risks, thus avoiding accidents, deaths, and penalties. L&I offers numerous no-fee services, including workshops and one-on-one consultations, to help employers improve their safety and health programs (See page 16).

B. Workers' Compensation and the Attending Doctor

The workers' compensation system and the attending doctor play important roles in helping workers recover from occupational injuries and illnesses.

Workers' compensation

Washington's workers' compensation program provides financial and medical benefits when a worker is hurt on the job. The goal is to ensure the worker receives quality medical care and returns to work as soon as possible.

The program

- Pays for medically necessary treatment of work-related medical problems.
- Replaces a percentage of wages lost while the worker's injury prevents him or her from returning to the job.
- Provides return-to-work assistance for those workers who need help.
- Provides pensions to workers who can never return to work and to the families of workers who die due to a work-related injury or disease.
- Pays for home, vehicle, and workplace modification.

The attending doctor's role

As the attending doctor of an injured worker, you:

- Identify work-related medical problems and initiate workers' compensation benefits by filing the appropriate report. The State Fund Report of Industrial Injury or Occupational Disease — the Accident Report — is explained further in Section 2J, page 19. The Self-Insurance Physician's Initial Report is explained in Section 2K, page 20.
- Treat workers for work-related injuries or diseases. (See Sections 3 and 4, page 23 and 33.)
- Educate your patients about the benefits they should and should not expect to receive from the workers' compensation system. (See Section 2D, page 7.)
- Report on injured workers' ongoing progress while they are being treated. (See Section 3B, page 24.)
- Help return workers to a productive work life. (See Section 2F, page 8.)
- Help determine which workers need assistance to return to work, for example, through job modification. (See Section 2F, page 8.)
- Rate impairment when a worker's condition has reached maximum medical improvement. (See Section 5, page 46.)
- Report unsafe working conditions that you may identify while treating patients injured on the job. (See Section 2H, page 16.)
- Agree to accept and abide by the department's *Medical Aid Rules and Fee Schedules*.

C. Preventing Long-Term Disability: Medical Providers Have a Key Role

Long-term disability has high costs, both in human and financial terms. In Washington State, roughly 20,000 people have been off work for more than one year due to work-related conditions. For many of these 20,000 individuals, work-related injuries have devastated their family life, self-esteem, personal finances, and many other aspects of their lives. Studies show that an injured person off the job for two years has less than a 15 percent chance of ever returning to work.

The financial impact is also great. Approximately $1 billion is spent annually in Washington State for medical and time-loss expenses for workers who have been off work for more than 120 days. What's more, ***less than 5 percent of all claims account for 84 percent of the costs***. High cost means high premiums paid by your patient and the employer. Premiums depend partly on the claim expenses of each employer and partly on the employer's industrial class. Premiums to cover workers in some jobs are astronomical. For example, costs for some loggers and roofers can be more than $8 per hour, just for the workers' compensation premium alone. What's more, the ***average*** cost of a time-loss claim is more than $20,000 per claim for the medical and time-loss benefits. A small company with 20 workers may pay an extra $60,000 or more in annual premiums if it doesn't prevent accidents and avoid long-term disability.

Early intervention by medical providers is key to preventing long-term disability. Medical providers have a unique role in helping injured workers understand how light-duty or transitional work, where applicable, can speed recovery.
(See Sections 2D, page 7 and 2F, page 8.)

Perhaps the most striking fact is that most of these claims are NOT from people who have lost limbs or suffered other catastrophic injuries while at work. Most are non-catastrophic claims — the muscle and back strains, for example — that linger and deter an otherwise able-bodied individual from returning to the work force. The silver lining, however, is that there are significant opportunities to prevent such a disability (even after the injury occurs).

The Occupational Health Services Project

The Occupational Health Services Project is a partnership between the Department of Labor and Industries and two health care organizations to expand occupational health care expertise and improve injured worker outcomes over the next several years. The project preserves a worker's choice of provider and makes clinical and administrative resources available when and where providers and workers need them most. This pilot study is a community-based effort to improve occupational health services for injured workers. It will specifically test the ability to use education and financial incentives to make improvements for three targeted conditions: carpal tunnel syndrome, low back sprain, and upper and lower extremity fractures. The pilot uses occupational health leaders to increase the occupational health skills and knowledge of providers who treat injured workers. The goals of the project are to improve outcomes and satisfaction in terms of care outcomes, incidence of disability, and duration of disability. Occupational Health Services at Valley Medical Center (Western WA) and St. Luke's Rehabilitation Institute (Eastern WA) have been selected to set up regional Centers of Occupational Health and Education (COHE) to provide occupational health training and mentoring for community doctors; and to facilitate effective and efficient communication among providers, workers, employers and the workers' compensation system. Researchers from the University of Washington will track worker outcomes for the three-targeted conditions, as well as worker and physician satisfaction. To learn more about the Centers of Occupational Health and Education, call 1-866-247-2643 (Eastern WA), 1-866-663-2643 (Western WA), or 360 902-6807 (Department of Labor and Industries).

D. The Rules of Workers' Compensation

As an attending doctor caring for a patient in Washington's workers' compensation system, certain rules may affect your practice:

The Revised Code of Washington (RCWs) are laws created by the state Legislature. For example, the RCWs require the doctor's assistance in filing the Accident Report. [RCW 51.28.020] The RCWs also forbid acceptance of a claim for mental stress. [RCW 51.08.142] Changing an RCW requires the passage of a bill through the Legislature and approval of the governor. Statutes covering industrial insurance (workers' compensation) laws are found in Title 51 RCW.

The Washington Administrative Code (WACs) are rules created by the Department of Labor and Industries (and other state agencies). They were adopted to administer the RCWs, and have the power of law. For example, the WACs detail the reporting requirements a doctor treating an injured worker must meet. [WAC 296-20-06101] The department's *Medical Aid Rules* are WACs. The WACs must go through a public hearing process before they are created, modified, or repealed.

Case law, or court decisions, interpret and clarify application of WACs and RCWs to specific situations. For example, *Vliet v. the Department of Labor and Industries*, 30 Wn. App .709 (1981), focused on RCW 51.32.080(2) and WAC chapter 296-20. The RCW directed the department to create rules for rating impairment that would help bring uniformity to the process. The department adopted the rules as WAC chapter 296-20, which contains categories of permanent partial disability. When the category system was challenged in court, the Washington Court of Appeals upheld the department's rating decision to require its use and rejected requests for the use of the percentage system. Courts interpret the RCWs and WACs as different situations occur and as parties disagree on what the statutes or regulations actually mean.

Throughout this booklet, you will find citations of RCWs and WACs. These annotations are added as a convenient reference for you. The WACs are published in the *Medical Aid Rules and Fee Schedules*. You can order a copy by calling the nearest L&I service location (see page 66). The RCWs are available at public libraries and at the Washington State Legislature's website: **http://slc.leg.wa.gov/**

E. Medical Necessity and Treatment Limits

By law, injured workers in Washington's workers' compensation system are eligible only for ***medically proper and necessary treatment.*** These are services that are in accordance with accepted standards of good practice; necessary for, and consistent with the diagnosis; the most appropriate level of care provided in the most appropriate setting; and not primarily provided for the convenience of the worker, the attending doctor or any other provider. Under the state system, injured workers may be eligible for the following:

- **Treatment for work-related injury or illness only.** Other non-occupational medical problems are not covered by the Washington workers' compensation system. [RCW 51.32.010; 51.36.010]
- **"Curative care"** — that is, medical care that is likely to improve the patient's medical or functional status. [WAC 296-20-010(7)] For example: suturing a laceration, treating occupational asthma, or the evaluating and treating of a fracture.
- **Screening and preventative care** in certain cases of job-related exposures to communicable diseases (See the section on treating occupational diseases, page 13.)
- S**tandard and usual medical care.** Workers are not eligible for medical treatment the department considers experimental, controversial, or obsolete. [WAC 296-20-03002]
- **Wage replacement (time-loss) payments** if a worker ***cannot*** return to work within three days of an occupational injury.
- **Return-to-work assistance**.
- **Permanent and partial disability benefits** (See the *Medical Aid Rules and Fee Schedules* for WAC 296-20-200 through-670.)

Workers are ***not*** eligible for "palliative care"—that is, care that may result in symptomatic relief but will not improve the patient's medical or functional status. [WAC 296-20-01002 and 296-20-03002] For example, in some instances, prolonged physical therapy, medication use, chiropractic care, or routine medical evaluations could be considered palliative for chronic musculoskeletal pain. Also, please refer to "Authorization for Services" on page 25.

SECTION

2

Initiating a Workers' Compensation Claim

A. The History and Physical

Include at least a brief occupational history in your initial history and physical. An occupational history creates a background for an injured worker that helps the claim manager make decisions. It also can help clarify issues of causation and identify job skills that might help return your patient to work.

Without an occupational history, many work-related diseases can be misdiagnosed. When documenting your patient's occupational history, be sure to explore the following areas:

- Employment from adolescence to present
- Military service
- Hobbies, especially those that may have exposed the patient to hazardous substances or repetitive trauma

A detailed occupational history is especially important for occupational diseases. (Please see Occupational Diseases, page 13, and Selected Billing Codes of Interest to Doctors, page 51, for more detail.)

> Objective findings are extremely important to claim managers in their decision-making process. You should be as specific and detailed as possible in describing objective findings to assure that the claim manager is able to make appropriate adjudicative decisions as expeditiously as possible and your patient receives the benefits to which he/she is entitled. (See Occupational Diseases, page 13, and Glossary of Terms, page 58, for more on objective findings.)

If the claim is not accepted, you will be paid for completing the report and generally will be paid for the initial office visit and necessary tests (except in unusual circumstances, for example, jurisdiction is determined to be the U.S. Department of Labor) [WAC 296-20-124].

B. Claim Filing Responsibilities

If you are the first doctor to diagnose a worker for an occupational injury or disease, you are responsible for reporting this to the State Fund or the self-insured employer. [RCW 51.28.020; WAC 296-20-025(2)] Failure to file a claim could result in a fine. You initiate the claim for your patient when you send an Accident Report to Labor and Industries or the self-insured employer.

> To make certain you are paid correctly and promptly, be sure you know if your patient's employer is self-insured or pays into the State Fund.
>
> Also, it is important to put the correct provider number on the Accident Report and identify the doctor or clinic by its full name, address, and phone number, along with the doctor's signature.

If your patient is not sure if his or her employer is covered by the State Fund or is self-insured, you can find out by calling the Provider Hotline: 800-848-0811 or the direct line: 360-902-6500.

For more information about State Fund claims and self-insured claims, see pages 19 and 20.

In deciding whether to file a claim for a particular patient, keep the following points in mind:

- **If your patient asks you to file a claim,** but you don't think the condition is work-related, you must file the claim anyway. You can indicate that the condition is not work-related on the Accident Report. (See Determining Work-Relatedness, page 7.) You can also inform the patient that the inappropriate filing of a claim may result in delays in coverage by other insurers.
- **If you think a condition is work-related,** but your patient does not want to file a claim, you are required to inform the injured worker of his or her rights under Title 51, and to lend all necessary assistance to the worker in making application for compensation. You are obligated to file a report of accident unless the worker

specifically directs you not to, after being informed of their rights under Title 51. However, if a report of accident is not filed, L&I cannot make reimbursement for the visit, and any costs of care for a condition arising out of work would be the patient's responsibility. Title 51 prohibits employers from paying directly for an injured worker's care in order to avoid the filing of a workers' compensation claim. Further, your patient cannot seek payment from other insurers by withholding that their condition is work-related.

- **Claims should be filed even for minor injuries,** such as those requiring only first aid. Title 51 RCW, the Industrial Insurance Act, does not distinguish between first aid and any other type of medical treatment. Whenever an injured worker receives treatment from a doctor, the provisions of the Act apply regardless of the severity of the injury. [RCW 51.28.010]
- **If your patient is afraid of being fired or of some other type of retaliation for filing a claim,** let him or her know that the law protects workers against such discrimination. [RCW 51.48.025] See page 22 for where to turn if your patient has been discriminated against for filing a claim.
- **For occupational illnesses** (for example, carpal tunnel syndrome, asbestosis, many pesticide-related illnesses), legal requirements are different than for injuries, so a detailed occupational history is required. (See Occupational Diseases, page 13, for more information.)
- **Physicians in the unique position of treating workers at a self-insured employer's on-site medical facility** may contact the department's Self insurance section at 360-902-6842 regarding reporting and record-keeping requirements.

C. Determining Work-Relatedness

Work-relatedness depends on a variety of factors (medical, legal and administrative) and can be difficult to determine. For example, the medical element may focus on the years of asbestos exposure while the administrative/legal may be concerned with where the incident took place.

The Accident Report requires the doctor to answer the question by circling either "yes," "probably," "possibly," or "no." By law, a claim can be accepted only if the doctor states that a condition is work-related on a "more probable than not" basis [*Zipp v. Seattle School District* (1984)]. This is interpreted to mean greater than 50 percent certainty and would be indicated by circling either "yes" or "probably."

One requirement for a condition to be work-related is that an industrial injury or exposure must be a "proximate cause" of the diagnosed condition. The term "proximate cause" means a cause which, in direct sequence, unbroken by any new independent cause, produces the condition and without which the condition would not have occurred. It is ***not*** required that the industrial injury or exposure be the ***only*** proximate cause of the condition. [*Hurwitz v. the Department of Labor and Industries* (1951)]. The phrase "without which the condition would not have occurred" is the basis for the "but for" rule of thumb, which may be familiar to some doctors.

Requirements for occupational diseases are different from those for occupational injuries. (See Occupational Diseases, page 13, for more detail.)

Claim managers need all details on the injury or disease and its causes. Please provide those in the initial history and physical. Even though you may feel the problem you've diagnosed is work-related, an investigation may determine otherwise.

When in doubt, wait until the medical evaluation is complete before making a statement about work-relatedness. Many health insurers will not reimburse medical costs if they suspect that a problem is work-related.

D. Educating Patients about Workers' Compensation

Many patients have grossly unrealistic expectations of workers' compensation. Many people believe that a work-related injury automatically entitles them to re-training, which in their understanding may mean a college education or post-graduate studies.

Misconceptions such as these may lead to anger and frustration with the system and may contribute to the development of long-term disability.

Doctors can play an important role by helping patients understand what benefits they should and should not expect to receive. Doctors should consider keeping a supply of patient brochures and giving a copy to the patient on the first visit, reinforcing key points, such as the fact that many benefits are defined by law and are not determined by the claim manager. Copies of the brochure "Workers' Guide to Industrial Insurance Benefits," in English or Spanish, may be obtained free of charge by mailing the form request card at the back of this handbook.

Ask for publication F242-104-000, or for patients who work for self-insured employers, P207-085-000.

Workers without general health insurance

Some workers fear claim closure because they lack general health insurance. Doctors can help patients prepare for resolution of their workers' compensation claim by informing them of low-cost general health insurance through the Washington State Basic Health Plan (BHP). The BHP offers health insurance on a sliding scale, through contracts with numerous large insurers. For more information, your patient may call the BHP at 800-826-2444.

E. Identifying Risk Factors — An Opportunity for Prevention

Long-term disability is a major problem in workers' compensation. (See page 4.) Doctors have a valuable opportunity to ***prevent*** long-term disability. By ***early*** identification of "at-risk" patients, on the very first visit or shortly thereafter, it is sometimes possible to mobilize resources to address the underlying problem(s). For a patient who has been on time-loss for three months, there is a 50 percent probability that he/she will still be on time-loss at one year. Therefore, it is critical to identify and attend to the patient's medical and return-to-work needs within the first month after injury.

Please consider using the Screening Checklist for Possible Risk Factors of Long-Term Disability. (See page 9 to identify "at-risk" patients.) Consider using it on the first or second office visit, and again at 4-8 weeks. Numerous physicians representing a broad range of specialties, drawing from both medical literature and clinical experience created this list. We hope that scientific validation of this checklist will lead to widespread use by physicians. We hope doctors will be able to use it to identify with great accuracy patients who will benefit from early intervention measures. For now, it can be used as a guide in looking for disability prevention opportunities. Also, you may want to develop an oral contract with the patient at the first visit so it is clear that treatment is aimed at recovery and return to work.

F. Helping Patients Return to Work

Injured or ill workers almost always have jobs, and Labor and Industries has learned that the best "medicine" for workers is to return to work as soon, and as safely, as possible.

Analysis of our claims shows that the longer workers are in the workers' compensation system, the harder it is for them to return to work.

Urge your patients to keep in touch with their employers. You can also contact the employer to discuss returning the worker to some kind of transitional work. Form a partnership with your patient and the employer to speed recovery and return him or her to a productive work life.

Early Return-to-Work intervention seeks to return injured workers to modify or limited-duty jobs while they continue to recover. This productive employment is tailored to each worker's limitations and assists you in caring for your patient. As a provider, your primary goal is your patient's recovery. Early Return-to-Work helps you achieve that goal by helping the worker return to work under medical supervision as soon as it is safe. It is designed to enhance your treatment plan, not interfere with it.

Examples of resources that may be available to prevent long-term disability include the following:

If you make the claim manager aware that your patient has:

- Trouble understanding English, the claim manager may be able to arrange for bilingual staff to explain the claim process, answer the patient's questions, and provide written or videotaped materials in their language.
- Chronic medical condition, such as diabetes, it may be possible to assign a nurse case manager to the case.
- Depression as a significant barrier to your patient's recovery, the claim manager may be able to authorize short-term psychiatric care.
- An patient's employer that is not cooperating with return-to-work efforts, a vocational rehabilitation counselor or employer consultant may be able to help the employer explore return-to-work options that will benefit all parties involved.
- Misconceptions about L&I vocational entitlement (such as re-training), a rehabilitation consultant or a vocational rehabilitation counselor may be able to help your patient understand the available options.

Figure 2.2
Screening Checklist for Possible Risk Factors of Long-Term Disability (LTD)

Use this checklist to identify patients who may be at high risk of long-term disability. It is not yet known which factors or combinations of factors accurately predict LTD, but you may wish to refer to Identifying Risk Factors, page 8, and other parts of the Attending Doctor's Handbook for ideas on measures that may be taken to reduce the risk.

Date form completed _____ Patient _____ Claim number _____

Days of time-loss _____ Originally non-time-loss claim that has become time-loss ____

Group 1: Catastrophic — Cases *with catastrophic injuries are very likely to benefit from medical case management.*

- ❑ 1. Catastrophic

Group 2A: High Risk — Cases *with any of these factors are likely to benefit from medical case management, unless there is clear evidence the worker is about to return to work.*

- ❑ 1. Hospitalized within 28 days of injury, for reasons related to industrial injury
- ❑ 2. Worker who is 45 years old or older with carpal tunnel syndrome
- ❑ 3. 90 or more days of time-loss

Group 2B: High Risk — *The presence of one or more of the following may indicate an increased likelihood of long-term disability and, therefore, some potential benefit from case management or other intensive services.*

A. Medical Factors

- ❑ 1. Presence of secondary medical condition
- ❑ 2. Injury to dominant hand
- ❑ 3. Hospitalized within 28 days of injury for reasons unrelated to industrial injury
- ❑ 4. Pre-existing psychiatric conditions

B. Injury Descriptions

- ❑ 1. Non-overt injury – injury occurring in course of usual work activities
- ❑ 2. No objective findings on examinations
- ❑ 3. Diagnosis not consistent with injury description
- ❑ 4. Time gap in reporting of the injury
- ❑ 5. Unwitnessed accident

C. Provider/Patient Factors

- ❑ 1. No identifiable treatment plan or goals
- ❑ 2. Over-utilization of health care delivery systems and services by either patient or provider, or over-referral by physician. May include frequent changes of attending physician
- ❑ 3. Misuse of scheduled medications by patient
- ❑ 4. Physician fostering illness beliefs
- ❑ 5. Number of surgeries both related and unrelated to work-related problem. May include a number of unsuccessful surgeries in the same area.
- ❑ 6. Spread of diagnosis over time; newly contended diagnosis
- ❑ 7. No documented medical progress

(Continued on next page)

Figure 2.2 (continued)

D. Psychosocial Factors

- ❑ 1. Exaggerated illness behavior: Presence of non-organic signs (Waddell signs); no objective findings.
- ❑ 2. Evidence of abuse of alcohol, illicit drug or prescription medication
- ❑ 3. Presence of depression or avoidance anxiety, post-traumatic disorder or other dysphoric affects (for example, anger at employer or supervisor or L&I)
- ❑ 4. History of childhood abuse, physical or sexual abuse, substance abuse in caretaker or family instability
- ❑ 5. Presence of personality traits or disorders. For example, presence of specific somatization traits or problematic interpersonal relationships; arrests

E. Demographic Factors

- ❑ 1. Low educational level, including illiteracy
- ❑ 2. English not primary language
- ❑ 3. Age greater than 50 and employed in heavy industry
- ❑ 4. Back or lower extremity injury with medium or heavy labor employment
- ❑ 5. Nearing retirement age

F. Job Factors

- ❑ 1. Anger at employer
- ❑ 2. Employer anger at worker
- ❑ 3. Miscellaneous employer factors: seasonal work, strike, plant closure, job becoming obsolete, etc.
- ❑ 4. Loss of job in which the injury occurred
- ❑ 5. Singular work history in heavy industry
- ❑ 6. Complaints of inability to function
- ❑ 7. History of poor job performance, frequent job change, short duration of employment, job dissatisfaction or job termination prior to claim filing
- ❑ 8. Employer or worker not active in return-to-work efforts
- ❑ 9. Worker is not clearly headed back to work
- ❑ 10. Perception of the worker that he or she will be retrained “for a better job” or other misperceptions of L&I vocational entitlement

G. Administrative Factors

- ❑ 1. Third-party involvement
- ❑ 2. Recent claim closures; application for reopening
- ❑ 3. Employer protest
- ❑ 4. Current income, including time-loss, compares favorably to net income prior to injury.
- ❑ 5. Multiple L&I claims (may include a number of previous claims)
- ❑ 6. Loss of driver’s license or other credentials
- ❑ 7. Loss of medical insurance
- ❑ 8. Originally non-time-loss claim that has become time-loss
- ❑ 9. Non-compliance with medical or vocational treatment
- ❑ 10. Worker or physician perception that L&I is unresponsive or adversarial

H. Other High-risk Factors Please *list.* _____

Please indicate action taken for high-risk claims (e.g., referred to nurse consultant): _____

_____

_____

Special return-to-work resources

Special resources may be available to help you and your patient. For more information about these, including a description of the *Attending Doctor's Return-To-Work Desk Reference,* and the brochure "Getting Back to Work: It's Your Job and Your Future," See Special Resources, page 16.

Transitional work and retraining

Studies show that injured workers recover more quickly and with less impairment when they return to work as soon as possible after injury. They are less likely to become treatment-dependent and more likely to feel valued and self-confident.

Helping injured workers return to work as soon as possible is the fundamental role of the vocational rehabilitation counselor. The counselor works closely with the employer, injured worker, and doctor to coordinate a successful return to work. *You and your patient should both understand, however, that by law, time-loss payments for temporary total disability may be discontinued when the patient's earning power, at any kind of work, is restored to that existing at the time of the injury.* [RCW 51.32.090]

Figure 2.1. Getting Back to Work: It's Your Job and Your Future.
This brochure has easy-to read information on return to work. Order a free supply to share with your patients. (To obtain a copy, see Special Resources, page 16).

If your patient can perform some form of transitional work during recovery, he/she may qualify for "loss of earning power" benefits (LEP), which usually allow the worker to earn more than if they were receiving time-loss compensation alone.

By state law, the counselor must follow established return-to-work steps. [RCW 51.32.095] (See Figure 2.3 on page 12.) The first four priorities focus on returning the worker to the same employer, possibly using transitional work.

Transitional work is one of the most valuable tools for returning injured workers to the job. It can lead to early recovery.

Transitional work gives workers an opportunity to perform light duty, graduated, part time, or modified work during recovery. The injured worker does not have to be medically stable to do transitional work. This kind of work opportunity is usually found with the same employer, but can be arranged with a new employer.

Flexibility is the key to setting up temporary or transitional jobs. Most jobs can be modified by such actions as restructuring work tasks, tools, work sites, work hours or work conditions to accommodate the injured worker.

If no return-to-work options are available with the same employer, the counselor will identify previous work skills that can be transferred to another job.

If the worker has permanent work restrictions, which prevent his or her return to the job of injury, the counselor will work with the employer to develop return to work options.

If the worker cannot return to the same employer, has no transferable skills and has a work-related disability, only then is on-the-job and/or formal retraining explored.

You may initiate a review for return-to-work assistance if you believe:

- Your patient may be able to do transitional work during recovery, even for a few hours a day.
- A job modification may speed your patient's return to work.
- Your patient might not be physically able to return to his or her former job.

Retraining is the last of the nine return-to-work priorities and is only used ***for a small percentage of workers.*** Even when retraining is available, retraining benefits are limited by law to $4,000 over a 12-month period. [RCW 51.32.095]

Contact your patient's claim manager or claims unit rehabilitation consultant to request these services (See Resource Telephone Numbers on page 62.)

Job modifications

Job modifications have been part of the workers' compensation benefit package since 1983. [RCW 51.32.250] Job modification benefits are intended to encourage employers to modify jobs to retain or hire injured workers with disabilities resulting from their accepted condition. Up to $5,000 per job or job site is available for modifications in order to enable the worker to return to his or her job or to a new job. Job modifications include work site adjustment(s), job restructuring, tools and equipment. You may request a job modification for your patient, or it may be requested by the patient, an occupational or physical therapist, a vocational counselor, or the employer.

Pre-job accommodations: A recent change to RCW 51.32.095 provides up to $5,000 for medically necessary pre-job accommodations for injured workers during retraining plans or when seeking employment. (Pre-job accommodations and job modifications combined cannot exceed a total of $5,000.) Please refer to Provider Bulletin 99-11 for more information regarding these benefits. (See page 75.)

Physical capacities evaluations and job analyses

State law requires your review, recommendation, and approval of a job description before the patient returns to work. A job description should contain the title, essential functions, tasks, physical demands, environment, work schedule, and other related information needed to determine if the job is appropriate. This may also be a formal job analysis.

A copy of the Doctor's Estimate of Physical Capacities form is provided in Appendix H on page 81. Billing codes for completion of this form can be found on page 54.

If you have questions about the job, we recommend you have a team meeting with the injured worker, employer, and vocational consultant. A meeting with an employer or vocational consultant is billable. (See Section 6D, page 51.) If you feel the job is too strenuous for the worker's abilities, you can explore ways to modify the job.

Figure 2.3: Return-to-Work Priorities

By state law, returning an injured worker to work **must be pursued in accordance with a prioritized list of return-to-work goals.** [RCW 51.32.095] Each goal must be addressed **in order of priority** and justification given as to why it was not feasible before moving to the next goal. These priorities are:

Returning to work with the same employer at:
1. The previous job.
2. The previous job, with modifications, including transitional return to work.
3. A new job in keeping with any limitations or restrictions.
4. A new job, with modifications, including transitional return to work.

Returning to work with a new employer or self-employment at:
5. The previous job, with modification.
6. A new job, based upon transferable skills.
7. A new job, with modifications.
8. A new job involving on-the-job training.

ONLY AS A LAST RESORT, after documenting that none of the above goals are feasible, can a return-to-work goal involve:
9. Short-term retraining and job placement.

NOTE: This table draws from the *Attending Doctor's Return-to-Work Desk Reference*. (See Special Resources, page 16, for more information.)

G. Occupational Diseases

The Revised Code of Washington (RCW) defines an occupational disease as an infection or disease that arises "naturally" and "proximately" out of employment. [RCW 51.08.140] Occupational disease cases generally need a logical, causal link between your patient's disease or infection and his or her job. Examples of occupational diseases include occupational carpal tunnel syndrome, noise-induced hearing loss, occupational dermatitis, and occupational asthma. Claims based on mental conditions caused by stress are excluded from this definition. [RCW 51.08.142]

Numerous resources are available to assist doctors in diagnosing and treating occupational diseases. See Appendix B, Occupational Disease Resources (page 58); Appendix C, General Reference Materials (page 60); and Appendix D, Resource Telephone Numbers at L&I (page 62).

Criteria for allowance of occupational disease claims

Criteria used by claim managers for allowance of an occupational disease, based on law and regulation, include the following:

- A physician must present an opinion that work conditions, on a more-probable-than-not basis (a greater than 50 percent chance), are the cause of the illness or have temporarily or permanently aggravated a pre-existing condition; ***AND***
- Objective medical findings must support the diagnosis; ***AND***
- The disease must arise "naturally and proximately" out of employment. [RCW 51.08.140]

To meet the definition of arising "naturally" out of employment [*Dennis v. Department of L&I* (1987)], an occupational disease must be:

- A natural consequence of distinctive conditions of employment (note that the conditions need not be ***unique*** to the particular employment); ***OR***
- More probably than not a natural consequence of work conditions rather than conditions in everyday life or all employment in general; ***OR***
- A natural consequence of conditions of employment rather than conditions occurring coincidentally in the workplace.

To meet the definition of arising "***proximately***" out of employment, "the cause must be proximate in the sense that there existed no intervening independent and sufficient cause for the disease, so that the disease would not have been contracted ***but for*** the [distinctive] condition existing in the ... employment" [*Simpson Timber Company v. Department of L&I* (1949)]. It is ***not*** required that the industrial injury or exposure be the ***only*** proximate cause of the condition [*Hurwitz v. the Department of L&I*, (1951)].

Occupational diseases are different from occupational injuries, which ***do not*** need to meet these criteria, and need only occur in the "course of employment."

Occupational disease claims must be filed within two years following the date the worker had written notice from a physician that the occupational disease exists ***and*** that a claim for disability benefits may be filed. [RCW 51.28.055]

Detailed occupational history for occupational diseases

Because the legal standard is different for occupational diseases than for occupational injuries, we need additional information from you and your patient. ***Also, a detailed occupational history is very important, since it can substantially reduce the time needed to process your patient's claim.*** This is especially true where several jobs with different employers may have contributed to the diagnosed condition. The reason is that an important step in the adjudication process may be to ***apportion or pro-rate the cost of benefits among employers whose employment contributed to the condition.*** (See page 14.)

A good occupational history is also important because it provides an important opportunity to ***prevent*** disease in your patient, your patient's family, and your patient's co-workers. (For example, the medical literature includes numerous documented cases of lead

Figure 2.4
Billing for a Detailed Occupational History for Occupational Diseases

You (or a medical, osteopathic, or podiatric physician consultant of your choice) may bill the department or self-insurer using code 1055M (which at the time of this publication pays $159.57) if you provide the services described below. A doctor can bill this code ***only once*** for each patient. ***This code is for diseases only, not injuries.*** Bills may be audited periodically to ensure that this code is used appropriately. Fee schedules are updated annually.

To be reimbursed for 1055M the practitioner must submit ***all three*** of the following as described below: 1) the Occupational Disease Work History Form (or a comparably detailed work history form containing all the same elements as the department form), ***and*** 2) an occupational history, ***and*** 3) an opinion on causation.

1. Occupational Disease Work History Form:

The doctor should ask the patient to arrive at least 30 to 60 minutes prior to the appointment to fill out the Occupational Disease Work History Form. An alternative would be to mail the form to the patient so he/she can bring the completed form to the appointment. The doctor must review the form with the patient to gather information necessary to provide the occupational history described below.

The form may be photocopied from Appendix H, pages 82-83, or copies may be obtained free of charge by mailing a request using the form request card at the back of this handbook. Ask for forms #F242-071-000 (first sheet) and #F242-071-111 (continuation sheet).

2. Occupational history:

The doctor must include a detailed occupational history in the dictated report. The occupational history must include at least the following ***for each employer*** listed on the Occupational Disease Work History Form:

a. A description of the patient's work practices.

b. Protective equipment used (for example, earplugs for hearing protection).

c. Engineering controls used (for example, rubber cushions placed under machinery to protect from noise exposure), and

d. Exposure history (including non-work exposures during the period of employment). The doctor may find it helpful to ask the patient to bring records of exposure levels from the employer(s), if any are readily available.

3. Opinion on causation:

In addition, the doctor's report ***must*** include a statement as to which jobs listed on the Occupational Disease Work History Form contributed to each diagnosed condition, on a more-probable-than-not basis, based on whatever information is available at the time of the examination. (See Section 2C, Determining Work-Relatedness, page 7.)

Since your opinion on causation, although necessary, may not be sufficient for claim acceptance, the following should be documented as fully as possible in order to support your opinion:

a. Any verifiable evidence to support a workplace exposure that could cause the diagnosed occupational disease, described in as much detail as possible (for example, by citing industrial hygiene measurements);

b. A clear description of the condition and of objective findings to validate presence of the occupational disease;

c. A clear statement of the likelihood of a causal relationship between the exposure and the condition, on a more-probable-than-not basis, including the basis for the opinion (such as a description of the temporal relationship, supporting references from medical literature, etc.)

For tips on the detailed occupational history for occupational diseases, please see the *Medical Examiners' Handbook*, pages 20-25.

poisoning in children exposed to lead in work clothes of a parent.) By taking a good occupational history, ***early*** identification of cases and even clusters of cases may be possible. (See page 18 for information about the SHARP program.) Once cases are identified, measures may be taken to remedy the underlying cause (for example, improvements in workplace ventilation).

In some cases, the claim manager may consult other sources (such as information from employers) to establish whether a condition can be attributed to a particular job. In any case, it is important for the doctor to make as accurate a determination as possible, based on whatever information is available at the time of the examination.

Communicable diseases

Labor and Industries, or the self-insured employer, will pay for testing and certain preventative treatment for workers who have been exposed to a communicable disease on the job. [RCW 51.36.010; WAC 296-20-340]

For example, if your patient were exposed to blood or body fluids through a needle stick while working, he or she would be entitled to the following *(Provider Bulletin 01-06)*:

- HIV, HBV, Hepatitis C or liver enzyme testing at the time of exposure, and at the third month, sixth month and one year following.
- Hepatitis B immunoglobulin and vaccination series (unless required by employers or in hospitals).
- Post-exposure evaluation and follow-up, including counseling and prophylaxis as recommended by the U.S. Public Health Service.

You should file an Accident Report for the work-related exposure. When the department pays for this testing and treatment, it is not bound to allow the claim. Claims for needle sticks are generally allowed as injuries. If a disease develops later, it will be necessary to complete a re-opening application. If the original claim was rejected, a new Accident Report should be filed using the date of diagnosis as the date of injury.

Chemically related illness (CRI)

Chemically related illness (CRI) is an emerging health issue facing workers, employers, and others. CRI refers to a variety of health problems caused by exposure to occupational and environmental chemicals. Examples of potentially harmful chemicals include solvents (such as those found in paints), metals (such as lead), and irritants (such as formaldehyde). Examples of CRI include occupational asthma, lead poisoning, and solvent-induced neuropathies.

When taking the occupational history for these conditions, be aware that employers are required to provide workers with detailed information about the chemicals to which they are exposed. [Chapter 49.70 RCW—Worker Right-to-Know law; WAC 296-62-052; WAC 296-62-054] One way for you to obtain this information is to ask your patient or the employer for relevant Material Safety Data Sheets (MSDS).

A special claims unit currently reviews CRI claims within its jurisdiction. (For more information, see Unit 3 in Appendix D, page 65.)

One resource for doctors treating patients with chemically related illness is the Center for Chemically Related Illness at Harborview Medical Center in Seattle. (See page 58 for more information.)

1. Pesticide exposures

If your patient has developed pesticide-related health problems from an exposure on the job, you should file a Report of Industrial Injury or Occupational Disease (Accident Report).

Doctors are required to report all potential pesticide exposures to the Department of Health. [RCW 70.140.055; WAC 248-100-217] This can be done by calling the Department of Health's pesticide section at 360-236-3360, or by calling the Washington Poison Center at 800-732-6985. The Department of Health can also give you information about pesticide exposure.

If you have trouble getting information on a pesticide, you should know that state law requires employers to provide detailed information to you immediately, upon request. [RCW 17.21.100]

2. Asbestos exposures

If a patient has evidence of asbestos-related disease or exposure from a job, a claim should be filed. If allowed, appropriate treatment will be covered, including yearly surveillance examinations. [WAC 296-20-124(3)] These examinations may include a physical exam, spirometry, and a chest X-ray.

A specialized claim unit handles all asbestos-related disease claims. Send billings and reports to the asbestos section for consideration. [WAC 296-20-124] These staff are available to you by phone: 360-902-6775 or 902-5816; FAX: 360-902-5156; or mail: Asbestos Fund Section, PO Box 44286, Olympia WA 98504-4286.

H. Special Resources

Numerous resources for providers are given in the appendices at the end of this document. This section briefly describes some of those resources.

Return-to-work resources

In addition to the other resources mentioned in this section (such as case management), there are a few resources that could be particularly helpful in returning your patient to work.

1. Booklets and brochures for doctors and patients.

The department produces a booklet with easy-to-read information and worksheets to help doctors return patients to work. *The Attending Doctor's Return-to-Work Desk Reference* is available free of charge by contacting the L&I Warehouse using the tear-out order card at the back of this handbook.

The department also produces a brochure written for your patients: "Getting Back to Work: It's Your Job and Your Future." This brochure has easy-to-read information on return to work. Order a free supply to share with your patients (also available from the L&I warehouse).

2. Unit rehabilitation consultants (RCs)

The RCs are rehabilitation professionals who support claims staff and can act as liaisons between the claim manager and vocational counselors. They are directly accessible to claim managers with return-to-work questions. They also are available to discuss with vocational counselors return-to-work issues involving specific claims.

If you have questions, you can call the vocational rehabilitation service section at the nearest Labor and Industries service location. (See page 66 for a list of service locations.)

3. Vocational services consultants

Vocational services consultants at the department help employers keep workers' compensation premiums low by encouraging employer commitment to worker safety and health and to timely, safe return to work. The vocational services consultant may be able to work with you and the employer to develop a plan for job modifications, light-duty, or other forms of transitional work. (To contact the vocational consultant nearest to you, see Resource Telephone Numbers at L&I, on page 66.)

4. Risk management consultants

The State Fund Risk Management Services section of L&I helps employers control their industrial insurance premiums, partly by developing effective loss control programs (which include accident prevention measures). Services provided by Risk Management include consultations on job modifications, job analysis, ergonomic analysis, training, and education. Consultations are free and include services by certified occupational and physical therapists located throughout the state. (To request a consultation, please call one of the numbers listed under Occupational and Physical Therapists on page 68, or under Risk Management Services on page 69.)

5. Industrial hygiene resources

The Washington Industrial Safety and Health Act (WISHA) places responsibility for the state's workplace safety and health within the Department of Labor and Industries. L&I's WISHA services division handles responsibilities placed on the department by WISHA law. WISHA services division offers consultation services to employers to assist them in assessing and improving working conditions for employees. Consultations are voluntary, requested by the employer, and at not cost to the employer, so they are frequently viewed as a desirable service.

What you can do if you think a workplace is unsafe

If you are concerned that a patient's workplace is not safe, L&I urges you to report this to the service location closest to you. You can discuss your concerns with a safety compliance or industrial hygiene supervisor. If appropriate, the supervisor may ask you to file a complaint, and the workplace will be investigated. (See page 66 for the address and phone number of the nearest location.)

An L& I office in your area has Industrial Hygienists that can assist you with specific questions and issues. Please call your area L&I office and ask for an Industrial Hygiene consultant (See page 69 for phone numbers of Safety and Health Consultants). You may also call 1-800-4BE-SAFE (1-800-423-7233) for other WISHA Services information.

Health-care resources

If a claim manager has a question about the health care an injured worker is receiving, he or she can consult with health care professionals (nurses and physicians) employed by or contracted with the State Fund. These consultants also are available to discuss cases with attending doctors.

1. Occupational nurse consultants (ONCs)

Occupational nurse consultants (ONCs) are registered nurses who work with claims staff and can act as liaisons between the claim manager and the attending doctor. ONCs assist the claim managers, workers and their families, physicians, employers, attorneys, and others involved in getting workers back to work following an injury. When the ONCs have medical questions, they can consult with the department's physician consultants (see below). ONCs can assist you with:

- Discharge planning and home health care.
- Placements in special programs (e.g., detoxification, drug and alcohol treatment, pain clinics, and specialty rehabilitation centers).
- Psychiatric care.
- Case management.
- Any medical issues in claims.

To contact the ONC assigned to your area or the ONC supervisor, call 360-902-5013 or turn to page 67 for the phone number of the ONC in your area.

2. Medical case management

Labor and Industries offers contracted medical case management services for injured workers with catastrophic injuries and complex medical problems. These services are provided to help the injured worker reach and maintain maximum medical recovery, functional capacity and return to work at the earliest point possible, consistent with good quality medical care.

Nurse case managers work with the attending doctor and injured worker to coordinate the medical treatment plan. They help identify potential barriers to recovery and communicate this information to the doctor and claim manager so revisions to the treatment plan can be made.

The Occupational Nurse Consultants do internal case management. They can be consulted if you feel a worker would benefit from additional external nurse case management services. Individual nurses now have provider numbers and are contacted by the ONCs once there are specific tasks or goals that are best done by community-centered nurses.

3. Physician and chiropractic consultants

Labor and Industries contracts with doctors of chiropractic, orthopedics, occupational medicine, psychiatry, and podiatry for claim consultation. All consultants have private practices and consult with the department part-time. A doctor specializing in physical medicine and rehabilitation also provides consultations.

The physician and chiropractic consultants are available to answer questions from ONCs and to discuss cases with attending doctors. In general, it is best to first discuss health issues relating to specific claims with the claim manager and the occupational nurse consultant. The physician and chiropractic consultants are active practitioners and are only available during certain hours each week. In cases where you know a certain physician or chiropractic consultant has reviewed your patient's file, and you wish to discuss the case with that consultant, you may call 360-902-4644. Support staff will help you reach the consultant. If you would like to speak with one of the Associate Medical Directors for Insurance Services, the Associate Medical Director for Chiropractic, or the Medical Director, you may contact them at 360-902-6298 or 360-902-5194.

4. Pharmacy consultant

Medication questions, billing issues or other pharmacy concerns relating to State Fund

claims, can be directed to the department's pharmacy consultant at 360-902-6792.

5. Advisory committees

Labor and Industries (the State Fund and the Self Insurance section) seeks advice from the provider community through the Washington State Medical Association (WSMA) and the Washington State Chiropractic Association's (WSCA) Chiropractic Advisory Committee (CAC).

- WSMA provides input to the department regarding medical and surgical treatment guidelines and policy.
- The CAC advises the department on chiropractic treatment guidelines, policies and professional continuing education programs. It also reviews the eligibility of applicants for the approved list of chiropractic consultants used by the department.

The guidelines and standards are available through the *Provider Bulletin* and the *Provider Update*. See appendix G, page 75. A guide entitled *Chiropractic Physicians Guide*, written specifically for chiropractors, is also available. Call 800-848-0811 or 360-902-6799.

Whether you are a member of the Washington State Medical Association, the Washington Osteopathic Medical Association, or the Washington State Chiropractic Association.

You have a voice in the direction of Labor and Industries' medical policies. All workers' compensation attending doctors are encouraged to contact these organizations with comments regarding Labor and Industries' medical policies.

Other special resources — SHARP program

The Safety and Health Assessment and Research for Prevention (SHARP) program is a multi-disciplinary research group within L&I. It includes epidemiologists, an occupational health physician, a toxicologist, industrial hygienists, ergonomists, an occupational health nurse practitioner and more. SHARP is responsible for a wide variety of occupational health research projects, works closely with the State Department of Health's Office of Epidemiology and local health departments, and is available as a resource to providers, as well as the employers and employees of Washington State. Broadly speaking, SHARP's activities fall into one of four areas:

1) Tracking health conditions related to work
2) Examining specific risk factors and health problems
3) Testing methods for identifying risks
4) Introducing strategies for prevention

Information on SHARP activities is available by calling 888-66SHARP (667-4277) or 360-902-5669.

I. Initial Visit / Accident Report

The first communication between you and the State Fund or self-insured employer will be the Accident Report. The Accident Report forms are the first notice that a worker has been injured, diagnosed with an occupational disease, or exposed to an infectious disease. They are due to L&I or the self-insured employer ***within five days*** of initial treatment or diagnosis. Please mail your Accident Reports three days after seeing the worker, so that your patients will receive benefits to which they are entitled as soon as possible. If you delay in mailing the Accident Report, your patient could face significant hardship as a result.

Where Do I Get These Forms?

- The State Fund requires use of the Report of Industrial Injury or Occupational Disease (F242-130-000, order by using the form at the back of this book). Self-Insured employers use the Physicians Initial Report; they should give to the worker at the time of injury. If the worker does not have this form when they arrive, obtain a copy by contacting the department's Self insurance section at 360-902-6898.

Which Form Should I Use?

Unsure which form to use? Here are some suggestions:

1) Ask your patient. They should know if the employer is self-insured. All other companies are covered by the State Fund.
2) How many employees does the company have? If it's a small number, e.g., 500, the employer is probably covered by the State Fund.
3) Obtain a list of self-insured employers for ongoing reference at http://www.lni.wa.gov/ClaimsInsurance or by calling the Self-Insurance Section at L&I at 360-902-6901.

How Do I Assure That I Get Paid As Quickly As Possible?

The following two sections offer some tips specific to filling out Accident Reports for the State Fund and self-insured employers. Errors may delay claim approval and payment of your bills.

State Fund Report of Accident Form (the "ROA")

- It is important to put the correct provider number on the Accident Report and identify the doctor or clinic by its full name, address, and phone number, along with the doctor's signature.
- You may order an Accident Report form using the card inside the back cover of this book, or by calling the Provider Hotline: 800-848-0811 or 360-902-6500 from Olympia.
- Mail the appropriate sections to L&I and your patient's employer within five days of initial treatment or diagnosis. We recommend mailing in three days to assure timely delivery.
- Distribution of the Accident Report is the responsibility of the medical provider. After the worker's and doctor's sections are completed and signed, give your patients their copy of the form and send the originals of these sections to L&I at PO Box 44299, Olympia, WA 8504-4299. Send the original employer's section, along with the employer's copies, to your patient's employer. Keep the doctor's copy for your records.
- Documents containing additional information should be attached to the Accident Report.
- ***The claim number should be in the upper right hand corner of every page of every document you submit.***
- A claim arrival card will be sent to let you know the Accident Report has been received. Any time your patient's claim status changes, the State Fund will let you know by sending you a notice for your records. (A chart, explaining the flow of a claim from your submission of the Accident Report to first payment, is provided in Appendix E, page 71)

The process of accepting or rejecting claims sometimes can take time. To expedite this process, please be sure to do the following:

- **Make sure the Accident Report is filled out completely** and signed by both you and your patient. If the condition is a disease, enter N/A for "not applicable" in the date of injury and time of injury boxes. Leaving this box blank may delay processing of the claim and your bills.
- **Include complete diagnosis and ICD codes.** Provide a Primary Diagnosis (ICD-9 code) that clarifies both a specific body site and definition of the injury. When unspecified sites or definitions are diagnosed, the Claim Manager (CM) may need to postpone claim adjudication while seeking clarification from you. If you diagnose both a specific and a non-specific diagnosis, the CM may notify you which diagnosis has been accepted for billing purposes.
- **Describe in detail how the occupational incident or exposure resulted in the injury or disease.** Explaining the mechanism of injury will help all parties understand what took place. Please include a copy of the history and physical, the emergency room evaluation, or your office notes with the Accident Report. ***However, these will not substitute for the completed Accident Report Form.***
- **Consider contacting the employer** if you have questions or concerns on specific issues. For example, you may need to ask for more information on the relationship between an exposure and the illness being treated, or to request material safety data sheets (MSDSs), or a walk through the job site. (For information on reimbursement for these services, see Billing for Services, page 49).
- **If the injury or disease has left your patient unable to perform any work,** you should estimate how much work time will be lost. Wage replacement benefits (time-loss compensation) will start only if your patient must miss three or more days of work.

Self-insurer's Physician's Initial Report (the "PIR")

If your patient works for a self-insured employer, you will communicate directly with the employer (or the employer's representative) rather than Labor and Industries.

- The physician's Initial Report form can be ordered by calling the department's Self insurance section at 360-902-6898.
- Please complete the Physician's Initial Report and mail the completed form to your patient's self-insured employer or the employer's representative.
- Obtain the address of the self-insured employer or their service company by calling 360-902-6901.
- Physicians in the unique position of treating workers at a self-insured employer's on-site medical facility may contact the department's Self-insurance section at 360-902-6842 regarding reporting and record-keeping requirements.

J. The State Fund Claim

Communicating with the department

If you need specific claim information or a copy of a claim, you can save time by using the Easy-Access Line at 800- 831-5227. (See page 63 for details on how to use the line.) You may also call the Provider Hotline at 800- 848-0811. Other useful numbers can be found in Appendix D, page 62.
Also, a wealth of detail about your patient's claim is available over the Internet.

What you can do if you think a patient is part of a disease cluster

If you believe that a case of occupational illness or injury is not just an isolated incident, but may be part of a larger problem, which requires investigation, the Safety and Health Assessment and Research Program can help. SHARP has expertise in epidemiological investigations, and can mobilize its multi-disciplinary team to respond as needed to a problem, or arrange for the appropriate office to help you. Health care providers may report conditions to public health officials (without a patient's authorization) if they believe such a report will avoid or minimize danger to the health or safety of the patient or other individuals.
[RCW 70.02.050; WAC 246-100-076]

Occupational Disease Reporting in Washington State: Most states require reporting of specific occupational diseases to public health agencies, in the same manner as certain communicable diseases. Washington State currently has only three reportable occupational conditions: occupational asthma, occupational lead poisoning and pesticide poisoning, although additional conditions (occupational dermatitis and toxic hepatitis) are currently under consideration for mandatory reporting by the Department of Health under direction from the legislature. Occupational lead poisoning is reported by laboratories, and health providers are required by regulation to provide supplementary information in the investigation of these cases, conducted by SHARP. [WAC 246-100-042] Pesticide poisoning cases should be reported to the Washington Poison Center. (See Appendix B, page 58.)

SHARP maintains a public health surveillance system for work-related asthma. Work-related asthma is a notifiable condition in the State of Washington, and under the Notifiable Conditions Rule, WAC 246-101, all health care providers are required to report any diagnosed or suspected case of asthma caused or exacerbated by workplace sensitizers or irritants in a worker employed in Washington State. Case reports should be submitted directly to the SHARP Program via one of the following methods:

- Over the phone, by calling 1-888-66-SHARP. An automated voice-messaging system can receive case reports 24-hours a day.
- By mailing a completed reporting form to: Reportable Conditions, SHARP Program, and PO BOX 44330, OLYMPIA, WA 98504-4330.
- By faxing a completed reporting form to 360-902-5672.

Reporting forms can be downloaded from SHARP's website at http://www.lni.wa.gov/sharp/reportable/asthma.htm, or by contacting SHARP at 1-888-66-SHARP.
Reporting a case of work related asthma to SHARP under the Notifiable Conditions Rule does not relieve the diagnosing physician of the responsibility to inform his or her patient of the right to file a workers' compensation claim.

Using a secure system to protect confidential information, attending doctors and their staff can use the Claim and Account Center to learn if a claim has been accepted, if a diagnosis has been allowed, if a bill has been paid, and much more. More information can be obtained on the L&I web site: www.ClaimInfo.LNI.wa.gov or by calling an Enrollment Coordinator at 360-902-5999. This system can be much faster than making phone calls and generally offers much more detailed information.

1. Claim managers

Claim managers do not have individual voice mailboxes. Dialing the unit's lead number (see p. 64) is the best way to get information about a claim, or to get information to a claim manager. At these lead numbers you will reach either a person or a voice mail. Another option is to call the local L&I service location. (See p. 66, local L&I offices.

- Claim managers are obligated to ensure that all information available (medical, administrative and legal) supports the doctor's conclusion. All documentation must be fully considered to fulfill the department's responsibility to ensure quality, cost-effective care. [WAC 296-20-024(5)]
- Claim managers are not medical experts. Their expertise is in industrial insurance law. To best serve your patient and his or her employer, claim managers must make decisions as quickly as possible. Therefore, please provide clear, detailed explanations of your reasons for reaching conclusions on causality, diagnosis, treatment, and other issues.
- As the major decision-maker on claim matters, the claim manager:
  1. **Ensures the injured worker receives the** medical and financial entitlements under the law.
  2. **Authorizes treatments.**
  3. **Manages the effort to return a disabled worker** to the job and/or bring the claim to a successful resolution.
- To make appropriate decisions, claim managers rely on facts received from attending doctors and from internally based advisors, such as physician, chiropractic and occupational nurse consultants and vocational consultants.
- The claim manager also relies on non-medical information, such as information received from employers, investigators, and others.
- If you wish to speak with a claim manager's supervisor, their phone numbers are listed on page 65. To help you identify which unit is assigned to your patient, see the reference map on page 71 that shows claims unit responsibility by county.

Claim managers are not automatically notified when materials arrive. Due to high caseloads, they don't always have time to review claims more than once every two to four weeks. Therefore, if you alert them to look for materials, they can frequently take action and save valuable time for you and your patient.

2. The local L&I service location nearest you

A local customer service specialist (CSS) will be able to get much of the information you need from the computer. If you need to get a message to the claim manager, the CSS may be able to send an electronic message directly to the claim manager on the department's statewide system. After the CM receives this message, he/she will generally respond within 48 hours. (See page 66, Local L&I Offices)

3. Imaging

Documents you send the claim manager are now sometimes accessible to the claim manager within 24 hours of receipt by the department. This is the result of state-of-the-art document scanning technology. You may find it helpful to notify the claim manager (for example, through the local L&I office or the Provider Hotline) that time-sensitive materials have been sent (for example, documents relating to a request for authorization for a procedure). **Write the worker's claim number and name in the upper right-hand corner of every page of all correspondence.**

K. The Self-Insurance Claim

Self-insurance means an employer manages his or her own workers' compensation program, sometimes using a third-party administrator or "TPA." The self-insured employer must follow the same rules and regulations that guide the State Fund. The Department of Labor and Industries' Self-insurance section regularly reviews and audits self-insured employers' workers' compensation programs to make sure they are consistent with the state's rules and regulations. The section also monitors self-insurers to ensure that injured workers receive benefits according to the law and to ensure the employer is financially able to meet all claim-related expenses. The Self-insurance section is separate from the State Fund.

Communicating with the self-insured employer

- Please send all reports and bills to the self-insured employer (or the employer's representative). The self-insurer will pay all bills for services directly to you. ***No notification to Labor and Industries is necessary.*** If you have questions about a patient's claim, please contact the self-insured employer (or the employer's representative).
- The self-insured employer must pay all allowable services according to state rules and the Medical Fee Schedules set by Labor and Industries.

If you have problems with a self-insurance claim, please contact the Self-insurance Claims Disability Adjudicator at:

Department of Labor and Industries
PO Box 44892
Olympia, WA 98504-4892

Or phone:

- **360-902-6858 for odd-numbered claims.**
- **360-902-6889 for even-numbered claims.**
- **360-902-6901 for general information.**

L. Time Limitations for Filing a Claim

The workers' compensation system has statutes of limitations (time limits) for filing a claim. Occupational disease claims must be filed within ***two years*** of the date the worker gets written notice from the doctor that an occupational disease exists and that a claim may be filed. [RCW 51.28.055] For industrial injury claims, the limit is ***one year*** after the date the injury occurred. [RCW 51.28.050]

M. Help for Workers Who Fear Discrimination

There are two systems for dealing with complaints about discrimination. One concerns fear of retaliation for filing a claim; the other concerns fears of retaliation for reporting an unsafe workplace.

Fear of retaliation for filing a claim

If your patient is concerned about employer retaliation for filing a claim, let him or her know that this type of discrimination is against Washington law. [RCW 51.48.025] Please tell your patient that Labor and Industries has a special unit that investigates discrimination complaints. Through this unit, the department will try to determine whether the discrimination did, in fact, happen. If the investigation proves discrimination, the department, with the help of the State Attorney General's Office, will work to resolve the problem with the employer and employee. If this proves impossible, the Attorney General's Office may pursue the case in court on your patient's behalf.

If your patient feels retaliated against, you or your patient can call the Investigations Unit at 360-902-6568 or write PO Box 44277, Olympia WA 98504-4277. The complaint must be filed in writing within 90 days of the date the alleged act of discrimination. The discrimination complaint form is available at www.lni.wa.gov/FormPublications. The form number is F262-009-000 or F262-009-999 (Spanish).

Fear of retaliation for reporting an unsafe workplace

If you are concerned that your patient may be retaliated against for reporting an unsafe workplace, you should know that workers are protected from this by the WISHA law. [RCW 49.17.160] The law protects workers, whether they report their safety and health concerns to Labor and Industries, the Environmental Protection Agency (EPA) or any other regulatory agency.

L&I's safety and health discrimination unit investigates complaints of retaliation. If your patient feels discriminated against for reporting safety and health concerns, he or she should ***file a complaint within 30 days*** after the discrimination occurs. Your patient may file a complaint by calling the nearest Labor and Industries service location (see page 66) or by writing the Safety and Health Discrimination Unit, PO Box 44601, Olympia, WA 98504-4601

Treating Patients in Workers' Compensation

A. Confidentiality

When your patient signs the Report of Industrial Injury or Occupational Disease (the "Accident Report") or the Physician's Initial Report form, he or she is also signing a medical authorization permitting you to release, without liability, the worker's medical records to Labor and Industries or the self-insured employer. This allows an exchange of information between the attending doctor and the department or self-insurer, eliminating the need for authorization forms if additional information is requested from you. [RCW 51.36.060]

The authorization to release medical records extends to Labor and Industries' representatives (such as the department's utilization review vendor, medical case managers, and vocational counselors), and to your patient's State Fund employer. [RCW 51.36.060]

If an employer requests medical information relevant to their employee's active workers' compensation claim, you may release the requested information directly to the employer. [RCW 51.36.060] If the information is relevant to the claim, you will not be held legally liable for releasing the information. You may charge the employer for copies of your records. If an employer requests information you consider irrelevant to the claim, you may refer the employer to the claim manager.

Since early conversations with an employer occur before a claim is accepted, it is a good idea to focus your conversation on return-to-work issues (such as work restrictions, availability of modified work) and what you are noting on the report of accident.

By law you must review and promptly approve or reject any job offer submitted by the employer of record. [RCW 51.32.090(4)(a)] The department encourages doctors to share information with employers about physical capacity and physical restrictions to facilitate a prompt return to work. To promote this working relationship on return-to-work issues, the department will pay for physical capacity and restriction information requested by an employer and for responding to job offers submitted by the employer. (See Section 6D, Selected Billing Codes of Interest to Doctors, page 51.)

Information on tests or treatment for sexually transmitted diseases may be supplied to insurers, such as the State Fund or self-insured employer, for use in evaluating claims and paying benefits. This information remains confidential. Only those persons actually handling a claim may have access to the information. [RCW 70.24.105]

Information in the claim file, including medical records, cannot be disclosed to the public. [RCW 51.28.070] If an unauthorized person requests information from your patient's file, you may refer him or her to the nearest L&I service location. (See page 66.)

Injured workers filing a claim under Title 51 are specifically exempted from the Health-Care Information Act. [Chapter 70.02 RCW]. Workers' Compensation is also exempt from the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HIPAA Privacy Rule exempts workers' compensation from its authorization requirement (45 CFR § 164.512(1)). This means you can disclose health information to the department or self-insured employer without an authorization from your patient, and without fear of violating HIPAA.

HIPAA also allows you to disclose health information without an authorization directly to employers of record regarding work related illnesses or injuries (45CFR § 164512(b)(v)(B)). This means you can release information about your patient's physical restrictions to an employer who may have light duty work available.

HIPAA does not overrule any state law that requires the disclosure of health information (45 CFR § 164.512 (a)). **RCW 51.36.060 specifically requires medical providers to disclose health information**

to the department of self-insured employer for workers' compensation claims.
For more information see:
http://www.lni.wa.gov/hsa/HIPAA/

B. Reports and Documentation

During the course of treatment for an injured worker, the State Fund will seek regular reports on your patient's condition and treatment. [RCW 51.36.060; WAC 296-20-06101; WAC 296-20-01002] A claim manager relies on current, complete medical information to make accurate and timely decisions on your patient's claim. The department requires that certain reports be provided within a specific time frame. (See Table 3.1 on page 25.) Failure to provide complete reports can significantly delay bill payment and delivery of benefits to your patient.
IMPORTANT: Please indicate your patient's name and claim number in the upper right hand corner of all pages of your reports. If you submit more than one report at a time on a claimant, please staple all reports together pertaining to the same claim number. Please refer to Section 2I, page 18, assisting the Claims Process, for correct use of ICD codes.

"SOAPER" format for chart notes

Doctors' office/chart/progress notes and 60-day narrative reports should include the SOAP contents: It is helpful to all parties to submit chart notes as often and as soon as possible after each office visit.

S The worker's subjective complaints

O The doctor's objective findings

A The doctor's assessment

P The doctor's treatment plan

This should include information on the patient's functional improvement. ***Also, if you notice any risk factors for chronic disability, please mention them in this section.*** (See Section 2E, page 8.) This should also include what you tell the worker regarding expectations for recovery, medication side effects, etc. It should also include the type of treatment to be given, specific modalities, frequency, duration, expected completion date, and anticipated outcomes.

In workers' compensation, claim managers have unique needs for work status information. To meet this need, we suggest adding an "ER" to the SOAP contents:

E Employment issues. Has the worker been released for or returned to work? Is the patient currently working, and if so, at what job? When is release anticipated?

R Restrictions to work. Describe the physical limitations, both temporary and permanent, that may be barriers to returning to work. What other limitations, including unrelated conditions may interfere with employment? Can the worker perform modified work or different duties while recovering (including transitional, part-time, or graduated hours)? Is there a need for return-to-work assistance? (Use the *Doctor's Estimate of Physical Capacities* form, when appropriate. See Section 2F, page 8 and Appendix H, page 77.)

You may avoid unnecessary requests from vocational counselors and others by providing the information indicated above ***in every chart note***. If there is no change in employment or restrictions since your patient's last visit, simply state this fact in your chart notes. This information may be critical for the vocational counselor to proceed with the vocational assessment and plan. This information is also critical to enable the claim manager to process your patient's time-loss compensation in a timely manner.

> Objective findings are extremely important to claim managers in their decision-making process. You should be as specific and detailed as possible in describing objective findings to assure that the claim manager is able to make appropriate adjudicative decisions as expeditiously as possible and your patient receives the benefits to which he/she is entitled. (See Occupational Diseases, page 13, and Glossary of Terms, page 55, for more on objective findings.)

Time-loss authorization: Since 1993, time-loss cards, signed by the worker and doctor, are no longer used to determine whether a worker is entitled to disability benefits. Instead, the claim manager relies on medical, vocational and work status information to determine eligibility. As a result, claim managers have an even greater need for the medical information described above. The claim manager may request that a Time-Loss Notification be completed by the worker and doctor to aid in determining the worker's entitlement.

The 60-day report

If you are treating an injured worker for an extended period, you must send the claim manager or self-insured employer a report every 60 days. [WAC 296-20-06101] You may send office notes, however they will not substitute if the department requests a 60-day report. In either case, please identify the report as the *60-day report*. In addition to the SOAPER information above, it should contain the following:

1. The condition(s) diagnosed with ICD-9-CM codes
2. The condition's relationship to the industrial injury, if any
3. The probability, if any, of permanent partial disability (PPD)
4. ***If you feel the patient is not able to return to work, an explanation of why he or she is still disabled***

Supplemental Medical Report

When you assess your patient's ability to return to work, the claim manager will need to know the basis for your assessment. To convey this information, the department has developed the Supplemental Medical Report (SMR) form. The claim manager will send you the form to complete when he or she determines it is needed.

Documentation to support billing

Providers are required to maintain documentation in workers' medical files to verify the level, type, and extent of services provided to injured workers. A provider's level of payment for a specific visit or service can be denied or reduced if the required report is not provided or indicates the level or type of service does not match the procedure code billed. [WAC 296-20-010(7)]

Please refer to the following recommendations for chart notes. Attention to these items may avoid billing problems.

Please mail your reports separately from your bills — sending the two documents together can delay or even prevent the information from reaching the claim manager.

Table 3.1: Reports and Documentation

Report Type	Due
Initial report of injury	Within 5 days of 1st visit
Office/ Chart/Progress Reports	Every 30-60 days
Supplemental reports	On request
Consultation reports	At 120 days of conservative care
IME reports	When authorized
Extended services reports	When service is billed
Time Loss Notification	On Request

See appendix I for a complete list of mailing addresses, page 84.

- Indicate patient name and claim number on all pages of your reports. The claim number should be in the upper right hand corner of every page of every document you submit.
- Staple together all reports pertaining to the same claim number.
- Write legibly.
- Create and send notes to the department for all follow-up visits.
- Substantiate the level and type of service rendered.
- Submit documents on 8 1/2 x 11 inch plain white paper.

For a complete list of items to include in chart notes and *60-day reports*, see the *Medical Aid Rules and Fee Schedules* under section entitled Chart Notes in WAC 296-20-01002.

The State Fund will pay for your reports. (See Section 6, page 49, for billing information.)

Self-insurance reporting

The self-insured employer will also pay for your reports. They follow the same reporting requirements set by state law as the State Fund. Contact the self-insured employer (or the employer's representative) for answers to billing questions on self-insured claims.

C. Authorization for Services

By state law, Labor and Industries must ensure injured workers receive quality health care in an efficient manner and in the most appropriate setting.

[WAC 296-20-024 and 296-20-01002] To that end, the department has set up utilization management programs designed to monitor and control the use of health-care services.

The specific type of treatment used determines what utilization review process is necessary. For example, the Inpatient Utilization Review program monitors the medical necessity of inpatient treatment. (See page 27.) As an attending physician, or representative of a hospital, you should be aware of programs affecting you. For more information on the utilization review programs, call the L&I service location nearest you. (See page 66.)

State regulations require pre-authorization of certain treatments. [WAC 296-20-03001] Authorization can be requested through your patient's claim manager. The claim manager can also help if you are uncertain whether a treatment requires prior authorization. Most treatments requiring prior authorization are summarized in Table 3.2 on page 27.

Some treatments do NOT require authorization. For example, up to 20 office calls are covered without authorizations during the first 60 days following a work-related injury. Other services not requiring authorization include, but are not limited to, initial diagnostic x-rays, the first 12 physical therapy treatments, routine laboratory studies reasonably necessary for the work-related condition, and consultations with specialists. Please refer to WAC 296-20-030 for details.

The State Fund has specific pre-authorization procedures. Self-insured employers' procedures may vary. Please contact your patient's self-insured employer (or the employer's representative) for more information.

For authorization for physical therapy, including authorization by fax, please see Provider Update 03-02, "Physical, Occupational, and Massage Therapy." See appendix G, page 75).

Some services are not authorized under any circumstance. [WAC 296-20-03002] These include, but are not limited to, iontophoresis, acupuncture, intra-thecal injections (except anesthetic or contrast), exercise programs, and treatment measures of an unusual, controversial, obsolete, or experimental nature.

For questions about the authorization process, call the Labor and Industries service location nearest you (page 66).

The following descriptions provide additional detail regarding the procedures requiring prior authorization.

1. *Aggravation of pre-existing conditions*

Normally, the Department of Labor and Industries does not pay for medical treatment, other than for work-related injury or disease. Occasionally, the department or self-insurer will pay for treatment of unrelated conditions if worsened or aggravated by a work-related exposure or injury. For example, a diabetic patient who develops an infection as the result of a work-related injury or exposure may require intensive treatment of his or her diabetes during recovery. [WAC 296-20-055]

If you feel your patient requires treatment for a pre-existing condition, please discuss this with the claim manager.

2. *Diagnostic studies*

The following require prior authorization:

- X-rays subsequent to the initial study. [WAC 296-20-121]
- X-rays other than immediately prior to and immediately following the initial chiropractic treatment. [WAC 296-23-190 (3)(d)]

3. *Home nursing or convalescent center care*

Please refer to WAC 296-20-03001(8) for information.

4. *Home and vehicle modification*

Special benefits may be available to a patient who has work-related paraplegia, quadriplegia, blindness, or other catastrophic disability. A patient may be eligible, whether his or her claim is open or pensioned.

The department or self-insurer can help pay for certain home and/or vehicle modification to allow the patient more independence and access.

Funds available for home and vehicle modification are limited by law. [RCW 51.36.020 (7) (8)]

Table 3.2: Services Requiring Prior Authorization

By regulation, the following treatments and benefits require prior authorization. See the text following this table for more detail.

1. **Aggravation of pre-existing conditions**
2. **Diagnostic studies** (X-rays subsequent to the initial study, X-rays other than immediately prior to and immediately following the initial chiropractic treatment)
3. **Home and vehicle modification**
4. **Home nursing or convalescent center care**
5. **Injections**
6. **Inpatient admissions**
7. **Job modification and pre-job accommodation assessments and/or equipment**
8. **Selected Outpatient procedures** (including diagnostic arthroscopies, surgical arthroscopies, shoulder surgeries, laminectomies/diskectomies, and neuroplasties)
9. **Psychiatric care**
10. **Specialty programs** (including obesity treatment; pain management programs, biofeedback, psychotherapy, rehabilitation programs, etc.)
11. **Unrelated conditions**

Please call the Provider Hotline 800-848-0811 when requesting authorization for orthotics, electromyogram (EMG), nerve conduction testing (NCV), studies, durable medical equipment, injections, second set massage therapy, bone scans, arthrograms, and outpatient procedures other than those listed in than those listed in the next paragraph.

To initiate pre-authorization, selected outpatient procedures and inpatient hospitilization, call the department's UR vendor at 800-541-2894.

This service must be pre-authorized. If your patient needs services, please discuss with your patient's claim manager or occupational nurse consultant.

5. *Injections*

The following require prior authorization: [WAC 296.20.03001(7), (12) and (14)]

1. Diagnostic or therapeutic injections
2. Injections of anesthetic and/or anti-inflammatory agents into the vertebral facet joints (by qualified specialists only).
3. Intra-muscular and trigger-point injections of steroids and other non-scheduled medications beyond the third injection.

6. *Inpatient admissions*

Prior authorization is necessary before electively admitting a patient to the hospital. If a patient is admitted to the hospital emergently, notification must be given within 24 hours of admission. Call 800-541-2894 (in Seattle, 206-366-3360) or FAX 877-665-0383 (toll free) or 206-366-3378 to request a review of an admission. The review procedure is outlined in Appendix F.

For more detailed information on the inpatient admissions process, see *Provider Bulletin 02-04*. You may order the *Bulletin* by calling Labor and Industries' Health services Analysis section at 360-902-6799, or 800-848-0811.

7. *Job modification*

Special benefits may be available to keep injured workers on the job or return them to new jobs. The worker must have a job before funds can be expended. See Section 2F, page 12, for more detail.

Accommodations also can be made to assist workers in re-training or job placement programs, when they have special equipment needs. These are called pre-job accommodations. Please refer to *Provider Bulletin 99-11* for more information about both of these benefits. (See Appendix G, page 75.)

8. *Outpatient procedures*

This program is for ***targeted*** outpatient procedures. Review services are provided by the department's UR vendor. The outpatient program includes prospective or pre-authorization review, retrospective review, and reconsideration. The targeted procedures include: ***diagnostic arthroscopies, surgical arthroscopies, shoulder surgeries, knee surgeries, laminectomies/ diskectomies, and neuroplasties.*** To initiate pre-authorization, call the department's UR vendor at 800-541-2894.

9. *Psychiatric care*

Claims for mental stress are not accepted in the Washington State workers' compensation system. [RCW 51.08.142 and WAC 296-14-300]. However, the department can accept claims for psychiatric trauma if they meet the criteria of an injury as defined by state law. [RCW 51.08.100] For example, a bank teller may suffer psychiatric trauma from a bank robbery. (Injury is defined in Appendix A, page 55.)

In some cases, workers' compensation will pay for short-term psychiatric care (for example, treatment for depression) if the condition retards the patient's recovery from a work-related injury or illness. [WAC 296-20-055; 03001(10)]

Psychiatric treatment must be pre-authorized by the worker's claim manager. Only psychiatrists and psychologists will be reimbursed for psychiatric services. [WAC 296-21-270]

10. *Specialty programs*

The following programs require prior approval: [WAC 296.20.03001(10)]

- Obesity treatment
- Pain management programs (see more details below)
- Biofeedback
- Psychotherapy
- Rehabilitation programs
- Post-acute head injury treatment programs (see more details below)
- Other programs designed to treat special problems
- Work Hardening

1. Pain management programs

Pain management programs offer multi-disciplinary treatment for injured workers with chronic pain. This is a contracted service. The department currently has contracts with eight approved pain management programs. The ultimate goal of the program is to return the worker to work.

For successful pain management program care, the pain clinic and a Labor and Industries assigned vocational counselor must develop a return-to-work action plan.

Pain management treatment may be considered when there is disabling pain treated conservatively for three or more months without improvement, when surgery is not being considered and the patient is unable to return to work.

As an attending doctor, you can help treatment succeed by considering early referral, providing information requested by the vocational counselor, and considering discharge recommendations. If you have questions or comments, call 360-902-6791.

2. Post-acute head injury treatment programs

These are rehabilitation programs with a multi-disciplinary team who determine cognitive function, severity of impairment, treatment goals and length of treatment. These programs work closely with the attending physician of record so there can be effective follow-up. Certain criteria must be met, and the Occupational Nurse Consultant works closely with the claim manager and attending physician to have an effective evaluation done. These are usually authorized by 30-day blocks.

11. *Unrelated conditions*

Labor and Industries or the self-insurer may pay for the temporary treatment of a condition unrelated to your patient's industrial injury or disease, if the condition directly impedes the recovery of the work-related injury or disease. [WAC 296-20-055] The department or self-insurer will pay for treatment only as long as it influences recovery from the industrial injury or disease.

For example, the department or self-insurer may pay for substance abuse or obesity treatment if it directly retards your patient's recovery from an industrial injury or disease.

D. Consultations

In cases presenting diagnostic or therapeutic problems, you may arrange a consultation with a specialist without prior authorization (except mental health consultations, which do require prior authorization). [WAC 296-20-051] If you have recently obtained a consultation and are notified that the claim manager is arranging an independent medical exam (IME), you should immediately advise the claim manager of the consultation. In some instances, the claim manager will request that you obtain a consultation, as described in WAC 296-20-045.

E. Psychiatric Issues

The Office of the Medical Director, in collaboration with numerous physicians and others, has developed a guideline to help you treat workers who have psychiatric conditions. It may be useful to:

- psychologists and psychiatrists
- physicians who treat injured workers' physical conditions, but whom from time to time refer injured workers to psychiatrists or psychologists for treatment of psychiatric conditions.

For example, the guideline says that doctors' objective measurements should be individualized to accurately show progress or lack of progress. Examples of such measurements to document in your reports include:

- the level of physical activity;
- improved participation in physical therapy, occupational therapy, work hardening, or vocational counseling programs;
- normalization of common behavior patterns such as sleep cycles and eating disorders; and
- changes in medication usage.

The complete guideline is contained in Provider Bulletin 03-03 "Guidelines for the Evaluation and Treatment of Injured Workers with Psychiatric Conditions". To obtain a copy, please see Appendix G, page 75. Also, see Section 3.C.9, page 28, for information on authorization of psychiatric care.

F. Change of Attending Doctor

By law, a worker has a right to choose the doctor to treat his/her occupational illness or injury (including licensed practitioners of medicine, osteopathic medicine and surgery, chiropractic, dentistry, podiatry, optometry and naturopathy). [RCW 51.36.010; WAC 296-20-01002] A worker may change to a new attending doctor of his/her choice during the course of treatment. [WAC 296-20-065]

If a patient requests that you become the new attending doctor, you should assist the patient in mailing a "Case Transfer" card to the claim manager immediately. (To obtain these cards, use the form request card at the back of this handbook, and ask for form #F245-037-000.) If the Case Transfer card is not submitted quickly, the claim manager may continue to send correspondence to the wrong doctor, possibly causing delays in payments and authorizations.

G. Para-Professionals

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 include 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. [WAC 296-20-015 (2)]

H. Physicians' Assistants

Physicians' assistants may perform only those medical services in industrial injury cases for which the physician's assistant is trained and licensed, and 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. [WAC 296-20-01501 (1)]

Physician's assistants may perform medical services, which are within the scope of their physician's assistant license for industrial injury cases within certain limitations. [WAC 296-20-01501(2,3)]

Physician's assistants may prepare a report of the accident, time loss cards, and progress reports for the supervising physician's signature. Physician's assistants may sign Reports of Accident and Physician's Initial Reports for simple industrial injury claims as defined by the department in rule. [WAC 296-20-01502]

I. Advanced Registered Nurse Practitioners

To treat injured workers under the Industrial Insurance Act, the advanced registered nurse practitioner (ARNP) must be appropriately licensed by the Washington State Department of Health. For out-of-state nurses an equivalent title and training may be approved at the department's discretion. An ARNP may provide care and treatment to injured or ill workers as allowed under their professional scope of practice and do not require physician supervision. ARNPs may perform the functions of an attending physician. For instance, ARNPs may sign Reports of Accident and Physician's Initial Reports, certify time–loss compensation, facilitate an early return to work, and expedite the vocational process by estimating physical or mental capacities that affect the worker's employability [WAC 296-23-241]. However, ARNPs may not rate impairment or perform Independent Medical Examinations (WAC 296-20-200). An ARNP must maintain a system to assure rapid and reliable physician consultations when needed by the worker (WAC 296-23-240). Billing procedures outlined in the Medial Aid Rules and Fee Schedules apply to all nurses.

J. Claim Closure

A workers' compensation claim is closed when the patient's injury or illness has reached maximum medical improvement and it is determined that the patient is able to work in any occupation.

The "Maximum Medical Improvement" concept

Impairment is at maximum medical improvement (MMI) when it is reasonably certain that further medical treatment will not predictably alter the course of the illness or medical condition, i.e., there is no significant probability that the level of impairment will be decreased by treatment. The terms "maximum medical improvement" (MMI) and "fixed and stable" are considered synonymous at L&I. [WAC 296-20-01002]

Fixed does not mean healed or static; rather, it means the worker has reached a stable plateau from which further recovery is not expected, though the passage of time may produce some benefit. A patient whose condition is fixed and stable may still have subjective complaints and objective physical findings that may fluctuate over time. Palliative care is not payable. [WAC 296-20-01002 and 296-20-03002]

In some cases, your patient may be eligible for a monetary award based on the degree of permanent impairment. (See Section 5, page 46.) The accepted condition can be rated when it has reached a peak of possible recovery, given the worker's total medical condition. For example, the background of the worker's total medical condition might include smoking, substance abuse, or concurrent medical problems. It is not necessary to defer the rating until all ongoing, potentially complicating, conditions have been resolved.

If the worker's condition is deteriorating at such a rate that medical treatment is needed for the accepted condition and the total loss of function cannot be predicted, the worker's condition is not stable and his or her impairment cannot be rated. In this situation, you should make treatment recommendations.
When a claim is closed, Labor and Industries and the self-insurer no longer pay for medical care not authorized by the department. Only services specifically requested by the department or self-insurer, and examinations and diagnostic services necessary to the completion and filing of a reopening application, will be paid. [WAC 296-20-124]
(For information on protest of claim closure, see Section 3K, Protests, and Appeals.)

K. Protests and Appeals

If you or your patient disagree with a decision made by the State Fund or self-insured employer, you have the right to protest or appeal ***within 60 days*** of the date you receive notification of the department's decision. If the request is not received ***within 60 days***, the decision becomes final. [RCW 51.52.050]

When the protest or appeal concerns only monetary recoupment from a medical provider to the department, the appeal period is 20 days.

- **Requests for reconsideration (protests)** are filed with L&I. [RCW 51.52.050]
- **Appeals are filed with the Board of Industrial Insurance Appeals (BIIA),** an independent three-member body created by the Legislature to hear such cases. A copy of the appeal is also sent to L&I. L&I has 30 days to decide whether or not to "reassume" (or take back) an appeal. Once we reassume an appeal, we have 90 days to issue a further order (or up to 180 days with good cause). [RCW 51.52.060]

To file a protest, send a letter to the claim manager stating that you are protesting a decision, the nature of the decision, and the reason for your protest. Please include the claim number and your patient's name on every page of your letter. Requests for reconsideration of claim closure should be supported by an outline of the current condition, treatment program, and prognosis.

When you protest a decision, the department will issue another decision that modifies, reverses, or reaffirms the original decision. If you still disagree with the department's decision, you may appeal to the BIIA. Again, the appeal must be filed within 60 days of the date you received notice of the last decision.

For additional information on the BIIA or how to file an appeal, contact the Board at 360-753-6823, or in writing to:

Board of Industrial Insurance Appeals
PO Box 42401
Olympia WA 98504-2401

You may also request a copy of the Board's booklet, *Your Right To Be Heard.*

L. Reopening Claims

To reopen a claim (after 60 days) after closure has become final, file an Application to Reopen Claim for Aggravation of Condition (reopening application) form. (See Section 3K, Protests and Appeals.) You can order reopening applications by using the form request card at the back of this handbook. Ask for Form # F242-079-000.

Criteria for reopening: Reopenings are based on proof that the patient's condition has worsened or been aggravated since the last claim closure or reopening denial. To prove aggravation, the condition must be causally related to the industrial injury or illness, and objective medical findings must indicate that the condition has worsened. (See Appendix A, Glossary of Terms.) The worsening cannot be due to an unrelated condition, natural progression, or a new injury. There is no time limit to request a claim be reopened for medical benefits. [RCW 51.32.160]

The State Fund or self-insurer will pay to complete the reopening application, an office visit, consultations with a specialist and diagnostic studies (examples: MRI, cat scans, x-rays, blood tests, ophthalmologic exams, etc.) necessary to complete the application, whether the request to reopen the claim is granted or denied. [WAC 296-20-124]

The department will issue an order either granting or denying the request for reopening. If the request is denied, the injured worker is responsible for treatment costs not authorized by the department. If the request is granted, the order will indicate an effective date for the reopening of the claim. This date may be up to 60 days prior to the date the reopening application is received by Labor and Industries or the self-insurer. The State Fund or self-insurer will pay for treatment administered beginning with the reopening effective date stated on the order [WAC 296-20-097]

M. Pensions

When injured workers are deemed permanently and totally disabled, they become eligible for pension benefits. (Permanent total disability is defined in Appendix A.)

Because the claim is considered closed on the date the pension takes effect, the department generally will not pay for medical treatment provided on and after that date. However, the State Fund or self-insurer may pay for some continued treatment under certain circumstances. The department or self-insurer cannot pay for schedule I, II, III, or IV substances. [RCW 51.36.010].

If you have questions about continued treatment for a pensioned patient, you can contact your patient's claim manager, the nearest L&I service location or the self-insurer.

N. Record Storage

Labor and Industries may audit records of the service you have provided your patient. For auditing purposes:

- **Medical records must be kept a minimum of *five years* from the date of service.** [WAC 296-20-02005]
- **X-rays must be kept for a minimum of *10 years.*** [WAC 296-20-121

O. What if I Suspect Fraud?

It is everyone's responsibility to make sure that the Workers' Compensation system is used appropriately. Potential problems include filing a claim when not actually injured on the job, collecting time-loss benefits while working; inappropriately continuing time-loss benefits; employers who encourage workers to not file claims or direct their worker's care; or billing for services not provided. The department takes fraud seriously; violating laws can have significant consequences.

If you have any questions or concerns about any potential misuses of the Workers' Compensation system call the fraud hotline at **1-888-811-5974**, or visit the L&I web site: www.LNI.wa.gov/ClaimsInsurance/WorkersCompFraud/

SECTION

4

Medical and Surgical Guidelines

To make sure that treatment of workers is medically necessary and of good quality, the department works with the medical community to develop screening criteria for surgical and diagnostic procedures, as well as treatment guidelines.

The criteria are intended as guidelines and do not establish "rules." For example, criteria might indicate four weeks minimum conservative care, but circumstances may occur where waiting for that period of time may place the patient at undue risk. The department understands exceptions and supports individual review of exception cases by medical consultants.

Three of the department's guidelines are presented in their entirety on the following pages. These examples have been selected partly because they represent issues and conditions frequently encountered by doctors treating injured workers. In addition, they represent the spectrum of formats used to convey this information.

In addition to guidelines developed by L&I in collaboration with the medical community, it may be helpful to use other guidelines developed by nationally recognized authorities. One example is presented in this handbook, "Acute Low Back Problems in Adults: Assessment and Treatment." This guideline was developed by a large multidisciplinary, private-sector panel comprising health care professionals and a consumer representative, sponsored by the Agency for Health Care Policy and Research (AHCPR), a division of the Public Health Service, U.S. Department of Health and Human Services.

You may also find it helpful to use the National Guideline Clearinghouse™ (NGC™), a public resource for evidence-based clinical practice guidelines. NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America's Health Insurance Plans [AHIP]). You can find it at www.guideline.gov.

The three guidelines we have included as examples are:

1. **Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, for Workers on Time Loss,** pages 34-38.

   Please note: A related guideline has been developed, dealing specifically with opioids. It is in Provider Bulletin 00-04 "Payment for Opioids to Treat Chronic, Non-Cancer Pain" (see Appendix G). This Provider Bulletin offers FREE Category 1 Continuing Medical Education (CME) credit. It is accredited by the American College of Occupational and Environmental Medicine (ACOEM), which designates this educational activity for a maximum of 2 category 1 credits toward the AMA Physician's Recognition Award.

2. **Indications for Lumbar MRI**, page 39.

3. **Acute Low Back Problems in Adults: Assessment and Treatment,** (AHCPR), pages 40-44.

See page 45, for a comprehensive listing of all 20 guidelines published as of June 2003.

Example Guideline # 1

Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, for Workers on Time-Loss

Developed by the Washington State Medical Association and the Washington State Department of Labor and Industries. Adopted 1992 by the Washington State Medical Association.

Purpose of the Guidelines

Repeated, long-term use of prescription controlled substances for chronic nonmalignant pain may be a factor in the development of long-term disability. This condition may be preventable if at-risk patients and practices are proactively identified and managed appropriately.

It is hoped that the prescribing guidelines listed below will lead to more accurate and timely identification of workers at risk for the development of long-term disability. These guidelines may also be a component of future intervention strategies aimed at preventing long-term disability.

Development of the Guidelines

These guidelines were developed by the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee and the Washington State Department of Labor and Industries. They are based on information from existing prescription guidelines, literature reviews, pharmacologic and medical references, seminars, interviews of experts, and consultations with physicians who have private practices in a wide variety of specialties.

Application of the Guidelines

The guidelines are intended for use in the management of chronic nonmalignant pain. Chronic nonmalignant pain is defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful. Application of these guidelines is intended only for outpatient prescriptions of nonparenteral controlled substances.

> The nonparenteral routes of administration are considered the only acceptable routes for treating chronic nonmalignant pain in the Washington State workers' compensation system. [WAC 296-20-03003]

It is recognized that the guidelines cannot apply uniformly to every patient. Also, the guidelines cannot be the sole determining basis for identifying patients at risk for a drug use problem or currently experiencing a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the patient or medical file by qualified health care professionals. For example, it may be acceptable to prescribe opioids to workers who are gainfully employed and not receiving time-loss. Similarly, the guidelines cannot substitute for detailed prescribing information found in many medical and pharmacological references.

These guidelines will be applied in the workers' compensation setting only. The guidelines will apply only to workers whose injuries occurred after the guidelines are adopted by WSMA and sufficient notice has been given to providers. ***The Department of Labor and Industries may impose sanctions if the guidelines are not followed.***

The guidelines are intended for use by physicians who begin treatment within 6 months of the worker's injury. Patients who have been on controlled substances for prolonged periods and come under the care of a new physician present special problems. These and other problems will be dealt with in a separate publication.

Finally, while the guidelines may not conflict with state or federal laws, by necessity they cannot cover in detail all of the many rules, regulations, and policies published by the various agencies enacting and enforcing these laws.

I. General Information

A. Please refer to the "Introduction" for more information on the purpose, development, and application of these guidelines.

   Physicians may be held accountable if their prescribing patterns fall outside these guidelines.

B. Documentation recommendations (as presented in Table 4.1) should be followed at all times, especially whenever the physician departs from the guidelines listed below.

II. Treatment of Acute Pain from Traumatic Injuries or Surgery (Post-discharge):

A. Schedule II drugs should be prescribed for no longer than 2 weeks.

B. Schedule III and Schedule IV drugs should be prescribed for no longer than 6 weeks. (See Table 4.3 for examples of controlled substances.)

III. Treatment of Chronic Non-malignant Pain*:

A. **Extreme caution** should be used in prescribing controlled substances for workers with one or more "Relative Contraindications" (see Table 4.2). (NOTE: When special circumstances seem to warrant the use of these drugs in the types of patients listed in Table 4.2, referral for review is indicated.)

B. For patients on a ***combination*** of opioids and scheduled sedatives:

Treatment with combinations should usually not extend beyond 6 weeks.

C. For patients on opioids ***OR*** scheduled sedatives (but not combinations of the two):

Treatment should usually not extend beyond 3 months.

D. Consultation or referral to a chronic pain specialist should be considered when any of the following conditions exist:

1. Underlying tissue pathology is minimal or absent, ***AND*** correlation between the structural derangement caused by the original injury and the severity of impairment is not clear.

2. Suffering and pain behaviors are present, and the patient continues to request medication.

3. Standard treatment measures have not been successful or are not indicated.

* Defined as pain persisting beyond the expected healing time for an injury, for which traditional medical approaches have been unsuccessful.

Table 4.1: Documentation Recommendations When Controlled Substances Are Prescribed

1. A thorough medical history and physical examination and medical decision-making plan should be documented, with particular attention focused on determining the cause(s) of the patient's pain.
2. A written treatment plan should be documented and should include the following information:
   - A finite treatment plan that does not exceed six weeks
   - Clearly stated, measurable objectives
   - A list of all current medications (with doses) including medications prescribed by other physicians (whenever possible)
   - Description of reported pain relief from each medication
   - Justification of the continued use of controlled substances
   - Documentation of attempts at weaning
   - Explanation of why weaning attempts have failed (including detailed history to elicit information on alcohol and drug use)
   - How the patient's response to medication will be assessed
   - Further planned diagnostic evaluation
   - Alternative treatments under consideration
3. The risks and benefits of prescribed medications should be explained to the patient and the explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.
4. The treatment plan should be revised as new information develops which alters the plan.

Table 4.2: Relative Contraindications for the Use of Controlled Substances

1. History of alcohol or other substance abuse, or a history of chronic, high dose benezodiazepine use
2. Active alcohol or other substance abuse
3. Borderline personality disorders
4. Mood disorders (e.g., depression) or psychotic disorders
5. Other disorders that are primarily depressive in nature
6. Off work for more than 6 months

***** Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.

TABLE 4.3: EXAMPLES OF CONTROLLED SUBSTANCES		
Schedule II	**Schedule III**	**Schedule IV**
Opioids	**Opioids**	**Opioids**
codeine fentanyl (Sublimaze, Innovar) hydromorphone (Dilaudid) levorphanol (Levo-Dromoran) meperidine (Demerol) meperidine w/ Promethazine (Mepergan) methadone (Dolophine) morphine (MS Contin, MSIR, OMS, RMS, Roxanol) oxycodone oxycodone w/ acetaminophen/aspirin (Percocet, Percodan, Roxicet, Roxiprin, Tylox)	acetaminophen with codeine (Codalan, Phenaphen 2, 3, 4, Tylenol 2, 3, 4) aspirin with codeine (Empirin 2, 3, 4) hydrocodone hydrocodone w/ acetaminophen/aspirin (Anexsia, Azdone, Bancap, Cogesic, Damason-P, Dolacet, Duocet, Endal-HD, Hyco-Pap, Hydrocet, Hyphen, Lorcet Plus, Lorcet HD, Lortab, Vicodin, Zydone) nalorphine paregoric	propoxyphene (Darvon) propoxyphene w/acetaminophen/aspirin (Darvocet, Dolene, Wygesic) pentazocine (Talwin)
Sedatives	**Sedatives**	**Sedatives**
amobarbital (Amytal)** secobarbital (Seconal)** pentobarbital (Nembutal)**	Any compound containing an unscheduled drug and: amobarbital ** secobarbital** pentobarbital** glutethimide (Doriden)	chloral hydrate chlorazepate (Tranxene) chlordiazepoxide (Librium) clonazepam (Klonopin) diazepam (Valium) ethchlorvynol (Placidyl) flurazepam (Dalmane) meprobamate (Equanil, Miltown) oxazepam (Serax) paraldehyde (Paral) phenobarbital ** prazepam (Centrax) triazolam (Halcion)
	Non-Narcotic Analgesic Combinations	
	butalbital w/acetaminophen/ aspirin (Fiorinal)	

* This table is not intended as an exhaustive listing of controlled substances. A few trade names have been given as examples. This listing should in no way be construed as an endorsement of any medication.

** Barbiturates are not paid for by the department at any time (except phenobarbital, which is allowed only for seizure disorders).

WSMA

Washington State Medical Association

To our patients:

What you should know about rules your doctor must follow to prescribe drugs that may be addictive

The Washington State Medical Association (WSMA) and the Department of Labor and Industries (L&I) believe that it may do you more harm than good to take addicting drugs for a long time.

Guidelines approved by the
Washington State Medical Association
must be followed by your physician.

So please help your physician to help you. Follow your doctor's instructions carefully.

Thank you!

A message from the Washington State Medical Association.

To the doctor: Please feel free to photocopy this sheet and distribute to your patients, preferably along with your first prescription for controlled substances.

Guidelines for Outpatient Prescription of Controlled Substances: Selected References

The following are a few of the published materials used to prepare these guidelines.

AHFS Drug Information '91, American Hospital Formulary Service, by the American Society of Hospital Pharmacists, Inc., Bethesda, MD, 1991.

"Chronic Opioid Therapy in Nonmalignant Pain," RK Portenoy, Journal of Pain and Symptom Management, Vol. 5, No. 1 (Suppl.) February 1990, pp. S46-S62.

Guidelines for Prescribing Controlled Substances for Chronic Conditions, California Medical Association, San Francisco, CA, April 12, 1985.

"Medications in Low Back Pain, " JP Robinson and PB Brown, Physical Medicine and Rehabilitation Clinics of North America, Vol. 2, No. 1, February 1991,, pp. 97-125.

"Prescribing Practices for Pain in Drug Dependence: A Lesson in Ignorance," LM Halpern and JP Robinson, Controversies in Alcoholism and Substance Abuse, The Haworth Press, Inc., 1986.

"Unlocking the Secrets of Pain – The Treatment – A New Era,"JD Loeser, Medical and Health Annual Encyclopedia Britannica, 1988, pp. 120-31.

Example Guideline # 2

Indications for MRI of the Lumbar Spine

Criteria Number 12 — MRI of the Lumbar Spine

Indications

- Any neurologic deficit, evidence of radiculopathy, cauda equina compression (e.g., sudden bowel/bladder disturbance)

Or

- Suspected systemic disorder, i.e., to r/o metastatic or infectious disease

Or

- Localized back pain with no radiculopathy (leg pain), clinical history of lumbar sprain or strain, and failed 6 week course of conservative care *

    * Plain x-rays, including flexion and extension films and an erythrocyte sedimentation rate, may also be included in the diagnostic work-up initiated at this time

Indications for Repeat MRI of the Lumbar Spine

- Significant change in clinical finding, i.e., new or progressive neurological deficit

NOTE:
The primary physician is strongly encouraged to coordinate with a subspecialist: i.e., a board certified spine specialist, orthopedist or radiologist, before ordering a repeat MRI of the lumbar spine.

Example Guideline #3

Acute Low Back Problems in Adults: Assessment and Treatment

In addition to guidelines developed by L&I in collaboration with the Washington State Medical Association (WSMA), it may be helpful to use other guidelines developed by nationally recognized authorities. One example is presented on the following pages. "Acute Low Back Problems in Adults: Assessment and Treatment" was developed by a large multidisciplinary, private-sector panel comprised of health care professionals and a consumer representative. It was sponsored by the Agency for Health Care Policy and Research (AHCPR), a division of the Public Health Service, U.S. Department of Health and Human Services.

A few excerpts have been selected to illustrate important concepts contained in the guideline. The complete guideline is published in three parts: The Clinical Practice Guideline, Quick Reference Guide, and a Consumer Booklet. If you wish to obtain the complete guideline, they are available on-line at http://www.ahcpr.gov/clinic/ and click on Clinical Practice Guidelines on-line. Or you can call the AHCPR clearinghouse at 800- 358-9295. The full citation is Bigos S, Bowyer O, Braen G, et al. *Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14.* AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December 1994.

Table 1. Red flags for potentially serious conditions

Possible fracture	Possible tumor or infection	Possible cauda equina syndrome
From medical history		
Major trauma, such as vehicle accident or fall from height. Minor trauma or even strenuous lifting (in older or potentially osteoporotic patient).	Age over 50 or under 20. History of cancer. Constitutional symptoms, such as recent fever or chills or unexplained weight loss. Risk factors for spinal infection: recent bacterial infection (e.g., urinary tract infection); IV drug abuse; or immune suppression (from steroids, transplant, or HIV). Pain that worsens when supine; severe nighttime pain.	Saddle anesthesia. Recent onset of bladder dysfunction, such as urinary retention,increased frequency, or overflow incontinence. Severe or progressive neurologic deficit in the lower extremity.
From physical examination		
		Unexpected laxity of the anal sphincter. Perianal/perineal sensory loss. Major motor weakness: quadriceps (knee extension weakness); ankle plantar flexors, evertors, and dorsiflexors (foot drop).

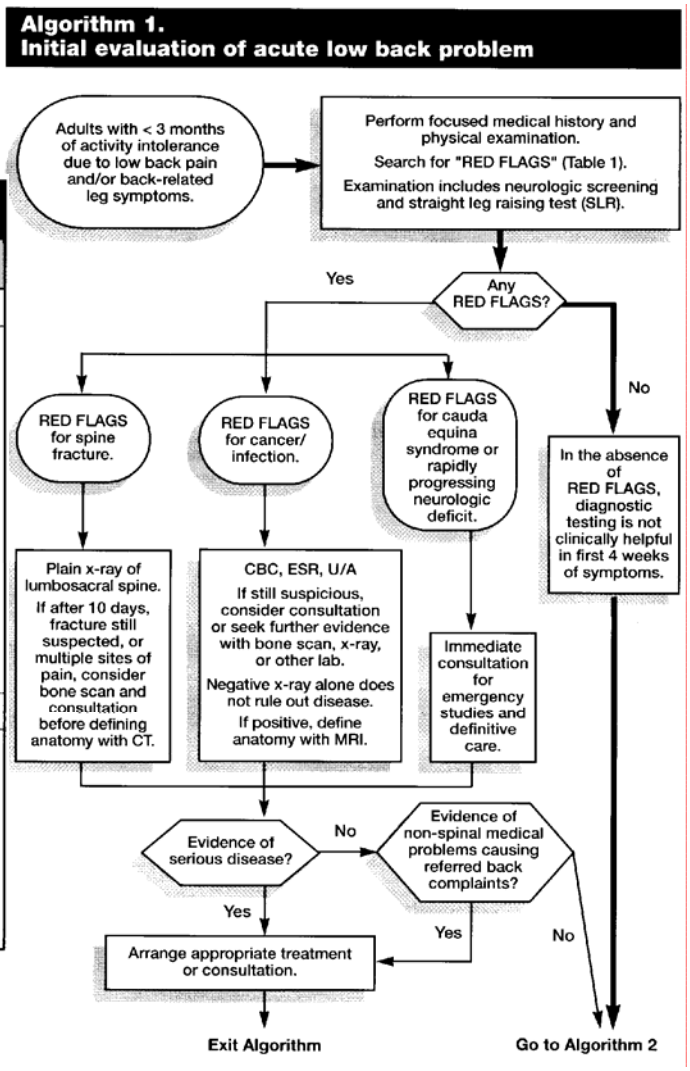
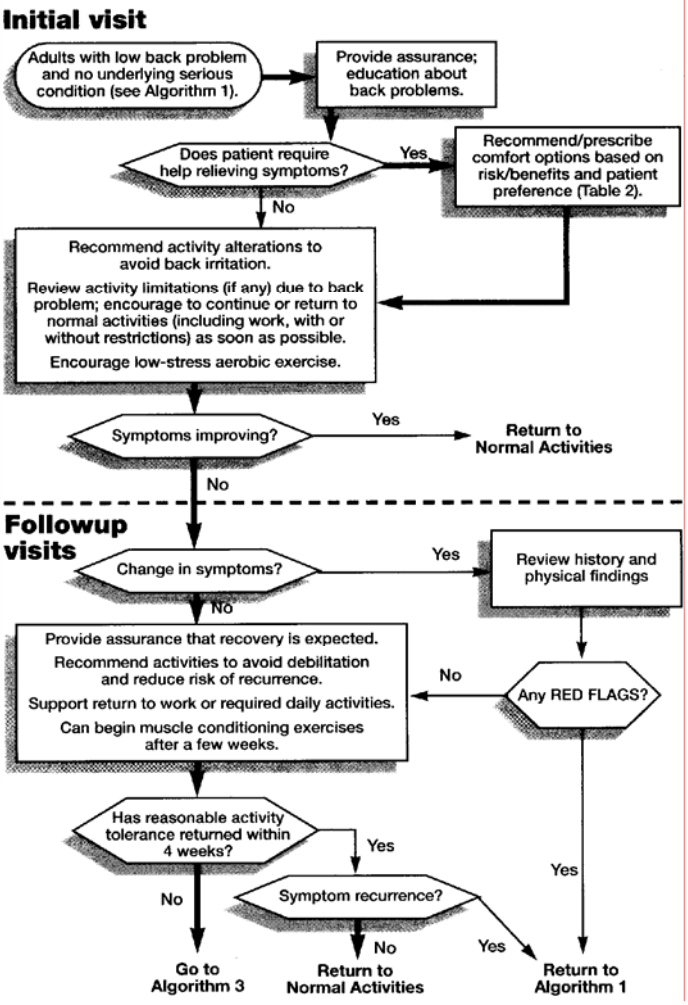


Table 2. Symptom control methods

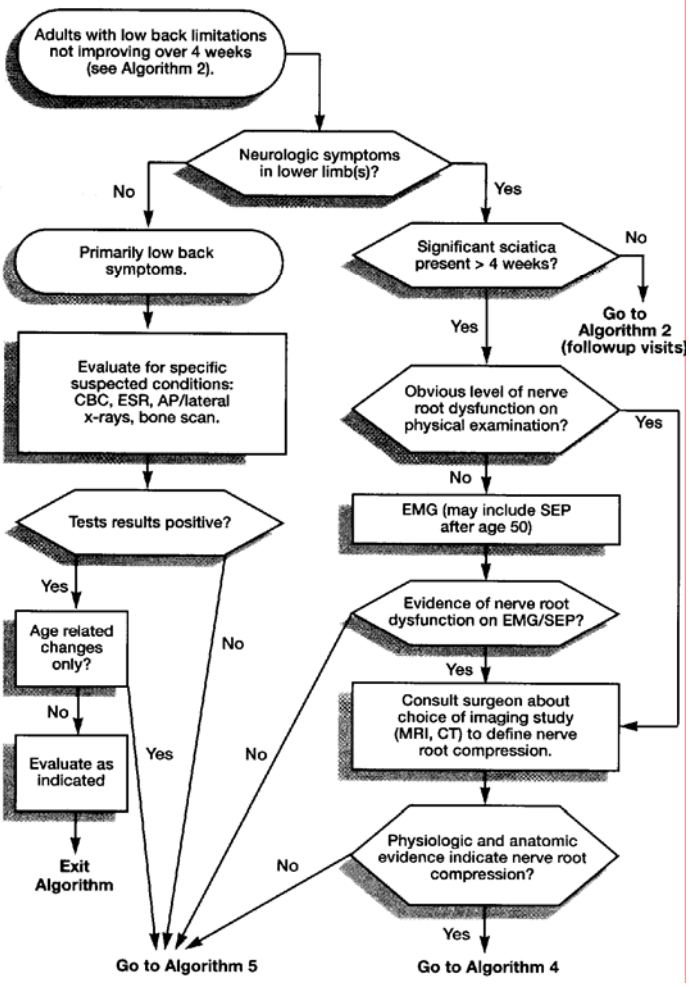
Recommended		
Nonprescription analgesics		
Acetaminophen (safest) NSAIDs (Aspirin,[1] Ibuprofen[1])		
Prescribed pharmaceutical methods	**Prescribed physical methods**	
Nonspecific low back symptoms and/or sciatica	**Nonspecific low back symptoms**	**Sciatica**
Other NSAIDs[1]	Manipulation (in place of medication or a shorter trial if combined with NSAIDs)	
Options		
Nonspecific low back symptoms and/or sciatica	**Nonspecific low back symptoms**	**Sciatica**
Muscle relaxants[2,3,4] Opioids[2,3,4]	Physical agents and modalities[2] (heat or cold modalities for home programs only) Shoe insoles[2]	Manipulation (in place of medication or a shorter trial if combined with NSAIDs) Physical agents and modalities[2] (heat or cold modalities for home programs only) Few days' rest[4] Shoe insoles[2]

[1] Aspirin and other NSAIDs are not recommended for use in combination with one another due to the risk of GI complications.
[2] Equivocal efficacy.
[3] Significant potential for producing drowsiness and debilitation; potential for dependency.
[4] Short course (few days only) for severe symptoms.

Algorithm 2. Treatment of acute low back problem on initial and followup visits



Algorithm 3. Evaluation of the slow-to-recover patient (symptoms > 4 weeks)



Note:

Algorithm 4 and algorithm 5 have not been included in this edition of the *Attending Doctor's Handbook*. If you wish to obtain the complete guideline, they are available on-line at http://www.ahcpr.gov/clinic/ and click on Clinical Practice Guidelines on-line. Or you can call the AHCPR clearinghouse at 800-358-9295.

Activity Alteration

To avoid both undue back irritation and debilitation from inactivity, recommendations for alternate activity can be helpful. Most patients will not require bed rest. Prolonged bed rest (more than 4 days) has potential debilitating effects, and its efficacy in the treatment of acute low back problems is unproven. Two to four days of bed rest are reserved for patients with the most severe limitations (due primarily to leg pain).

Avoiding undue back irritation. Activities and postures that increase stress on the back also tend to aggravate back symptoms. Patients limited by back symptoms can minimize the stress of lifting by keeping any lifted object close to the body at the level of the navel. Twisting, bending, and reaching while lifting also increase stress on the back. Sitting, although safe, may aggravate symptoms for some patients. Advise these patients to avoid prolonged sitting and to change position often. A soft support placed at the small of the back, armrests to support some body weight, and a slight recline of the chair back may make required sitting more comfortable.

Avoiding debilitation. Until the patient returns to normal activity, aerobic (endurance) conditioning exercise such as walking, stationary biking, swimming, and even light jogging may be recommended to help avoid debilitation from inactivity. An incremental, gradually increasing regimen of aerobic exercise (up to 20 to 30 minutes daily) can usually be started within the first 2 weeks of symptoms. Such conditioning activities have been found to stress the back no more than sitting for an equal time period on the side of a bed. Patients should be informed that exercise might increase symptoms slightly at first. If intolerable, some exercise alteration is usually helpful.

Conditioning exercises for trunk muscles are more mechanically stressful to the back than aerobic exercise. Such exercises are not recommended during the first few weeks of symptoms, although they may later help patients regain and maintain activity tolerance.

There is no evidence to indicate that back-specific exercise machines are effective for treating acute low back problems. Neither is there evidence that stretching of the back helps patients with acute symptoms.

Work Activities

When requested, clinicians may choose to offer specific instructions about activity at work for patients with acute limitations due to low back symptoms. The patient's age, general health, and perceptions of safe limits of sitting, standing, walking or lifting (noted on initial history) can help provide reasonable starting points for activity recommendations. Table 3 provides a guide for recommendations about sitting and lifting. The clinician should make clear to patients and employers that:

- Even moderately heavy unassisted lifting may aggravate back symptoms.
- Any restrictions are intended to allow for spontaneous recovery or time to build activity tolerance through exercise.

Activity restrictions are prescribed for a short time period only, depending upon work requirements (no benefits apparent beyond 3 months).

Table 3. Guidelines for sitting and unassisted lifting

	Symptoms						
	Severe	→	**Moderate**	→	**Mild**	→	**None**
Sitting[1]	20 min	→	→	→	→	→	50 min
Unassisted lifting[2]							
Men	20 lbs	→	20 lbs	→	60 lbs	→	80 lbs
Women	20 lbs	→	20 lbs	→	35 lbs	→	40 lbs

[1]Without getting up and moving around.
[2]Modification of NIOSH Lifting Guidelines, 1981, 1993. Gradually increase unassisted lifting limits to 60 lbs (men) and 35 lbs (women) by 3 months even with continued symptoms. Instruct patient to limit twisting, bending, reaching while lifting and to hold lifted object as close to navel as possible.

Table 5. Summary of Guideline Recommendations

** This table was re-created from the Clinical Practice Guideline No. 14, Acute Low Back Problems in Adults: Assessment and Treatment. Published by the U.S. Department of Health and Human Services, December 1994.*

The ratings in parentheses indicate the scientific evidence supporting each recommendation according to the following scale:

A = strong research-based evidence (multiple relevant and high-quality scientific studies).
B = moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).
C = limited research-based evidence (at least one adequate scientific study in patients with low back pain).
D = Panel interpretation of evidence not meeting inclusion criteria for research-based evidence.

The number of studies meeting panel review criteria is noted for each category.

	Recommend	Option	Recommend against
History and physical exam 34 studies	Basic history (B). History of cancer/infection (B). Signs/symptoms of cauda equina syndrome (C). History of significant trauma (C). Psychosocial history (C). Straight leg raising test (B). Focused neurological exam (B).	Pain drawing and visual analog scale (D).	
Patient education 14 studies	Patient education about low back symptoms (B). Back school in occupational settings (C).	Back school in non-occupational settings (C).	
Medication 23 studies	Acetaminophen (C). NSAIDs (B).	Muscle relaxants (C). Opioids, short course (C).	Opioids used >2 wks (C). Phenylbutazone (C). Oral steroids (C). Colchicine (B). Antidepressants (C).
Physical treatment methods 42 studies	Manipulation of low back during first month of symptoms (B).	Manipulation for patients with radiculopathy (C). Manipulation for patients with symptoms > 1 month (C). Self-application of heat or cold to low back. Shoe insoles (C). Corset for prevention in occupational setting (C).	Manipulation for patients with undiagnosed neurologic deficits (D). Prolonged course of manipulation (D). Traction (B). TENS (C). Biofeedback (C). Shoe lifts (D). Corset for treatment (D).

Injections 26 studies		Epidural steroid injections for radicular pain to avoid surgery (C).	Epidural injections for back pain without radiculopathy (D). Trigger point injections (C). Ligamentuous injections (C). Facet joint injections (C). Needle acupuncture (D).
Bed rest 4 studies		Bed rest of 2-4 days for severe radiculopathy (D).	Bed rest > 4 days (B).
Activities and exercise 20 studies	Temporary avoidance of activities that increase mechanical stress on spine (D). Gradual return to normal activities (B). Low-stress aerobic exercise (C). Conditioning exercises for trunk muscles after 2 weeks (C). Exercise quotas (C).		Back specific exercise machines (D). Therapeutic stretching of back muscles (D).
Detection of physiologic abnormalities 14 studies	If no improvement after 1 month, consider: Bone scan (C). Needle EMG and H-reflex tests to clarify nerve root dysfunction (C). SEP to assess spinal stenosis (C).		EMG for clinically obvious radiculopathy (D). Surface EMG and F-wave tests (C). Thermography (C).
X-rays of L-S spine 18 studies	When red flags for fracture present (C). When red flags for cancer or infection present (C).		Routine use in first month of symptoms in absence of red flags (B). Routine oblique views (B).
Imaging 18 studies	CT or MRI when cauda equina, tumor, infection, or fracture strongly suspected (C). MRI test of choice for patients with prior back surgery (D). Assure quality criteria for imaging tests (B).	Myelography or CT-myelography for preoperative planning (D).	Use of imaging test before one month in absence of red flags (B). Discography or CT-discography (C).
Surgical considerations 14 studies	Discuss surgical options with patients with persistent and severe sciatica and clinical evidence of nerve root compromise after 1 month of conservative therapy (B). Standard discectomy and microdiscectomy of similar efficacy in treatment of herniated disc (B). Chymopapain, used after ruling out allergic sensitivity, acceptable but less efficacious than discectomy to treat herniated disc (C).		Disc surgery in patients with back pain alone, no red flags, and no nerve root compression (D). Percutaneous discectomy less efficacious than chymopapain (C). Surgery for spinal stenosis within the first 3 months of symptoms (D). Stenosis surgery when justified by imaging test rather than patient's functional status (D). Spinal fusion during the first 3 months of symptoms in the absence of fracture, dislocation, complications of tumor or infection (C).
Psychosocial factors	Social, economic, and psychological factors can alter patient response to symptoms and treatment (D).		Referral for extensive evaluation/treatment prior to exploring patient expectations or psychosocial factors (D).

Previously Published Guidelines: Comprehensive List

To obtain copies, visit http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp

See also Appendix G, page 75.

Topic	Provider Bulletin

SECTION

5

Impairment Ratings

If, after reaching medical stability (see definition of "Maximum Medical Improvement," page 30), your patient is left permanently impaired, he or she should undergo an impairment rating examination. This examination can be performed by attending doctors, a consulting doctor or through an independent medical examination. The rating exam usually will be initiated by the claim manager based on your reports, but can be initiated by you (through the claim manager) or the self-insured employer.

The rating will determine the monetary award level your patient is eligible to receive for the permanent impairment.

A. Impairment Versus Disability

The terms "impairment" and "disability" often can be confusing.

- **Impairment is the loss of function of an organ or part of the body.**
- **Disability is the inability to perform a specific task or job.**

For example, if a classical pianist and a truck driver both lose a finger, both would have the same impairment and receive the same award amount. However, their disabilities would be different because the truck driver would be able to continue in his or her job and the pianist would not.

Awards must be based on impairment and not on disability. [WAC 296-20-200(4)]

B. Who Should Do Impairment Ratings?

The law allows only certain practitioners to perform rating and independent medical examinations. [WAC 296-20-2010 and WAC 296-23-317] Doctors licensed in the following fields may conduct these exams:

- **Medicine and surgery**
- **Osteopathic medicine and surgery**
- **Podiatric medicine and surgery**
- **Dentistry**
- **Chiropractic (department-approved chiropractic examiners only)**

You do not have to be an independent medical examiner or have special credentials to rate your own patient except that chiropractic examiners need to be approved by the department.

Attending doctors are encouraged to rate impairment for their own patients. Both the doctors and their patients may find they prefer it! Here are some advantages:

- **The attending doctor is able to provide a rating based on their management of the patient's care *over a period of time*.** For this reason, a rating done by the attending doctor can take into account ***fluctuations in the patient's condition,*** which other examiners may not be able to do.
- **Reimbursement for this service is higher than many doctors realize.** (See Section 6D, Selected Billing Codes of Interest to Doctors, page 51.)
- **By doing your own rating exam, you may save your patient a long wait for an Independent Medical Examination (IME),** as well as the inconvenience of recounting the history of the injury or disease to a new doctor.
- **Your patient's monetary award for impairment may be significantly expedited.**
- **Risks of litigation may be significantly lower** (as compared with IMEs). This is partly because, according to case law, the opinion of the attending doctor is "entitled to special consideration" in department decisions [*Hamilton v. Department*, 111 WN.2d 569 (1988)].
- **Patients often have more confidence in the rating provided by their attending doctor** (or a referral consultant chosen by the attending doctor).

- **The impairment rating report can be BRIEF!** Many doctors assume the department wants a lengthy report, similar to an Independent Medical Examination. This is generally not true.

To ensure reimbursement, you should request authorization from the claim manager. Also, if you prefer, you may consider asking a consultant to perform the rating. Please note that these consultant codes are payable only to doctors the department has approved as examiners.

C. How to Do a Rating

Most physicians can do ratings after a brief reading of the *Medical Examiners' Handbook* (MEH), which offers FREE category 1 Continuing Medical Education (CME) credit. The MEH is accredited by the American College of Occupational and Environmental Medicine (ACOEM), which designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award.

The handbook is a guide to the Washington State impairment system. It includes a complete copy of the Washington State Category Rating System. This is the system used to rate impairment of most parts of the body, including the spine; the respiratory, cardiac, gastrointestinal, dermatologic, and urologic systems; and mental health.

If you are interested in doing impairment ratings on your own patient or in becoming an independent medical examiner, you can order a copy of the *Medical Examiners' Handbook* by contacting the Labor and Industries service location nearest you, or by calling the warehouse at 360-902-5754, Form # F252-001-000.

The most important thing to remember about rating impairment is that the claim manager is looking for a fair, reasonable rating with a clear statement about the objective findings on which the rating is based. Extreme ratings, either too high or too low, generally cause problems of adjudication, so every effort should be made to assure that the rating is equitable and consistent with the rating system used.
To rate extremities (except amputations), hearing loss, and other systems not covered by the Category Rating System, MDs, and DOs should use the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. A copy can be ordered by calling 800-621-8335 or 312-464-5651, or by writing to the following address:

Order Department
American Medical Association
PO Box 109050
Chicago, IL 60610-9050

D. Independent Medical Examinations (IMEs)

You may prefer to have your patient undergo a rating exam through an independent medical examination (IME). IMEs are used to establish medical facts about an injured worker's physical condition so that appropriate assistance can be given to the worker and administrative decisions made about his or her claim. They also are used to determine impairment ratings.

Like rating exams, IMEs can be requested by the claim manager, by you (through the claim manager) or by the self-insured employer.

Doctors conducting IMEs must be approved by Labor and Industries' Health Services Analysis section and the Office of the Medical Director. Doctors wishing to be approved should obtain a copy of the *Medical Examiner's Handbook*, described above.

As the attending doctor, you should automatically receive copies of all IMEs done on your patients. The claim manager may ask for your assessment of the exam findings. Please reply to the claim manager as soon as possible

Quality IMEs

The Legislature has mandated that Labor and Industries monitor the quality of independent medical examinations [RCW 51.32.114] and set standards for conducting exams [RCW 51.32.112].

To that end, the department has developed a tracking system for worker complaints about IMEs.

If your patient feels he or she was treated unfairly during an IME, please encourage the patient to report this (preferably in writing) to the Provider Review and Education Unit. The patient can send the complaint to the address shown in item # 9 in Appendix I.

Doctors also may report problems to the same address. Be sure to include the worker's name, claim number, the name of the examiner(s) and the date and location of the IME.

Billing for Services

A. State Fund

The Washington State Fund is money reserved for industrial insurance, sustained solely through premiums paid by employers and employees and administered by Labor and Industries as an insurance program covering all employers in the state who are not self-insured.

Claim designation

State Fund claims are six digit numbers preceded by one of the following: B, C, F, G, H, J, K, L, M, N, P, X, Y and AA.

The provider account number

To receive payment for the services you provide to a Washington State Fund injured worker, you must have a provider account number. Each attending doctor, even in group practices, must have an individual provider account number. Provider account numbers are assigned by the department following an application and approval. Your tax identification number is ***not*** your provider number.

You can apply for a provider account number by completing a Provider Account Application and submitting the required documents. To receive an application, contact Labor and Industries. The address, URL and phone numbers are shown in item #12 in Appendix I.

When you return the completed Provider Account Application and the required documents, your application will be reviewed, your eligibility confirmed, and you will be sent a provider account number.

If you are denied a provider account number, the reason will be explained to you. If you disagree with the decision, you may file an appeal by sending documentation supporting your position to Labor and Industries at the address shown in item #13 in Appendix I.

If you have any question about your eligibility, what services are covered, or what to do if you treated an injured worker before receiving your provider account number, call the Provider Hotline at 800-848-0811, 360-902-6500 from Olympia.

Once you have a provider account number, be sure to notify the department if any information on your application changes, such as your address, federal tax identification number, or business status. If we don't have current information, your payments could be delayed.

Billing for services

- **General information/paper billing:** When you bill Labor and Industries for medical services to an injured worker, please include the worker's claim number and your provider account number on all correspondence.

  The department publishes a General Provider Billing Manual for all providers and separate billing instructions by specific provider type. Please refer to these publications for more detailed information. They can be obtained by contacting the Provider Accounts Section at 360-902-5140.

  The State Fund uses an automated system called the Medical Information and Payment System (MIPS) to process your bills. With MIPS, the department can receive your bills on paper or electronically.

- **Electronic billing:** Electronic billing increases the efficiency of bill processing and allows the department to pay providers faster. It also allows you greater control over the payment process with no delay for entry time. Reporting requirements for electronic bills are the same as paper bills.

When you bill the department electronically, you have the option of receiving your Remittance Advice by electronic media. (See the *General Provider Billing Manual* for detailed information on remittance advices.)

For more information about these electronic options, call or write Labor and Industries at the address shown in item # 6 in Appendix I.

B. Self-insurers

The term self-insurers refer to an employer's assumption of financial risk for industrial insurance (workers' compensation). In other words, an employer handles his or her own workers' compensation coverage instead of the state. Self-insured employers in Washington must meet certain requirements and be certified by Labor and Industries.

Claim designation

Self-insured claims are six digit numbers preceded by an S, T, W, or SA.

Billing for services

All bills are paid by the self-insured employers and should be submitted to them (or their representative). If you have questions about a Self-insurance billing, please call your patient's employer (or their representative) or Labor and Industries' Self-insurance section at 360-902-6901.

C. Medical Aid Rules and Fee Schedules

When you accept a provider account number with the department, you are automatically agreeing to accept as full payment the reimbursement amount established by Labor and Industries for each particular service. [WAC 296-20-020] 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, nor can the worker be charged a fee, either for interest or completion of forms, related to services rendered for the industrial injury or condition. Refer to Chapter 51.04 RCW.

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. [WAC 296-20-020]

Doctors outside of Washington, Oregon, and Idaho should refer to WAC 296-20-022, "Payment of out-of-state providers." Payment policies, reimbursement amounts, and payment indicators are listed in the *Medical Aid Rules and Fee Schedules*. A copy is included in the new provider packet; annual revisions are sent to all providers and can also be obtained by calling the Provider Accounts section at 360-902-5140.

The *Medical Aid Rules*, WAC 296-20-010, sections 2, 5, and 6 state:

> 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.
>
> No fee is payable for missed appointments unless the appointment is for an examination arranged by the department or self-insurer.

Resource based relative value scale (RBRVS)

The department adopted the RBRVS payment methodology on September 1, 1993. It applies to several, but not all, provider types. Fees for services reimbursed under RBRVS are calculated multiplying geographically adjusted ***relative value units (RVUs)*** by a dollar ***conversion factor***. The RVUs are determined by the federal Centers for Medicare and Medicaid Services (CMS) with consultation from the American Medical Association and representatives from professional associations. The conversion factor is evaluated on an annual basis, and is determined by the department by performing detailed data analysis and research in areas such as budget levels, cost of living changes, and other



Workers' Compensation REFORMS

Historic Changes to Workers' Compensation

An Overview for Medical Providers in Washington State

The 2011 Washington State Legislature passed and Governor Gregoire signed into law some of the most significant changes to Washington's workers' compensation system since its founding in 1911.

The legislation creates a statewide medical provider network, expands the Centers of Occupation Health and Education (COHEs), promotes getting workers back on the job faster, and includes other changes that reduce the system's overall costs.

These reforms are briefly summarized below. Links to more information online are provided for your convenience.

Medical Provider Network

Beginning Jan. 1, 2013, all current and new providers in Washington State of the following types must be in the workers' compensation network in order to provide ongoing care for injured workers. Ongoing care means treatment beyond the initial office or emergency-room visit.

Providers who must be in the network by Jan. 1, 2013, are:

- Physicians (some hospital-based physicians don't need to enroll, visit the **www.Lni.wa.gov** for more information)
- Chiropractors

(Continued on next page)

- Naturopathic Physicians
- Podiatric Physicians & Surgeons
- Advanced Registered Nurse Practitioners
- Physician Assistants
- Dentists
- Optometrists

Injured workers covered by the Department of Labor & Industries (L&I) and by self-insured businesses will need to obtain treatment from network providers except for an initial office or emergency-room visit.

L&I will manage the new network. It is an open network — L&I will accept all qualified providers who meet network requirements.

L&I worked closely with the Provider Network Advisory Group of worker, employer, and provider representatives and the standing Industrial Insurance Medical Advisory Committee to develop rules on network standards and processes.

The legislation also directs L&I to provide new incentives to providers who use occupational health best practices, beginning later in 2013.

For more information on the network, visit **www.ProviderNetwork.Lni.wa.gov**.

To enroll in the network, visit **www.JointheNetwork.Lni.wa.gov**.

Centers of Occupational Health and Education

The Centers of Occupational Health and Education (COHEs) are health-care delivery organizations such as clinics or hospitals that help medical providers coordinate care and use occupational-health best practices to treat injured workers. Research has shown that COHEs help injured workers return to work sooner and reduce claim costs.

In 2012, four COHEs in Washington State treat about one-third of all State Fund workers' compensation claims. The goal of the legislation is to extend COHE access to at least 50 percent of injured workers by December 2013 and to all injured workers by December 2015.

For more information, visit **www.Lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/OHS/default.asp#6**.

Washington Stay at Work Program

"Stay at Work" is a new L&I program that provides financial incentives to employers who bring their injured workers quickly and safely back to light-duty or transitional jobs. Eligible employers can be reimbursed for up to 50% of the injured worker's base wage, and for some of the cost of the training, tools or clothing the worker will need. The program promotes the best practice of keeping injured workers at work in medically approved, light-duty or transitional work.

Research shows that this type of on-the-job engagement and light activity can actually help injured workers with their recovery, while reducing costs to employers and the system.

Health-care providers who treat injured workers play an important role in returning them to light-duty or transitional work as quickly as medically appropriate. Providers can bill for several "return to work" specific services and procedures. Please see *Attending Provider's Return to Work Desk Reference* (**www.Lni.wa.gov/IPUB/200-002-000.pdf**) for more details.

For more information about the Stay at Work Program, visit **www.StayatWork.Lni.wa.gov**.

Structured Settlement

Structured settlement provides an option to resolve disability benefits for a qualified workers' compensation claim. In a structured settlement, the worker is paid an amount of compensation through periodic payments spelled out in a written agreement. Workers who enter into a structured settlement can still receive medical treatment authorized under their claim.

To be eligible, an injured worker must reach age 55 and have an accepted workers' compensation claim. L&I, or the employer if the business is self-insured, must have received the worker's claim at least 180 days before negotiations begin. The age requirement drops to 53 beginning January 1, 2015, and drops further to 50 beginning January 1, 2016.

All parties to the claim must agree to the settlement. If the employer pays premiums to L&I, the parties include the worker, the employer, and L&I. L&I is responsible for negotiating the agreement. If the employer is self-insured, the parties are the worker and the employer. All agreements must be approved by the Board of Industrial Insurance Appeals.

For more information about Structured Settlement, visit **www.Settlement.Lni.wa.gov**.

More Fraud Prevention

L&I continues its stepped-up fraud-fighting efforts, including participating in a national insurance information exchange with other workers' compensation insurers. By cross-matching claim information with workers' compensation insurers in other states, L&I can more easily identify duplicate claims. The bill also requires L&I to address fraudulent billing practices by medical providers.

(Continued on next page)

E-correspondence Launching in 2013

In 2013, L&I will offer an "electronic" correspondence option that will significantly reduce paperwork for many health-care providers in Washington.

Currently, L&I is required by law to mail a copy of every legal notice and correspondence to **all three parties** in each workers' compensation claim — the provider, the employer, and the injured worker. As a result, your practice may receive large amounts of mail that you must sort and, ultimately, dispose of.

By April 2013, you will have the option of receiving most of this mail electronically, thanks to legislation passed by the 2011 Washington Legislature at L&I's request. L&I will still be required to send paper versions of communications related to claim closure.

If you choose to receive electronic copies, you will have less L&I paperwork to sort, saving your practice both time and money. The savings will be significant for L&I as well. We estimate that we spent $1 million in 2009 on postage, handling, and paper for courtesy copies sent to health-care providers alone.

Other Changes

Other changes included the following:

- Eliminating the cost of living increase for workers' comp pension and time-loss recipients in 2011, and deducting permanent partial disability payments from pension awards.
- Making the Safety and Health Investment Projects (SHIP) Grant Program permanent and including grants for innovative return-to-work programs.
- Conducting an independent study of occupational disease claims and a performance audit of the workers' compensation claims management system (including self-insured claims).
- Establishing a rainy day fund for the workers' compensation system.

Stay Current: Receive Updates by Email

To stay informed about e-correspondence and other changes reported in this fact sheet and to learn the latest news for providers who treat injured workers, join the L&I Medical Provider News Email List at **www.Lni.wa.gov/Main/Listservs/Provider.asp**. Simply provide your name and email address.

current health care issues. Changes to the RBRVS conversion factor are subject to the public hearing process. Further information about RBRVS, coding, and other reimbursement methods, and policies can be found in the *Medical Aid Rules and Fee Schedules*.

D. Selected Billing Codes and Other Information of Interest to Attending Doctors

The department frequently requests that doctors provide certain services (for example, impairment ratings) that may be different from those required for patients with non-occupational conditions. The department acknowledges that providing such services can be challenging.

In this section, selected billing codes are presented to make it easier for you to bill the department whenever such services are provided, and to assist your staff in using the codes appropriately. More detail on some of these codes is given in *Provider Bulletins*. (See Appendix G, Index of Provider Bulletin Subjects, page 75.)

The selected billing codes are presented in this section in the following order:

- **Codes for Attending Doctor and Consultant Impairment Ratings** (Table 6.1)
- **Codes for Conferences and Telephone Calls** (Table 6.2)
- **Other Miscellaneous Codes:** detailed occupational history, job analysis, physical capacities evaluation, review of IME, etc. (Table 6.3)

Also, note the following:

- **If the claim is not accepted,** you will be paid for completing the report of accident and will generally be paid for the initial office visit and necessary tests (except in unusual circumstances, for example, jurisdiction is determined to be the U.S. Department of Labor or another state).
- **Physician assistant (PA) billing procedures are described in** WAC 296-20-01501 and WAC 296-20-12501.

Table 6.1: Codes and Descriptions for Attending Doctor and Consultant Impairment Ratings*

For more on appropriate use of these codes, refer to the most current *Medical Aid Rules and Fee Schedules* and other department publications on this topic.

Definitions of limited, standard, and complex impairment rating exams are as follows:

Limited: Examination of an injury or condition limited to one system or region of the body, where a review of systems is unlikely to show pre-existing or systemic illnesses influencing or complicating treatment. Records are reviewed. The physical examination is directed only toward the affected portion of the body. ***Impairment rating is performed.*** REPORT REQUIRED and included in this fee.

Standard: Examination includes a complete physical examination to delineate the role of systemic, pre-existing, or subsequent conditions on the accepted injury or condition. The records are reviewed. Diagnostic tests needed are ordered and interpreted. ***Impairment rating is performed***. REPORT REQUIRED and included in this fee.

Complex: Examination includes extensive physical examination to delineate the role of systemic, pre-existing, or subsequent condition on the accepted condition. The report conclusions list four or more systems or body areas with a description of how each relates to the accepted injury or condition. The records are reviewed. ***Impairment rating is performed***. REPORT REQUIRED and included in this fee.

Attending Physicians:

1190M, **Limited impairment rating exam by Attending Doctor**

1191M, **Standard impairment rating exam by Attending Doctor**

1192M, **Complex impairment rating exam by Attending Doctor**

Consultants: (Payable only to Approved IME Examiners; to become an Approved Examiner, see Section 5, Impairment Ratings, page 46.)

1193M, **Limited impairment rating exam by Consultant**

1194M, **Standard impairment rating exam by Consultant**

1195M, **Complex impairment rating exam by Consultant**

**** No-show fees will not be paid for an appointment time scheduled for an impairment rating by an attending doctor or consultant. No-show fees are paid only when the department or self-insurer has set the time and place for an Independent Medical Examination. [WAC 296-20-010]***

Table 6.2: Selected Billing Codes for Conferences and Telephone Calls

These codes may be used for face-to-face or telephone meetings with vocational counselors, employers, claim managers, department nurse consultants, and other department representatives. The department allows attending physician charges for case management services, including telephone calls (codes 99371 to 99373) and on-site visits (codes 99361 and 99362), as specified in the CPT. These services must be performed by the physician (not staff). Documentation must reflect the date, length of the call or visit, who was contacted, nature of the call or visit, and any medical decisions made during the call. Phoning prescriptions to a pharmacy is a ***bundled*** service.

For more on appropriate use of these codes, refer to the most current *Medical Aid Rules and Fee Schedules* and other department publications on this topic.

Physician Conferences

Code	Description
99361	In-person medical conference of approx. 30 min.
99362	In-person medical conference of approx. 60 min.
99371	Brief (under 15 min.) phone call by physician
99372	Intermediate (15-30 min.) phone call by physician
99373	Complex (over 30 min.) phone call by physician

Table 6.3: Other Miscellaneous Codes and Descriptions

These administrative codes are for use by attending doctors when it is permitted within their scope of practice. This includes doctors of medicine, osteopathic medicine and surgery, chiropractic, naturopathy, podiatry, dentistry, and optometry. See Appendix G in the "Washington RBRVS Payment Policies" section of the Medical Aid Rules and Fee Schedule for authorization and other information about these codes. Please be sure to use these codes ***appropriately*** by referring to the most current version of the *Medical Aid Rules and Fee Schedules*, relevant sections of this handbook, the CPT manual, and any *Provider Bulletins* on related topics.

Code	Description
99080	Special report requested by the agency or 60 day report. Do not use this code for other forms or reports with assigned codes.
1026M	Attending physician final report (PFR) form completed at the request of insurer. Not payable in addition to office visit on same day.
1027M	Loss of Earning Power (LEP) form completion by the attending doctor at the insurer's request.
1028M	Each additional JA reviewed on the same day.
1037M	Provide physical capacity or restriction information to employer (State Fund only).
1038M	Review of job offer or analysis (JA) by attending doctor performed at the request of the insurer or State Fund employer. First job offer or analysis per day.
1039M	Time Loss Notification Form (TLN), only when specifically requested by the department.
1040M	Completion of the Report of Industrial Injury or Occupational Disease (Report of Accident, ROA) form.
1041M	Reopening application. A fee for an evaluation and management service will be paid for this reopening examination when justified by a report. Diagnostic studies and X-rays associated with the reopening application will be allowed in addition to the fee.
1044M	Physical medicine modality (ies) and/or procedure(s) by the attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to first six visits, except when a doctor practices in a remote area. *
	**** Code 1044M is not payable to optometrists. See WAC 296-21-290 for remote area exceptions.***
1046M	Mileage, per mile; allowed when round trip exceeds 14 miles.
1048M	Completion of a Doctor's Estimate of Physical Capacities form.
1051M	Copies of medical records, payable to any provider when requested by the department or Self-insurer or their representative(s); not payable when required to support billing for services performed, per page. *
	**** Code 1051M is only payable directly to providers providing care or services to an injured worker. It is not payable to commercial copy centers or printers who reproduce records for providers.***
1055M	Detailed occupational disease history. Payable only to attending doctors.
1056M	Supplemental Medical Report (SMR), when requested by the department.
1063M	Attending doctor's review of an independent medical examination (IME), which was requested by the department or self-insurer.

APPENDIX

A

Glossary of Terms

abeyance An order placing a previous order on hold pending the receipt of further information.

aggravation A worsening of a once-fixed and stable occupational injury or disease that leads to temporary or permanent increase in disability.

Americans with Disabilities Act (ADA) The 1990 federal civil rights law that prohibits discrimination against the disabled in the areas of employment, public accommodations, public services, transportation and telecommunications.

chiropractic consultant A chiropractor identified by Labor and Industries and the Chiropractic Advisory Committee as eligible to give chiropractic second opinions in Washington State.

chiropractic consultant program A program under which the Chiropractic Advisory Committee reviews and Labor and Industries approves chiropractors to perform chiropractic second-opinion examinations (consultations in Washington State), maintains an approved list of chiropractic consultants, and assures quality of chiropractic consultations. Chiropractic second opinions are arranged by the attending doctor. Generally, no prior authorization is required.

claim A written request for and an assertion of the right to compensation under Washington State's Industrial Insurance Act, not to be confused with a bill for services rendered. When you complete and submit the Report of Industrial Injury or Occupational Disease or the Physician's Initial Report form, you initiate your patient's claim.

curative care Medical care that is likely to improve the patient's medical condition. In Washington State's workers' compensation system, curative and rehabilitative care are the only types of care injured workers are eligible to receive and for which the program will reimburse attending physicians. ***See palliative care, page 56.***

disability The inability to perform a specific task or job (e.g., the inability to play the piano). A disability generally results from an impairment. ***See impairment, below.***

doctor A person licensed to practice one or more of the following professions: medicine and surgery; osteopathic medicine and surgery; chiropractic; drugless therapeutics; podiatry; dentistry; optometry.

employable Having the skills and training that are commonly and currently necessary in the labor market to be gainfully employed on a reasonably continuous basis, when considering the person's age, education, experience, physical and mental capacity due to the industrial injury.

fee schedule A list of the maximum amounts Labor and Industries or a self-insured employer can pay providers for authorized medical services and equipment. [WAC 296-20-020]

fixed and stable ***See Maximum Medical Improvement below.***

gainful employment Any job, including self-employment that allows a worker to be compensated with wages or other earnings. State or federal minimum wage is used as the minimum acceptable level of compensation.

impairment The loss of function of an organ or part of the body (e.g., the loss of a finger). ***See disability, above.***

independent medical examination (IME)	A medical examination requested by the department or a self-insurer or attending doctor to establish medical facts about a worker's physical condition.
injury	A sudden and tangible happening of a traumatic nature producing an immediate or prompt result and occurring from without, and such physical conditions as result therefrom.
Labor and Industries	The Washington State Department of Labor and Industries, the state agency responsible for Washington's workers' compensation program as well as workplace safety and health, building and construction safety inspection services, child labor, employment standards, apprenticeship and crime victims compensation.
light duty	Temporary or permanent work that is less vigorous or less physically taxing than that which the worker performed before the injury or illness.
Maximum Medical Improvement	The point reached when an impairment is unlikely to be significantly improved by further medical treatment and the injured worker has reached a stable plateau from which further recovery is not reasonably expected. ***See page 30 for more detail.***
Medical Aid Rules and Fee Schedules	A publication of rules, billing codes and maximum fees explaining what providers must do to comply with industrial insurance laws and the levels of reimbursement allowed for medical services. [WAC chapters 296-20 through 296-23A]
modified work	A temporary or permanent adjustment in the type or scheduling of job tasks within the work environment that enables a worker to safely perform the duties of a given position.
more probable than not	When there is a greater than 50 percent chance that an injured worker's medical condition was caused by an occupational injury or exposure.
objective findings	The essential elements of the medical history, physical examination, and test results that support the diagnosis, the treatment plan, and the level of impairment. Also defined as "those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by physicians." Also defined as "those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by physicians."
occupational disease	A disease or infection that arises naturally and proximately out of employment. ***See page 13 for more detail.***
palliative care	Medical care that results in symptomatic relief, but will not result in improvement of the patient's medical condition. Injured workers in Washington State's workers' compensation system are not eligible for palliative care. ***See Curative Care. See also page 5.***
permanent partial disability (PPD)	An insurance term that describes a partial disability that is a lasting but not totally disabling impairment and has been deemed unlikely to improve.
permanent total disability (PTD)	Also **"total permanent disability (TPD)."** An insurance term that describes a disability that permanently and completely incapacitates a worker, preventing him or her from ever performing any gainful employment.
Proper and Necessary	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. (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.

	The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Please refer to WAC 296-20-01002 "Definitions" for a complete description of this term.
Provider Bulletin	A publication mailed to providers to notify them of pertinent changes in laws and Labor and Industries administrative rules, policies and programs. *Provider Bulletins* can be ordered by calling 800-848-0811 or 360-902-6799.
return-to-work priorities	A formal hierarchy of vocational goals established by state law that must be followed when developing a return-to-work plan. ***See Figure 2.3, page 12.***
Revised Code of Washington (RCW)	Laws adopted by the Legislature. Changing an RCW requires a bill to be passed by the House and Senate and signed into law by the Governor. Statutes covering industrial insurance (workers' compensation) laws fall under Title 51.
self-insurance	An organization's assumption of financial risk for industrial insurance (workers' compensation). In other words, an employer handles his or her own workers' compensation coverage instead of the state. Self-insured employers in Washington must meet certain requirements and be certified by Labor and Industries.
state fund	Money reserved for industrial insurance, sustained solely through premiums paid by employers and employees and administered by Labor and Industries. The State Fund covers all employers in the state who are not self-insured. The term is also used to describe Labor and Industries in its function as the insurer of workers' compensation.
transitional return-to-work	Any return-to-work strategy that assists a gradual resumption of work tasks, e.g., modified work. Allows the worker to return to the workforce during medical instability.
treatment plan	For State Fund claim adjudication purposes, a treatment plan is a report from the attending doctor, used by the claim manager to monitor an injured worker's medical progress. It should contain specific information: the condition(s) diagnosed; the type of treatment to be given; the date the treatment will be completed; expected outcomes; and any physical restriction connected to the patient's return to work.
Washington Administrative Code (WAC)	Department regulations authorized by statute and holding the force of law, adopted to support the RCW. WAC rules must go through a public hearing process before they are approved.
WISHA	The initials refer to the Washington Industrial Safety and Health Act. The term is used synonymously for the Department of Labor and Industries' WISHA Services Division, which is responsible for workplace safety and health in Washington State.
work hardening	An interdisciplinary, individually structured, job-specific program of activities with a goal of return to work. It uses education, real or simulated work tasks and graded conditioning exercises based on the individual's measured tolerances. ***Only approved providers are reimbursed for this service.***
work pattern	An indication of whether the job was or is full-time, part-time, seasonal or on-call.
work simulation	Arrangement of work tasks and activities that simulate, biomechanically and behaviorally, an actual job or components of a job.

APPENDIX

B

Occupational Disease Resources

This appendix presents resources that may be helpful in preventing, diagnosing, and treating occupational diseases. Please refer to Section 2G, Occupational Diseases, page 13 for more information and basic definitions relevant to this topic.

A. Chemically Related Illness

Center for Chemically Related Illness at Harborview Medical Center

In 1993, the Legislature passed a law directing the Department of Health and the Department of Labor and Industries to establish "one or more centers for research and clinical assessment of chemically related illness" [Engrossed Substitute House Bill 2696].

As a result, the department, with the participation of the Department of Health, has contracted with the University of Washington's Occupational and Environmental Medicine Clinic at Harborview Medical Center to operate the Center for Chemically Related Illness (CRI). The Center opened August 31, 1995.

The CRI Center is affiliated with satellite clinics to provide comprehensive access to care for patients throughout the state of Washington. Occupational Medicine Associates in Spokane and the Yakima Valley Farm Workers Clinic in Toppenish provide service to patients in eastern and central Washington.

Through funding provided by the Legislature, the center has equipped a mobile van/laboratory to provide on-site environmental evaluations. The center also offers comprehensive industrial hygiene assessment and testing; medical toxicology consultations; diagnostic testing and development of treatment plans; patient education; assistance, when appropriate, with filing of workers' compensation claims; and opportunities to participate in clinical research on a voluntary basis when eligible.

Physicians should call 206-731-3005 to refer patients to the center. The general community can call the same number for information about appointments.

Pesticides

For information on the health effects of pesticide exposure:

- Washington Poison Centers 1-800-732-6985 (statewide).
- Pesticide 24-hour emergency number: 800-858-7378 ***(for toxicology, medical information or for reporting exposures).***
- Chemtrec information number: 1-800-424-9300. Chemtrec is a service offered by the Chemical Manufacturers Association to assist with response to chemical spills.
- Washington State Department of Agriculture, Pesticide Management Division: 360-902-2040.
- Washington State Department of Health, Pesticide Section: 360-236-3360.

For more information, board-certified occupational health physicians are available for consultation at Providence Medical Center in Seattle: 206-320-2029; Harborview Medical Center: 206-731-3005; and Virginia Mason Medical Center: 206-223-6600.

B. Investigations and Research (SHARP Program)

The Safety and Health Assessment and Research for Prevention (SHARP) program is a multi-disciplinary research group within L&I created by the legislature in 1990. The group has doctoral-level expertise in epidemiology, toxicology, industrial hygiene, ergonomics, and occupational medicine. It is available as a resource related to occupational diseases.

SHARP conducts a wide variety of research projects, and maintains the state's occupational lead poisoning registry. SHARP's staff is available to providers for telephone consultation. Providers are also welcome to request SHARP investigations of occupational disease cluster or formal research projects.

Requests for investigations and research are prioritized and conducted as resources permit. SHARP can be reached at 360-902-5669. ***For additional information, see p. 18.***

C. AIDS/HIV

Madison Clinic
206-731-5100
The clinic offers psychological counseling, social work and drug and alcohol counseling.

Northwest AIDS Education and Training Center (AIDS ETC)
206-221-4944
The center is connected with the University of Washington's School of Medicine. It offers AIDS education and training to health-care professionals: clinical training rotations, grand rounds, and specialized courses.

MEDCON
Seattle: 206-543-5300
Outside of Seattle: 800-326-5300
MEDCON also is associated with the University of Washington's School of Medicine. Through MEDCON, doctors can consult with an AIDS specialist, who will return telephone calls. (MEDCON can also connect a provider with all kinds of specialists at the UW free of charge, including Occupational Medicine specialists.)

The Center for Disease Control
National AIDS 24-hr Hotline: 800-342-2437
TTY (10am–10pm EST, Monday-Friday): 800-234-7889
SIDA (8am-2am): 800-344-7432

The Department of Health
HIV/AIDS Information Hotline:
800-272-AIDS

APPENDIX

C

General Reference Materials

A. Materials Available from L&I

Numerous brochures, forms, and other publications are described in this handbook. Most of them may be obtained free of charge by mailing a request using the form request card at the back of this handbook. In addition, a few other materials are described below.

Booklets and Brochures for doctors and patients

The department produces a booklet with easy-to-read information and worksheets to help doctors return patients to work. *The Attending Doctor's Return-to-Work Desk Reference* is available free of charge by contacting the L&I Warehouse using the tear-out order card at the back of this handout. The department also produces a brochure written for your patients: "*Getting Back to Work: It's Your Job and Your Future Form"* F200-001-000. This brochure has easy-to-read information on return to work. Order a free supply to share with your patients (also available from the L&I Warehouse).

See also Section 2F, Helping Patients Return to Work.

Inter-library loans from the L&I library

Some materials may be borrowed from the library at L&I. Simply speak with the librarian at any public library, hospital library, or similar lending institution and request an inter-library loan with the Department of Labor and Industries. You may give the librarian the L&I library phone number to arrange the loan: 360-902-5498. Examples of materials you may wish to borrow include:

- *Achieving Success With Workers' Compensation: A Comprehensive Training Program for Physicians and Health Care Professionals.* This program includes six audiotape cassettes with presentations by physicians, vocational rehabilitation counselors, claim adjusters, and others. It also includes a reference manual with detailed information about workers' compensation across the United States. The manual contains forms such as patient questionnaires and pain drawings. The program is accredited by the American College of Occupational and Environmental Medicine.
- *How to Use Guides to the Evaluation of Permanent Impairment:* This set of five videocassettes includes presentations by physicians of several specialties explaining how to use the American Medical Association's *Guides to the Evaluation of Permanent Impairment.* The cassettes are accompanied by a manual containing worksheets, pain diagrams, and other materials.
- *Making Claims Work:* This videocassette, available in English and Spanish, may be a valuable tool to help you and your patients understand some of the basic concepts and procedures of workers' compensation. Primarily intended for workers, it lasts about 10 minutes and was produced by L&I in 1995.

B. Textbooks on Occupational Medicine Topics

The books listed below may be helpful in diagnosing and treating injured workers. It is best to obtain them from your own medical library or bookstore rather than from the L&I library, since many of them may not be readily available.

Barth, Peter S. and H. Allan Hunt. *Workers' Compensation and Work-Related Illnesses and Diseases.* Cambridge, MA: MIT Press, 1982.

Bonica, John J. *The Management of Pain.* 2nd ed. Vol. 2. Philadelphia: Lea & Febiger, 1990.

Glass, Lee S., ed. *Occupational Medicine Practice Guidelines*. 2nd ed. Beverly Farms, MA: OEM Press, 2004.

Kirkaldy-Willis, William H, ed. *Managing Low Back Pain.* 2nd ed. New York: Churchill Livingstone, 1988.

Kirkaldy-Willis, William H., ed., and Burton, Charles *Managing Low Back Pain.* 3rd ed. New York: Churchill Livingstone, 1992.

Kottke, Frederic J., G. Keith Stillwell and Justus F. Lehmann. *Krusen's Handbook of Physical Medicine and Rehabilitation.* 3rd ed. Philadelphia: W. B. Saunders, 1982.

Kottke, Frederic J., Krusen, Frank Hammond and Justus F. Lehmann. *Krusen's Handbook of Physical Medicine and Rehabilitation.* 4th ed. Philadelphia: W. B. Saunders, 1990.

Maibach, Howard I., ed. *Occupational and Industrial Dermatology.* 2nd ed. Chicago: Year Book Medical Publishers, 1987.

Morgan, Donald P. *Recognition and Management of Pesticide Poisonings.* 4th ed. Washington: EPA, 1989.

Rosenstock, Linda and Mark R. Cullen. *Clinical Occupational Medicine.* Philadelphia: W. B. Saunders, 1986.

Rosenstock, Linda and Mark R. Cullen. *Textbook of Clinical Occupational and Environmental Medicine.* Philadelphia: W. B. Saunders, 1994.

Sataloff, Robert Thayer and Joseph Sataloff. *Occupational Hearing Loss.* New York: Marcel Dekker, 1987.

Sataloff, Robert Thayer and Joseph Sataloff. *Occupational Hearing Loss.* 2nd ed. New York: Marcel Dekker, 1993.

Zenz, Carl. *Occupational Medicine: Principles and Practical Applications.* 2nd ed. Chicago: Year Book Medical Publishers, 1988.

Zenz, Carl, Dickerson, O. Bruce, and Horvath, Edward P. *Occupational Medicine: Principles and Practical Applications.* 3rd ed. Mosby, 1994.

APPENDIX

D

Telephone and Internet Resources at L&I

This appendix lists the L&I resources that are available to help you to work effectively with the State Fund. L&I's main TDD number for people with hearing and/or speech impairment is 360-902-5797. Most L&I field offices also have active TDD telephone lines.

A. Automated Claim Information (Easy Access)

Many questions about claims can be answered using the automated telephone service called "Easy Access." You can get specific information you need about a claim quickly and directly between 6:00 am and 7:00 p.m, Monday through Friday.

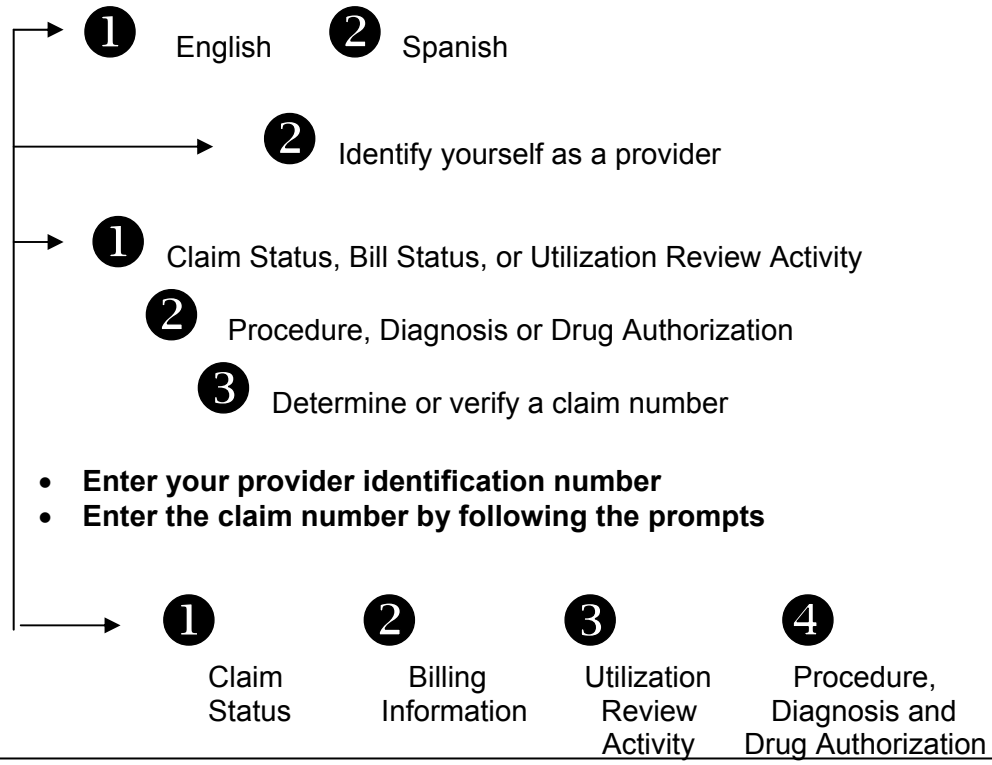
This line gives you access to status information, authorized diagnosis and procedure codes, and drug restrictions. You can even order a copy of a claim. A touch-tone phone is all you need to use the automated information line.

Automated telephone service 800-831-5227

Table D-1

Use this line if you need information quickly on: Whether a claim has been accepted or rejected; a bill's status; utilization review activity; or authorization status for procedures, diagnosis, or drugs. Information presented by this interactive voice response (IVR) is "real time," exactly what a claim manager would see on their screen if they could be reached by phone.……800-831-5227

*Using a touch-tone phone, follow the corresponding keys below to access the desired information



For more information about this resource, see Section 2J, page 20

B. Billing Information

Provider Accounts 360-902-5140

Provider accounts staff will help you apply for a provider account number.

Electronic Billing Information 360-902-6511
You can get information on electronic transfer, tape-to-tape or direct entry billing at this number.

To obtain a copy of the **Fee Schedule** and for Fee Schedule and billing questions **.....800-848-0811**

For more information about this resource, see Section 6, page 49.

C. Claims Unit Telephone Numbers

Unit A	360-902-4472	Unit M	360-902-6602	Unit 3 – CRI	360-902-6775
Unit B	360-902-4472	Unit N	360-902-4472	Unit 5 – Yakima	509-454-3713
Unit C	360-902-4472	Unit O	360-902-4261	Unit 6 – Hearing Loss	360-902-6929
Unit D	360-902-6602	Unit P	360-902-4474	Unit 7 – Out of State	360-902-4474
Unit E	360-902-4472	Unit R	360-902-4474	Unit 8 –	360-902-6602
Unit F	360-902-4472	Unit T	206-515-2811	Unit 9 –	360-902-6602
Unit G	360-902-6602	Unit U	360-902-4474		
Unit H	360-902-4261	Unit W	360-902-4474		
Unit J	360-902-6602	Unit X	360-902-6602		
Unit K	360-902-4261	Unit Y	360-902-4474		
Unit L	360-902-4261	Unit Z	360-902-4261		

* Unit T handles the majority of claims filed by L&I employees.

* Unit 3 handles the following types of claims: asbestos; chemically related illness claims from January 1, 1994 to present; tuberculosis; lead; and some claims filed by L&I employees. The unit may be called for information about specific claims or for general information on any of the areas mentioned above.

For more information about communicating with claim managers, see Section 2J, pages 20-21.

You may also fax the claims units at the following numbers:	
Units A, B, C, E, F, and N	360-902-4472
Unit D, G, J, M, X, 8 & 9	360-902-6602
Units H, K, L, O, Z	360-902-4261
Units P, R, U, W, Y & 7	360-902-4474
Unit T – University of Washington	206-281-5529
Unit 1 – Yakima	509-454-3710
Unit 3 – CRI	360-902-5156
Unit 4 – Everett LTD	206-290-1339
Unit 5 – Yakima LTD	509-454-3791
Unit 6 – Hearing Loss	360-902-6252
Unit 7 – Out-of-state	360-902-4483
Unit 9 – Tacoma	360-902-6666

When faxing documents include the patient's name, claim number, your name, telephone number, and address on all pages.

D. Claims Unit Supervisors

If for any reason you need to speak with a claims unit supervisor, you may call the following numbers directly:

Unit A	360-902-4262	Unit M	360-902-6463	Unit 1 – Yakima	509-454-3716
Unit B	360-902-4280	Unit N	360-902-6670		
Unit C	360-902-4295	Unit O	360-902-5208	Unit 3 – CRI	360-902-6774
Unit D	360-902-4310	Unit P	360-902-4369	Unit 6 – Hearing Loss	425-290-1387
Unit E	360-902-4323	Unit R	360-902-4384	Unit 7 – Out-of-State	360-902-6668
Unit F	360-902-4336	Unit T	206-515-2811	Unit 8 – Everett	360-902-4548
Unit G	360-902-6413	Unit U	360-902-4398	Unit 9 – Tacoma	360-902-4742
Unit H	360-902-6430	Unit W	360-902-4413		
Unit J	360-902-6445	Unit X	360-902-4426		
Unit K	360-902-4351	Unit Y	360-902-4439		
Unit L	360-902-6730	Unit Z	360-902-4455		

E. Discrimination Investigation

If your patient fears discrimination for filing a claim **.....360-902-5480**

If your patient fears retaliation for reporting an unsafe workplace**..... Call nearest service location**

(See page 66)

For more information about these resources, see Section 2M, page 22.

F. Vocational Services Consultants ----- Vocational / Return-to-Work Services (Formerly called "Employer Consultants")

Bellevue	425-990-1472	**Seattle**	206-515-2831
Bellingham	360-647-7337	**Spokane**	509-324-2581
East Wenatchee	509-886-6571	**Tacoma**	253-596-3884
Everett	425-290-1383	**Tukwila**	206-835-1000
Longview	360-575-6931	**Tumwater**	360-902-6780
Mt. Vernon	360-416-3043	**Yakima**	509-454-3700

For more information about this resource, see Section 2H, page 16.

G. IME Program

For more information about this resource call..... **360-902-6818**

H. Local L&I Offices ("Service Locations")

Region 1, Northwest Washington

Bellingham
1720 Ellis St., Suite 200
Bellingham, WA 98225-4647
360-647-7300

Everett
729 100th Street SE
Everett, WA 98208-3727
425-290-1300

Mt. Vernon
525 E. College Way, Suite H
Mt. Vernon, WA 98273-5500
360-416-3000

Region 2, King County

Bellevue
616 120th Ave. NE, Suite C201
Bellevue, WA 98005-3037
425-990-1400

Seattle
315 5th Ave S, Suite 200
Seattle, WA 98104-2607
206-515-2800

Tukwila
12806 Gateway Dr.
PO BOX 69050 (for mail)
Seattle, WA 98168-1050
206-835-1000

Region 3, Pierce County/Peninsula

Bremerton
500 Pacific Ave., Suite 400
Bremerton, WA 98337-1943
360-415-4000

Tacoma
950 Broadway, Suite 200
Tacoma, WA 98402-4453
425-596-3800

Port Angeles
1605 E. Front St., Suite C
Port Angeles, WA 98362-4628
360-417-2700

Region 4, Southwest Washington

Aberdeen
415 W. Wishkah, Suite 1B
PO BOX 66 (for mail)
Aberdeen, WA 98520-4315
360-533-8200

Longview
900 Ocean Beach Hwy.
Longview, WA 98632-4013
360-575-6900

Tumwater
7273 Linderson Way SW
P O Box 44850
Olympia, WA 98504-4850
360-902-5799

Vancouver
312 SE Stonemill Dr., Suite 120
Vancouver, WA 98684-6982
360-896-2300

Region 5, Central Washington

East Wenatchee
519 Grant Rd.
East Wenatchee, WA 98802
509-886-6500

Moses Lake
3001 W Broadway Ave.
Moses Lake, WA 98837-2907
509-764-6900

Kennewick
4310 W. 24th Ave.
Kennewick, WA 99338
509-735-0100

Okanogan
1234 2nd Ave. S.
Okanogan, WA 98840-9723
509-826-7345

Walla Walla
1815 Portland Ave., Suite 2
Walla Walla, WA 99362-2246
509-527-4437

Yakima
15 West Yakima Ave., Suite 100
Yakima, WA 98902-3480
509-454-3700

Region 6, Eastern Washington

Colville
298 S. Main, Suite 203
Colville, WA 99114-2416
509-684-7417

Pullman
1260 Bishop Blvd. SE, Suite G
PO BOX 847
Pullman, WA 99163-0487
509-334-5296

Spokane
N. 901 Monroe St., Suite 100
Spokane, WA 99201-2149
509-324-2600

I. Medical Director's Office

Medical Director **360-902-5020**
Associate Medical Director **360-902-5022**
360-902-4256
Associate Medical Director for Chiropractic **360-902-4998**
Physician and Chiropractic Consultants **360-902-4644**

For more information visit us on the World Wide Web at: http://www.wa.gov/lni/omd or see Section 2H, page 16.

J. Nurse Consultants (ONCs) for State Fund Claims

County	State Fund Claim Unit(s)	ONC	Phone
King	A, B	Lucille LaPalm	360-902-4293
Snohomish, San Juan Island	D, M,	Midori Higgs	360-902-4322
King	E, F	Marianne Schuh	360-902-4335
Pierce	G, J	Lori Barney	360-902-6690
Grays Harbor, Mason, Thurston, Pacific, Wahkiakum, Lewis, Cowlitz, Clark, Skamania, Klickitat	K, L	Virginia Keefe-Hardy	360-902-6743
Clallum, Jefferson, Whatcom, Skagit, Kitsap	N, O, 6	Kim Skoropinski	360-902-6682
Out-of-State, Chelan, Douglas, Grant, Kittitas, Okanogan, Yakima	U, 7	Loni Parr	360-902-4382
King, Okanogan, Chelan, Douglas, Kittitas, Yakima, Grant	C, X	Barbara Sainitzer	360-902-4411
Okanogan, Chelan, Douglas, Kittitas, Grant, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin	W, Y	Kathy Betzig	360-902-5820
Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams, Whitman	P, R	Monica Howell	360-902-4520
Snohomish and Pierce	8, 9	Lindsay Shuster	360-902-9105
All Counties	Chemically Related Injury and Asbestos Claims	Vicki Skeers	360-902-6804
Logging/Timber, Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum	H, Z	Dorothy Tassoni	360-902-6425
All Counties	Crime Victims Compensation	Pat Macier	360-902-4896
Service Locations			
Everett		Mariyln McMahon	425-290-1331
Seattle		Chuck Shifren	206-515-2812
Spokane		Liz Ottmar	509-324-2559
SW Washington		Simone Stilson	360-902-6319
Tacoma		Diane Oltman	206-596-3904
Yakima		Lynda Mackey	509-454-3729
ONC Supervisor		Pat Patnode	360-902-5030
ONC Support Staff		Shelly Sargent	360-902-5013

For more information about this resource, see Section 2H, page 16.

K. Occupational and Physical Therapists

Everett	425-290-1382	**Tumwater**	360-902-6768
Tukwila	206-835-1020	**Yakima**	509-454-3784
Tacoma	253-596-3880	**Spokane**	509-324-2624

For more information about this resource, see Section 2H, page 16.

L. Patient Resource Number

Injured Workers' Questions..... 800-LISTENS
800-547-8367

M. Pharmacy Consultant for State Fund Claims

If you have questions about the medications being provided, billing issues or other pharmacy concerns call: Jaymie Mai, PharmD at **.....360-902-6792**

For more information about this resource, see Section 2H, page 17.

N. Project HELP Program

For help with labor-management issues and educational programs **.....800-255-9752**
The Project HELP program facilitates labor/management communication, helping parties to resolve their industry issues. In addition, Project HELP provides educational programs on how the workers' compensation system works, and is a resource for claim issues. This service is a cooperative effort between the Washington State Labor Council, the Department of Labor and Industries and the employer community.

O. Provider Education

For copies of the *Provider Bulletin, Provider Update* or *Medical Aid Rules* and *Maximum Fee Schedule*.....**800-848-0811**
360-902-6799

For more information about this resource, see Section 2H, page 18.

P. Provider Hotline in Washington (toll-free)

Provider Hotline questions.....**800-848-0811**
360-902-6500

These lines are staffed from 8 a.m. to 4:55 p.m. weekdays. You can get answers to billing and remittance advice questions, authorization other than inpatient, and verification of diagnosis or procedure codes.

To save time:

- Try the Automated Claim Information (Easy-Access) line first at 800-831-5227(see first part of this appendix). It may have just the information you need and save you time on hold.
- If you're calling for authorization, please be ready to state the claim number, provider number, procedure codes, dates of service, referring physician and basis for the procedure request. For billing questions, also have the 17-digit Internal Control Number (ICN) and total bill charge.
- If your claim number begins with an "A," please contact the U.S. Department of Labor in Seattle by calling 206-553-5508 or 553-5521.

Q. Risk Management Services

Bremerton	360-415-4011	**Spokane**	509-324-2581
Bellevue	425-990-1456	**Tacoma**	253-596-3874
Bellingham	360-647-7319	**Tukwila**	206-248-8280
Everett	425-290-1364	**Tumwater**	360-902-6762
Seattle	206-515-2832	**Yakima**	509-454-3779 509-454-3785

For more information about this resource, see Section 2H, page 16.

R. Safety and Health Consultants

Region	Counties	Telephone Numbers
1	Island, San Juan, Skagit, Snohomish, Whatcom	425-290-1300
2	King	206-515-2880
3	Clallam, Jefferson, Kitsap, Pierce	253-596-3800
4	Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Thurston, Wahkiakum	360-902-5799
5	Adams, Benton, Chelan, Columbia, Douglas, Franklin, Grant, Kittitas, Okanogan, Walla Walla, Yakima	509-454-3700
6	Southeast Adams, Asotin, Ferry, Garfield, Lincoln, Stevens, Pend Oreille, Spokane, Whitman	509-324-2600 Toll-free: 1-800-509-8847

For more information about this resource, see Section 2H, page 16.

S. Self-Insurance Information

For questions about this program **.....360-902-6901**

Claims Disability Adjudicator:
Odd-numbered claims 360-902-6858
Even-numbered claims 360-902-6889

Labor and Industries' Self-insurance section can answer your questions about treating an injured worker employed by a self-insured business.

For more information about this resource, see Section 2K, page 22.

T. Safety and Health Assessment and Research for Prevention (SHARP)

For questions about this program **.....360-902-5669**
SHARP is a multi-disciplinary research group within L&I; in addition to epidemiologic research, SHARP manages the state's occupational lead poisoning registry, receives disease reports for public health investigations, and is available for inquiries from doctors on a variety of technical subjects. See also pages 18 and 59.

U. Utilization Review (Inpatient and Outpatient)

To receive authorization call.....1-800-541-2894

This number must be called for authorization of all hospital admissions and certain outpatient procedures. Call at least five days prior to elective hospitalization and within 24 hours, or the next business day, for emergency admissions.

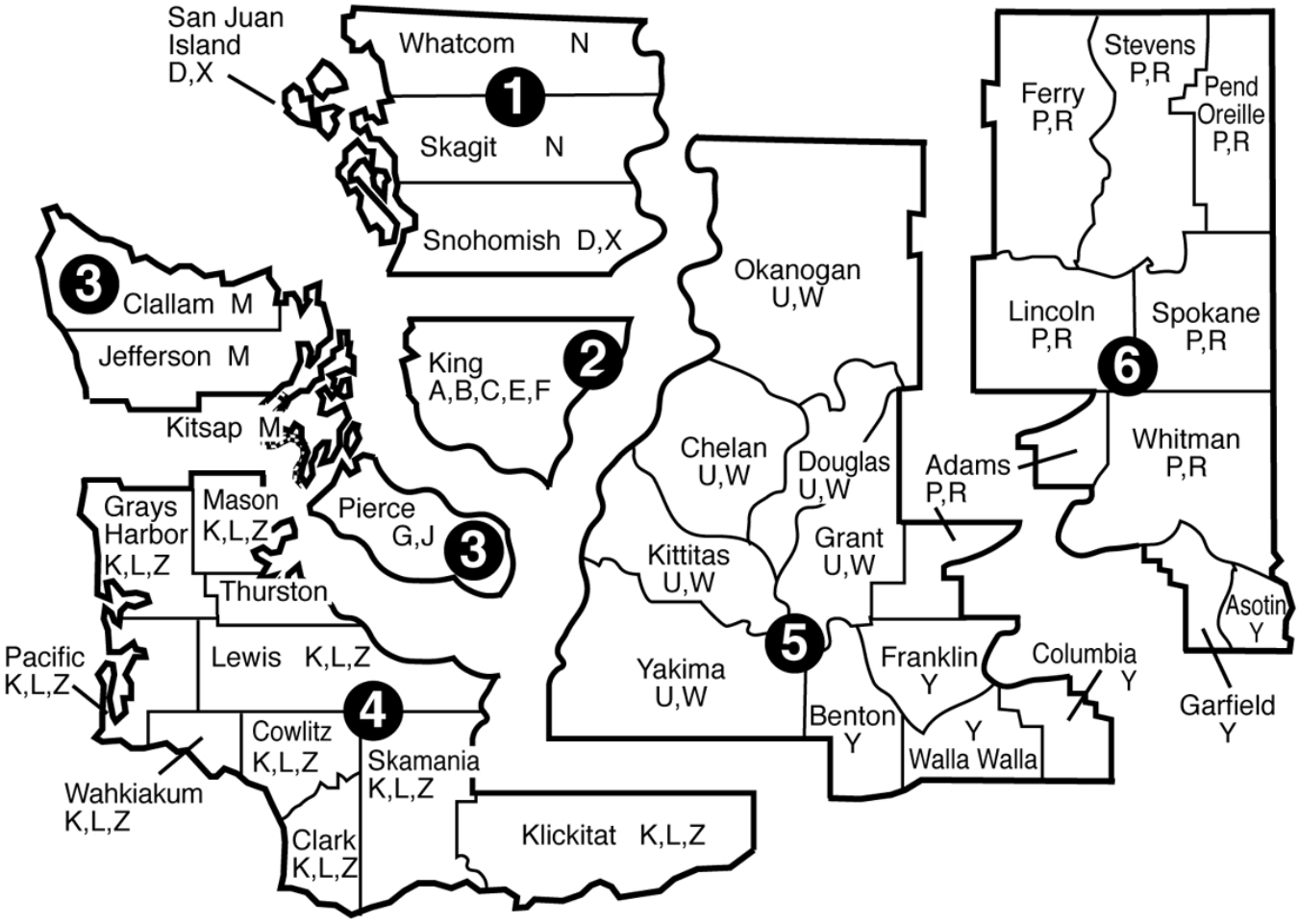
For more information about this resource, see Section 3C, page 25.

APPENDIX

E

Claims Unit Information

A. Map of L&I State Fund Regional Boundaries/Claims Unit Responsibility by County

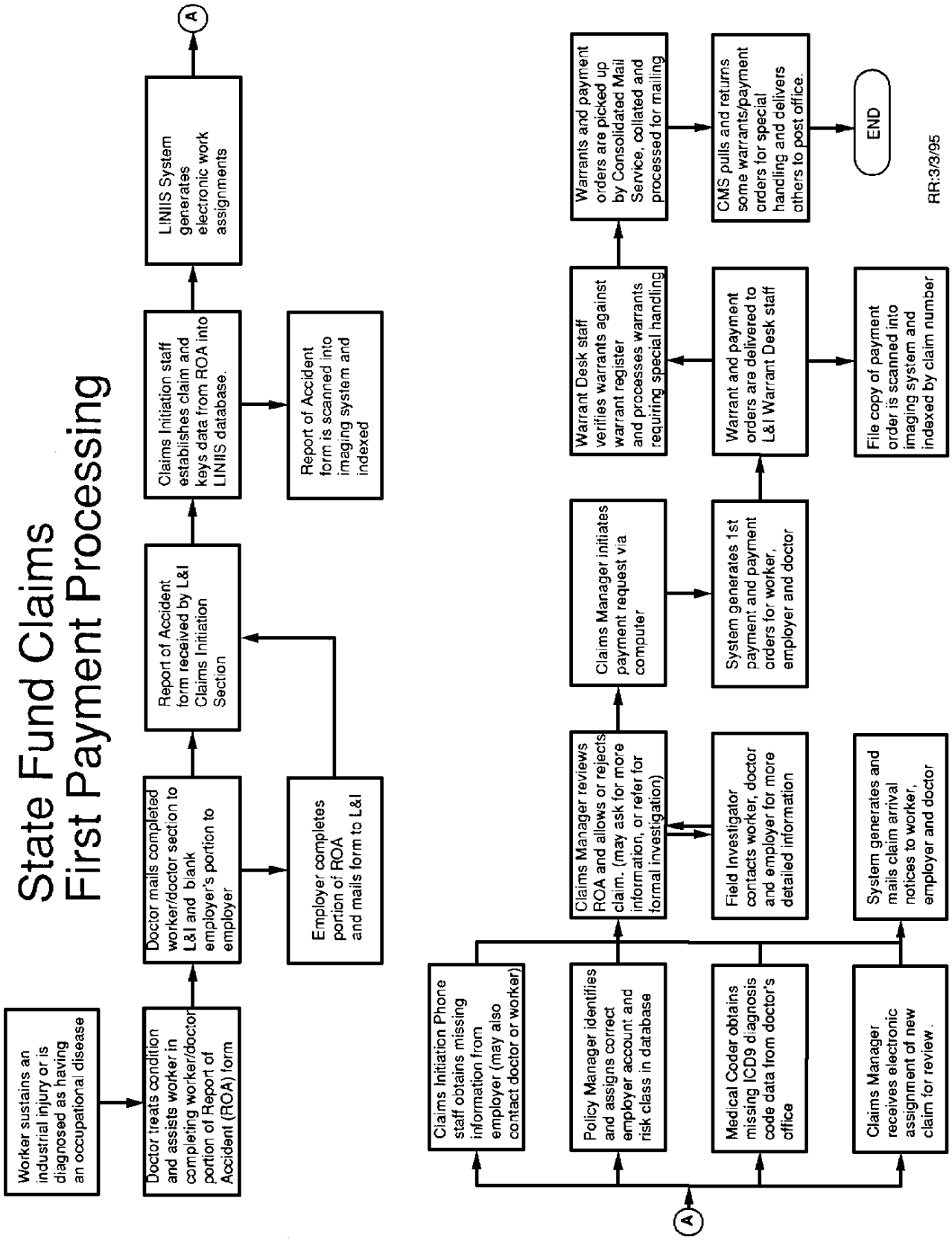


White numbers in black circles represent Labor and Industries' regional boundaries within the state.

Region 1: Units D, G, J, M, N, X, 8 and 9
Region 2: Units A, B, C, E, F and N
Region 3: Units D, G, J, M, X, 8 and 9
Region 4: Unit H, K, L, O, Z and 3
Regions 5 & 6: Units P, R, U, W, Y and 7

Note: There is no correlation between the claims unit and the first letter of the claim number. Claims unit assignment is based on where the injured worker lives or works. The map applies only to State Fund claims.

B. State Fund Claims Process Flow Chart



Utilization Review Procedures

If your patient has a State Fund claim (not self-insured) and needs to be hospitalized, or requires a selected outpatient procedure, you must first get authorization from the department. Currently, the department contracts with an outside vendor, which reviews these requests. This is called the "utilization review process."

The admitting physician is responsible for notifying the vendor and cooperating with the process. We have outlined the steps you must take below. Please note that a knowledgeable nurse or office staff member familiar with the patient's history may perform many of the admitting physician's tasks.

A Step-By-Step Guide to the Utilization Review (UR) Process:

1. The Admitting Physician:

- **Calls 800-541-2894 to request review** of a planned admission / procedure for a State Fund-covered injured worker. The call must be made five (5) or more calendar days prior to an elective admission or within 24 hours of an emergent admission.
- **To make notification after 5 p.m. or on a weekend: Call 800-541-2894.** The call will be forwarded to an electronic mailbox. Requests may be faxed at any time to 877-665-0383
- **Provides the following information:**
    a. Patient/claimant name
    b. L&I claim number
    c. Proposed or actual date of admission
    d. ICD-9-CM admitting diagnosis(es)
    e. CPT-4 codes for planned procedure(s)
    f. L&I Provider number
    g. Convenient time for the nurse reviewer to call back

2. UR Vendor:

- **Gathers information** from the caller and the claims administration on-line records.
- **If there is a question of coverage or eligibility,** advises caller and takes a message for the claim manager. UR may be discontinued.
- **If the patient has been discharged,** Retrospective review would be required.
- **Assigns the case to a nurse reviewer.**

3. UR Nurse Reviewer:

- **Calls the admitting physician** to discuss:
    a. Proposed treatment.
    b. Requested length of stay
    c. Treatment plan (including proposed ancillary services, diagnostic test and related interventions)
    d. Clinical evidence supporting inpatient admission and treatment, including:
        1) History and physical
        2) Results of lab tests, pathology reports, and diagnostic tests
        3) Unrelated conditions and other pertinent clinical information
    e. Non-medical factors that may require admission
- **Screens the case** against Labor and Industries criteria, other clinical guidelines, and L&I policy and procedures.
- **Conveys a notification/authorization number** to the admitting physician for use on the hospital bill or;
- **If criteria are not met, refers case to a UR physician advisor.**

4. UR Physician Advisor:

- **Calls admitting physician** to discuss the case. Refers recommendations back to UR nurse reviewer.

5. UR Nurse Reviewer:

- **Sends initial report treatment recommendations to Labor and Industries claim manager.**

6. L&I Claim Manager:

- **Authorizes or denies admission and procedure.** Enters into the State Fund on-line bill payment system (MIPS): hospital admission, authorization number, authorization status, admission date span, length of stay and procedure codes.
- **Calls admitting physician with decision.**
- **If treatment/admission is denied,** sends confirming decision letter.
- **Conveys authorization number to hospital at time of admission.**

7. Admitting Physician:

8. UR Nurse Reviewer:

- **Periodically calls hospital staff or utilization review department** to conduct Continued Stay Review, Length of Stay Evaluation, and Discharge Coordination.
- **Confirms discharge with the hospital**.
- **Sends Final UR Report** to Claim manager.

9. L&I Claim Manager:

- **Verifies coverage and authorization** for accurate bill processing. Updates bill payment system.

10. Hospital:

- **Indicates authorization number** in space 91 of the UB-92 billing form.

Index of Provider Bulletin Subjects

To order any of the following publications, call 800-848-0811 or 360-902-6799, or you may print all Provider Bulletins currently in effect, from our website; http://www.lni.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/

Miscellaneous Topic Update	**PU 99-01**
Ambulatory Surgery Center Payment	**PB 01-12**
Authorizing Vocational Retraining Policies 6.51, 6.52 & 6.53	**PB 98-09**
Bone Growth Stimulators and Tobacco Use Cessation for Spinal Fusions	**PB 03-13**
Chiropractic Consultant Program	**PB 03-06**
Carpal Tunnel Syndrome, Guidelines for Electrodiagnostic Evaluation of	**PB 95-10**
Center of Excellence for Chemically Related Illness, Introducing the	**PB 95-08**
Coverage Decisions	**PB 03-02**
Coverage Decisions – July 03 to December 03	**PB 04-01**
CRPS (Complex Regional Pain Syndrome)	**PB 97-05**
Facet Neurotomy	**PB 03-11**
Fee Schedule Update: 2004 Codes and AWP Price Updates	**PB 04-04**
Fibromyalgia	**PB 98-11**
HIPAA Impacts on L&I	**PB 02-03**
Home Health Care and Hospice Care	**PB 94-16**
Home Modification Policy 11.10	**PB 96-11**
Hospital Outpatient Prospective Payment System	**PB 01-13**
Hospital Outpatient Prospective Payment System Device Pass Through Pymt Update	**PB 02-05**
Hyaluronic Acid Treatment of Osteoarthritis of the Knee	**PB 98-10**
Implementation of Senate Bill 6088 and the Preferred Drug List	**PB 04-02**
Interpreter Services January 2003	**PB 03-01**
Interpreter Services August 2003	**PB 03-10**
Job Modification and Pre-Job Accommodations	**PB 99-11**
Lumbar Fusion, Guidelines for	**PB 01-05**
Miscellaneous Topic Update	**PU 98-02**
Miscellaneous Topic Update	**PU 00-01**
Miscellaneous Topic Update	**PU 01-01**
Neurontin	**PB 02-11**
NMES Device	**PB 97-04**
Non Coverage Decisions	**PB 03-09**
Obesity Treatment Policy 7.13	**PB 97-03**
Outside of WA State Provider Reimbursement Policies	**PB 00-06**
Payment of Job Analysis Review	**PB 99-02**
Payment for Opioids to Treat Chronic, Non-Cancer Pain	**PB 00-04**
Payment Policies for Attendant Services	**PB 01-08**
Payment Policy for Nurse Case Management	**PB 98-01**
Physical, Occupational and Massage Therapy	**PU 03-02**
Physician Assistant Provider Numbers	**PB 99-04**
Post-Acute Brain Injury Rehabilitation for State Fund & Self-Insured Employers	**PB 98-02**
Post-Acute Brain Injury Rehab Treatment Programs, Reimbursement Policy for	**PB 98-04**
Prospective Drug UR Program	**PB 03-07**
Prosthetic and Orthotic (P&O) Fee Schedule	**PB 03-14**
Psychiatric Guidelines	**PB 03-03**
Rating Permanent Impairment	**PB 02-12**
Recent Formulary Coverage Decisions and Drug Updates	**PB 01-14**

Recent Medical Coverage Decisions on Intradiscal Heating (IDET) & Vertebral Axial Decompression Therapy (Vax-D)	**PB 00-09**
Review Criteria for Knee Surgery	**PB 03-16**
Shoulder Surgery Criteria	**PB 02-01**
Spinal Injection Policy	**PB 02-06**
TENS	**PB 01-11**
TENS Units	**PU 03-01**
Testing for and Treatment of Bloodborne Pathogens	**PB 01-06**
The Pharmacy On-Line Point-of-Service Billing System	**PB 03-15**
Thoracic Outlet Syndrome (TOS)	**PB 95-04**
Utilization Review Program	**PB 00-08**
Utilization Review Program – New UR Firm	**PB 02-04**
Vocational Rehabilitation & Claims Information	**PB 02-07**
Vocational Rule Changes	**PB 03-08**
Vocational Provider Performance Measurement	**PB 01-04**
Vocational Provider Performance Measurement System Enhancements	**PB 03-12**
Vocational Rehabilitation Billing Payment Guidelines	**PB 01-03**
Vocational Rehabilitation Purchasing	**PB 01-01**
Vocational Rehabilitation Rule Changes	**PB 04-03**
Vocational Services	**PU 01-02**
Spring Vocational Update	**PU 02-01**
Fall Vocational Update	**PU 02-02**
Winter Vocational Update	**PU 02-03**

APPENDIX

H

Sample Forms

Samples of three key forms are included on the following pages. All three are available online or by calling the Department of Labor and Industries' Warehouse at 360-902-5754. You may also order them using the mail-in request card at the back of this handbook.

A. Provider Application and Notice to Provider (form number F248-011-000)
Download from www.LNI.wa.gov/Forms/pdf/248011a0.pdf

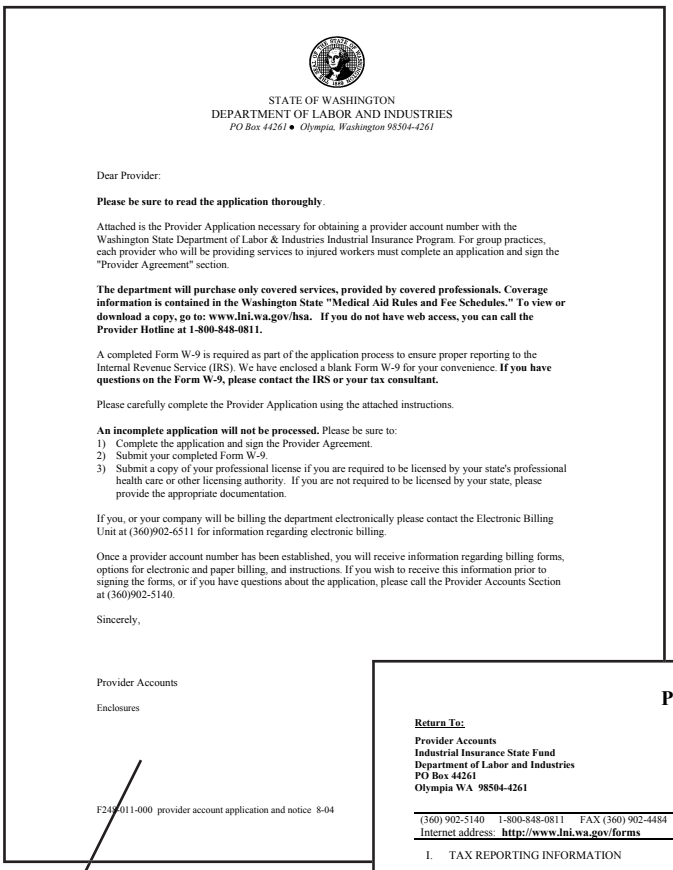
B. Doctor's Estimate of Physical Capacities (form number F242-002-000)
Download from www.LNI.wa.gov/Forms/pdf/242022a0.pdf

C. Occupational Disease Work History (form number F242-071-000)
Fillable form available at www.LNI.wa.gov/forms/pdf/242071af.pdf

L&I forms and publications are available free of charge.

The *Provider Account Application and Notice* is an eight-page application packet that includes the following items. You can print the packet from the web at www.LNI.wa.gov/Forms/pdf/248011a0.pdf.
The online packet includes form F248-036-000, Request for Taxpayer ID, which is a required part of the application.

To order a printed copy, contact the L&I Warehouse, 360-902-5754, and request form F248-011-000 (Provider Account Application and Notice) **AND** form F248-036-000, Request for Taxpayer ID.



STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 ● Olympia, Washington 98504-4261

Dear Provider:

Please be sure to read the application thoroughly.

Attached is the Provider Application necessary for obtaining a provider account number with the Washington State Department of Labor & Industries Industrial Insurance Program. For group practices, each provider who will be providing services to injured workers must complete an application and sign the "Provider Agreement" section.

The department will purchase only covered services, provided by covered professionals. Coverage information is contained in the Washington State "Medical Aid Rules and Fee Schedules." To view or download a copy, go to: www.lni.wa.gov/hsa. If you do not have web access, you can call the Provider Hotline at 1-800-848-0811.

A completed Form W-9 is required as part of the application process to ensure proper reporting to the Internal Revenue Service (IRS). We have enclosed a blank Form W-9 for your convenience. **If you have questions on the Form W-9, please contact the IRS or your tax consultant.**

Please carefully complete the Provider Application using the attached instructions.

An incomplete application will not be processed. Please be sure to:
1) Complete the application and sign the Provider Agreement.
2) Submit your completed Form W-9.
3) Submit a copy of your professional license if you are required to be licensed by your state's professional health care or other licensing authority. If you are not required to be licensed by your state, please provide the appropriate documentation.

If you, or your company will be billing the department electronically please contact the Electronic Billing Unit at (360)902-6511 for information regarding electronic billing.

Once a provider account number has been established, you will receive information regarding billing forms, options for electronic and paper billing, and instructions. If you wish to receive this information prior to signing the forms, or if you have questions about the application, please call the Provider Accounts Section at (360)902-5140.

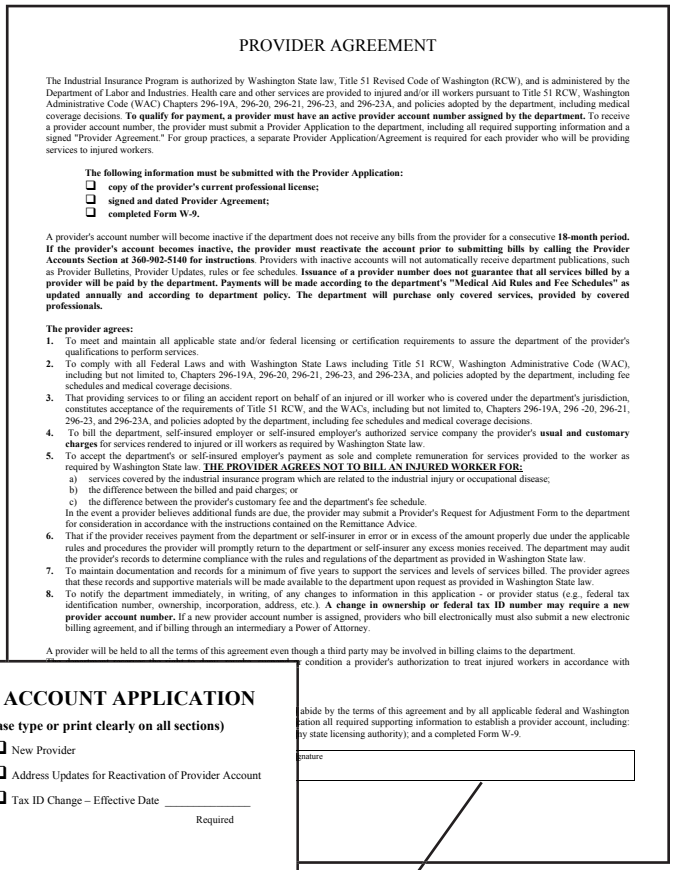
Sincerely,

Provider Accounts

Enclosures

F248-011-000 provider account application and notice 8-04

Cover letter. Provides information and explains that an incomplete application will not be processed.



PROVIDER AGREEMENT

The Industrial Insurance Program is authorized by Washington State law, Title 51 Revised Code of Washington (RCW), and is administered by the Department of Labor and Industries. Health care and other services are provided to injured and/or ill workers pursuant to Title 51 RCW, Washington Administrative Code (WAC) Chapters 296-19A, 296-20, 296-21, 296-23, and 296-23A, and policies adopted by the department, including medical coverage decisions. **To qualify for payment, a provider must have an active provider account number assigned by the department.** To receive a provider account number, the provider must submit a Provider Application to the department, including all required supporting information and a signed "Provider Agreement." For group practices, a separate Provider Application/Agreement is required for each provider who will be providing services to injured workers.

The following information must be submitted with the Provider Application:
- ❑ **copy of the provider's current professional license;**
- ❑ **signed and dated Provider Agreement;**
- ❑ **completed Form W-9.**

A provider's account number will become inactive if the department does not receive any bills from the provider for a consecutive **18-month period. If the provider's account becomes inactive, the provider must reactivate the account prior to submitting bills by calling the Provider Accounts Section at 360-902-5140 for instructions**. Providers with inactive accounts will not automatically receive department publications, such as Provider Bulletins, Provider Updates, rules or fee schedules. **Issuance of a provider number does not guarantee that all services billed by a provider will be paid by the department. Payments will be made according to the department's "Medical Aid Rules and Fee Schedules" as updated annually and according to department policy. The department will purchase only covered services, provided by covered professionals.**

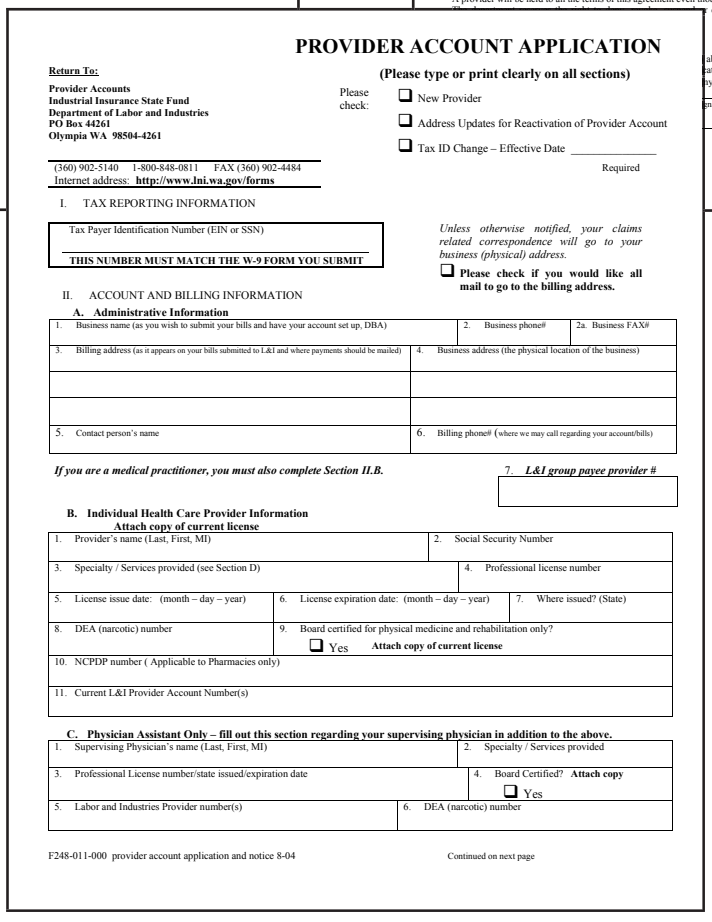
The provider agrees:
1. To meet and maintain all applicable state and/or federal licensing or certification requirements to assure the department of the provider's qualifications to perform services.
2. To comply with all Federal Laws and with Washington State Laws including Title 51 RCW, Washington Administrative Code (WAC), including but not limited to, Chapters 296-19A, 296-20, 296-21, 296-23, and 296-23A, and policies adopted by the department, including fee schedules and medical coverage decisions.
3. That providing services to or filing an accident report on behalf of an injured or ill worker who is covered under the department's jurisdiction, constitutes acceptance of the requirements of Title 51 RCW, and the WACs, including but not limited to, Chapters 296-19A, 296 -20, 296-21, 296-23, and 296-23A, and policies adopted by the department, including fee schedules and medical coverage decisions.
4. To bill the department, self-insured employer or self-insured employer's authorized service company the provider's **usual and customary charges** for services rendered to injured or ill workers as required by Washington State law.
5. To accept the department's or self-insured employer's payment as sole and complete remuneration for services provided to the worker as required by Washington State law. **THE PROVIDER AGREES NOT TO BILL AN INJURED WORKER FOR:**
   a) services covered by the industrial insurance program which are related to the industrial injury or occupational disease;
   b) the difference between the billed and paid charges; or
   c) the difference between the provider's customary fee and the department's fee schedule.
   In the event a provider believes additional funds are due, the provider may submit a Provider's Request for Adjustment Form to the department for consideration in accordance with the instructions contained on the Remittance Advice.
6. That if the provider receives payment from the department or self-insurer in error or in excess of the amount properly due under the applicable rules and procedures the provider will promptly return to the department or self-insurer any excess monies received. The department may audit the provider's records to determine compliance with the rules and regulations of the department as provided in Washington State law.
7. To maintain documentation and records for a minimum of five years to support the services and levels of services billed. The provider agrees that these records and supportive materials will be made available to the department upon request as provided in Washington State law.
8. To notify the department immediately, in writing, of any changes to information in this application - or provider status (e.g., federal tax identification number, ownership, incorporation, address, etc.). **A change in ownership or federal tax ID number may require a new provider account number.** If a new provider account number is assigned, providers who bill electronically must also submit a new electronic billing agreement, and if billing through an intermediary a Power of Attorney.

A provider will be held to all the terms of this agreement even though a third party may be involved in billing claims to the department.
[illegible] condition a provider's authorization to treat injured workers in accordance with

abide by the terms of this agreement and by all applicable federal and Washington
ation all required supporting information to establish a provider account, including:
ny state licensing authority); and a completed Form W-9.

gnature

Provider Agreement. Must be signed and returned with the completed application.



PROVIDER ACCOUNT APPLICATION

(Please type or print clearly on all sections)

Return To:
Provider Accounts
Industrial Insurance State Fund
Department of Labor and Industries
PO Box 44261
Olympia WA 98504-4261

(360) 902-5140 1-800-848-0811 FAX (360) 902-4484
Internet address: **http://www.lni.wa.gov/forms**

Please check:
- ❑ New Provider
- ❑ Address Updates for Reactivation of Provider Account
- ❑ Tax ID Change – Effective Date _____ Required

I. TAX REPORTING INFORMATION

Tax Payer Identification Number (EIN or SSN)
THIS NUMBER MUST MATCH THE W-9 FORM YOU SUBMIT

Unless otherwise notified, your claims related correspondence will go to your business (physical) address.
❑ **Please check if you would like all mail to go to the billing address.**

II. ACCOUNT AND BILLING INFORMATION

A. Administrative Information

1. Business name (as you wish to submit your bills and have your account set up, DBA)	2. Business phone#	2a. Business FAX#
3. Billing address (as it appears on your bills submitted to L&I and where payments should be mailed)	4. Business address (the physical location of the business)	
5. Contact person's name	6. Billing phone# (where we may call regarding your account/bills)	

If you are a medical practitioner, you must also complete Section II.B.

7. ***L&I group payee provider #***

B. Individual Health Care Provider Information
Attach copy of current license

1. Provider's name (Last, First, MI)	2. Social Security Number	
3. Specialty / Services provided (see Section D)	4. Professional license number	
5. License issue date: (month – day – year)	6. License expiration date: (month – day – year)	7. Where issued? (State)
8. DEA (narcotic) number	9. Board certified for physical medicine and rehabilitation only? ❑ Yes **Attach copy of current license**	
10. NCPDP number (Applicable to Pharmacies only)		
11. Current L&I Provider Account Number(s)		

C. Physician Assistant Only – fill out this section regarding your supervising physician in addition to the above.

1. Supervising Physician's name (Last, First, MI)	2. Specialty / Services provided
3. Professional License number/state issued/expiration date	4. Board Certified? **Attach copy** ❑ Yes
5. Labor and Industries Provider number(s)	6. DEA (narcotic) number

F248-011-000 provider account application and notice 8-04 Continued on next page

Provider Account Application (F248-011-000), Page 1.
See instructions for completing the form.

D. Other Administrative Information

* Must include a copy of privilege letter with each facility

** Physical medicine must include copy of board certification

*** Must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)

**** Must include copies of the following: State license (in states where required). and Medicare Certification or Accreditation by JCAHO, AAAHC or AAAASF.

1. Type of service **(PLEASE CHECK ONE):**

____ Adult Family Home	____ Home Health Agency	____ Physical Therapist
____ Ambulance	____ Hospital	____ Physician **
____ Ambulatory Surgery Center ****	____ Hospital Outpatient	____ Physician Assistant
____ ARNP	____ Hospital Psychiatric	____ Prosthetist/Orthotist
____ Attendant Care	____ Interpreter **(Must have attestation sheet)**	____ Psychologist
____ Audiologist		____ Radiologist
____ Chiropractor	____ IV Therapy	____ Rehab Training Facility
____ Clinic	____ Lab Facility	____ Rehab Training Supplier
____ CRNA	____ LMP	____ School **(Include license, i.e., business, accreditation)**
____ Day Care Provider	____ Nurse Case Management	
____ Dentist	____ Nursing Home	____ Skilled Nursing Facility
____ Denturist	____ Naturopathic Physician	____ Speech Pathologist
____ DME Supplier	____ Occupational Therapist	____ Tape Intermediary
____ Drug & Alcohol Treatment	____ Optician	____ Toll Bridge
____ Ferry	____ Optometrist	____ Job mod/pre-job mod supplier
____ First Surgical Assist (RNFA) *	____ Osteopathic Physician **	____ Job mod/pre-job mod consultant
____ Filter/Dispenser	____ Pain Clinic ***	____ Retraining
____ Free Standing Emergency Room	____ Panel Exam Group	____ Work Hardening
____ Head Injury Program ***	____ Pharmacy **(Copy of DEA permit/pharmacy license/NCPDP# required)**	
____ Hearing Center		
____ Other: (specify)		

2. Specialty in above field Sub-Specialty

*

F248-011-000 provider account application and notice 8-04

Provider Account Application (F248-011-000), Page 2.
See instructions for completing form.

APPLICATION INSTRUCTIONS

NOTICE:
Each medical practitioner must complete Section II.B. of the application.
If additional copies are needed, copy all portions of the application from the internet or call (360) 902-5140. Photo copies can be made of this application for completion.

SECTION I TO BE COMPLETED BY ALL PROVIDERS
Enter the Tax Payer Identification Number (EIN or SSN). **The number you will use to report earnings to the IRS - This must match the information on the W-9.**

SECTION II: TO BE COMPLETED BY ALL PROVIDERS

A. Administrative Information
1. Enter the name of the business you wish to submit your bills and have your account set up as, (DBA).
2. Enter the phone number of the business.
2a. Enter the fax number of the business.
3. Enter the billing address as it appears on your bills submitted to Labor & Industries and where payments should be mailed.
4. Enter the physical address of the business.
5. Enter the contact person's name to call. This allows us to contact the appropriate person if we have questions regarding your bills or your account.
6. Enter the billing phone number where we may call to ask questions regarding your bills or your account, if necessary.
7. If you will be attached to a group, please provide group number (for billing purposes).

B. Individual Provider Information – All providers must complete this section.
1. Enter the name of the person providing services to injured workers.
2. Enter your Social Security Number.
3. Enter the type of service(s) provided.
4. Enter your professional license number.
5. Enter the date the license was issued (month, day and year). **ATTACH COPY**
6. Enter the date the license will expire (month, day and year).
7. Enter the state where your license was issued.
8. Enter your Drug Enforcement Agency (DEA) number.
9. Check board certified and **Include a copy of certification.** (Applicable to PMR only)
10. Enter your NCPDP number, (formerly known as NABP number.) (Applicable to Pharmacies only)
11. Enter any current Labor and Industries Provider Account Number(s) you now have.

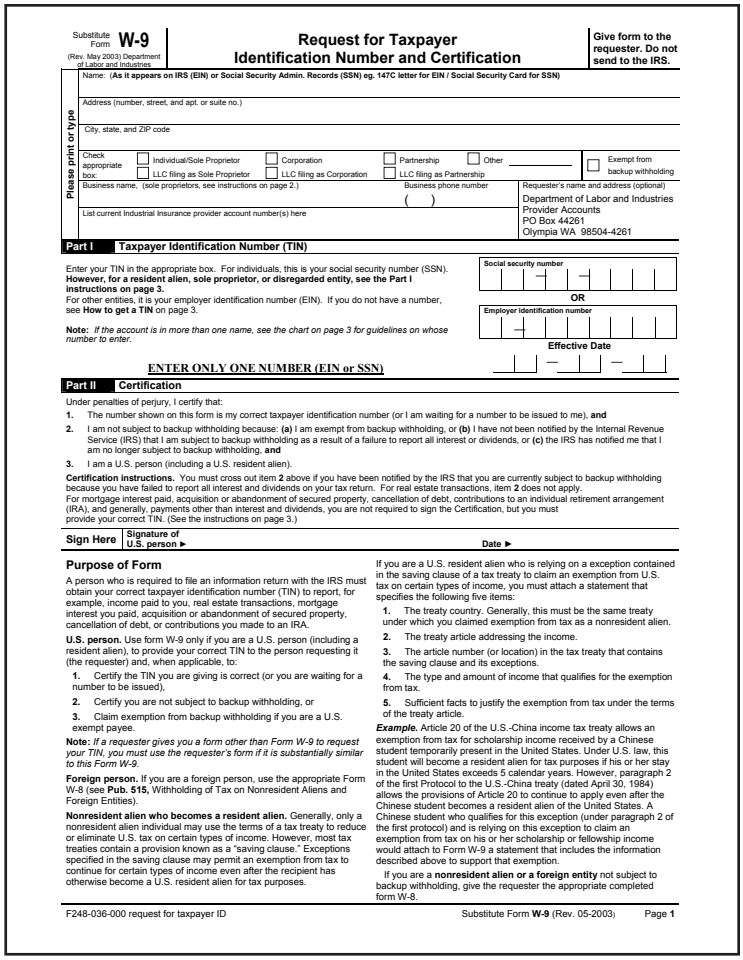
C. Physician Assistant Section
1. Enter the name of the supervising physician. If practicing under more than one supervising physician, see instruction #7 below.
2. Enter the supervising physician's specialty.
3. Enter the supervising physician's professional license number, the state the license was issued in and the date the license expires.
4. Supervising physician Board certified? If checking yes, **include a copy of certification.**
5. Enter supervising physician's Labor & Industries Provider Number.
6. Enter the supervising physician's Drug Enforcement Agency number.
7. Physician assistants with more than one supervising physician must submit the information contained in Section C on a separate sheet of paper for each physician or employer for whom they work.
8. Submit a Provider Application/Agreement for each supervising physician with different tax I.D.'s under which you will bill for treating Washington State injured or ill workers.

*** Each January the Internal Revenue Service requires us to send a completed Form 1099 MISC reporting payments of $600.00 or more made to a Federal Tax Identification Number (EIN or SSN) during the last calendar year. If you received payments from more than one department program, you may receive more than one Form 1099 Misc.**

PLEASE DO NOT FORGET TO READ AND SIGN THE "PROVIDER AGREEMENT".

F248-011-000 provider account application and notice 8-04

Application Instructions. Explains how to complete the Provider Application, including the Provider Agreement.



Substitute Form **W-9**
(Rev. May 2003) Department of Labor and Industries

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Please print or type

Name: (**As it appears on IRS (EIN) or Social Security Admin. Records (SSN) eg. 147C letter for EIN / Social Security Card for SSN**)

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Check appropriate box: ☐ Individual/Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other ____ ☐ Exempt from backup withholding
☐ LLC filing as Sole Proprietor ☐ LLC filing as Corporation ☐ LLC filing as Partnership

Business name, (sole proprietors, see instructions on page 2.) | Business phone number ( ) | Requester's name and address (optional)

Department of Labor and Industries
Provider Accounts
PO Box 44261
Olympia WA 98504-4261

List current Industrial Insurance provider account number(s) here

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.**
For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 3 for guidelines on whose number to enter.*

Social security number ___ — ___ — ____

OR

Employer identification number ___ — ____

Effective Date ___ — ___ — ____

ENTER ONLY ONE NUMBER (EIN or SSN)

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 3.)

Sign Here **Signature of U.S. person ►** **Date ►**

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

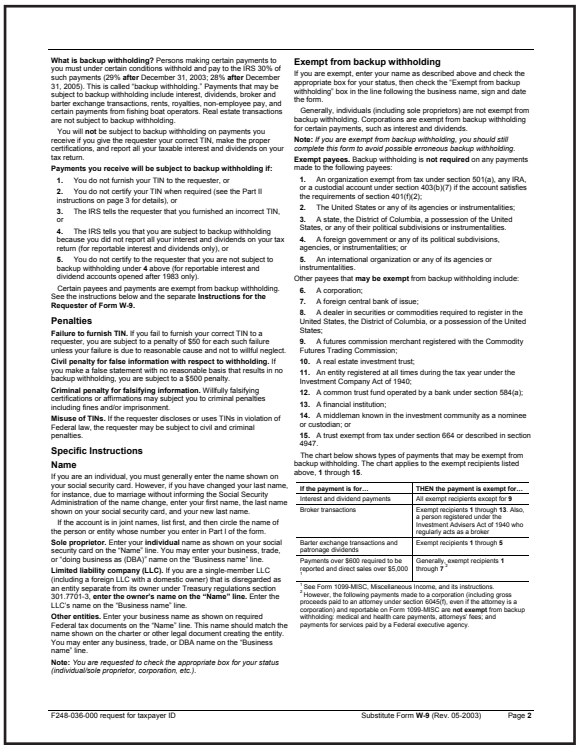
If you are a U.S. resident alien who is relying on a exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed form W-8.

Request for Taxpayer Identification Number and Certification. This is form F248-036-000 (Page 1), a required part of the application packet.



What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, non-employee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt from backup withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);
2. The United States or any of its agencies or instrumentalities;
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or
5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

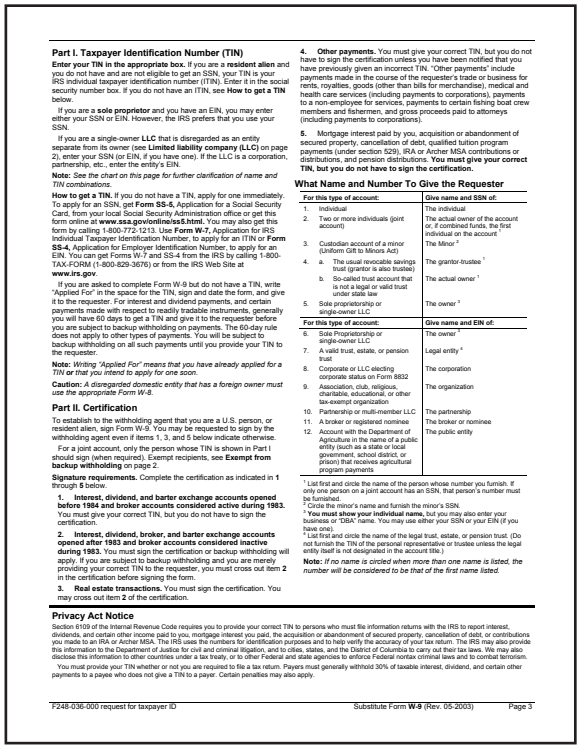
6. A corporation;
7. A foreign central bank of issue;
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;
9. A futures commission merchant registered with the Commodity Futures Trading Commission;
10. A real estate investment trust;
11. An entity registered at all times during the tax year under the Investment Company Act of 1940;
12. A common trust fund operated by a bank under section 584(a);
13. A financial institution;
14. A middleman known in the investment community as a nominee or custodian; or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, **1** through **15.**

If the payment is for...	THEN the payment is exempt for...
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13**. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.
[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Request for Taxpayer Identification Number and Certification. Page 2, instructions for completing the form.



Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner **LLC** that is disregarded as an entity separate from its owner (see **Limited liability company (LLC)** on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office or get this form online at **www.ssa.gov/online/ss5.html.** You may also get this form by calling 1-800-772-1213. Use **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** on page 2.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. **Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.
2. **Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.
3. **Real estate transactions.** You must sign the certification. You may cross out item **2** of the certification.
4. **Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a non-employee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).
5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. **You must give your correct TIN, but you do not have to sign the certification.**

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The Minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole Proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.
[2] Circle the minor's name and furnish the minor's SSN.
[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or your EIN (if you have one).
[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to other Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Request for Taxpayer Identification Number and Certification. Page 3, instructions for completing the form, continued.

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

DOCTOR'S ESTIMATE OF PHYSICAL CAPACITIES

Name of Claimant

Claim Number

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A. Percentages refer to a workday.

I. In an 8 hour workday, worker can: (Circle full capacity for each activity)

	Total at one time (hours)										
A)	Sit	0	1/2	1	2	3	4	5	6	7	8
B)	Stand	0	1/2	1	2	3	4	5	6	7	8
C)	Walk	0	1/2	1	2	3	4	5	6	7	8

	Total during entire 8 hour day (hours)										
A)	Sit	0	1/2	1	2	3	4	5	6	7	8
B)	Stand	0	1/2	1	2	3	4	5	6	7	8
C)	Walk	0	1/2	1	2	3	4	5	6	7	8

II. Worker can lift: *(Address any restrictions in lifting from the floor or to overhead in "Remarks" section)*

III. Worker can carry:

		Never		Seldom (0 - 1%)		Occasionally (2 - 33%)		Frequently (34 - 66%)		Continuously (67 - 100%)	
		Lift	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**
A)	Up to 5 lbs										
B)	6 - 10 lbs										
C)	11 - 20 lbs										
D)	21 - 25 lbs										
E)	26 - 50 lbs										
F)	51 - 100 lbs										

IV. Worker can use hands for repetitive tasks such as:

		Simple grasping				Pushing & pulling				Fine manipulating			
A)	Right		Yes		No		Yes		No		Yes		No
B)	Left		Yes		No		Yes		No		Yes		No

V. Worker can use feet for repetitive movements as in operating foot controls:

Right ☐ Yes ☐ No Left ☐ Yes ☐ No

VI. Worker is able to:

		Not at all	Seldom (0 - 1%)	Occasionally (2 - 33%)	Frequently (34 - 66%)	Continuously (67 - 100%)
A)	Bend					
B)	Squat					
C)	Kneel					
D)	Crawl					
E)	Climb					
F)	Reach above shoulder level					

VII. Restriction on activities involving:

		Yes	No	If "Yes," explain:
A)	Unprotected heights			
B)	Being around moving machinery			
C)	Exposure to marked changes in temp & humidity			
D)	Driving automotive equipment			

E) Exposure to dust, fumes and gasses (Restrictions): _____

Remarks (on above, on other functional limitations):

If a performance-based physical capabilities evaluation is requested, may the worker be tested to tolerance? If not, what are the restrictions?

☐ Yes ☐ No

Date Signature of Physician

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

RESET

OCCUPATIONAL DISEASE WORK HISTORY

Claim Number

Name	Start date of first employment

Please list any breaks or interruption in your work history. ***We must account for all months since your FIRST START DATE.***

From: Month	From: Year	To: Month	To: Year	Reason for work interruption

Employment History

Please start with your most RECENT job and work BACKWARDS Specify month and year for employment date.

If additional space is needed, use the continuation form (F242-071-111) or make additional copies of this form.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	
Describe the job duties and type of equipment or tools used or operated.		

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	
Describe the job duties and type of equipment or tools used or operated.		

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	
Describe the job duties and type of equipment or tools used or operated.		

Page of

I certify that the information is true and correct to the best of my knowledge.

Date: Signature:

RESET

OCCUPATIONAL DISEASE WORK HISTORY (CONTINUATION)

Page of	Name	Claim Number

(This is a continuation sheet. Must complete original form first.)

Please CONTINUE with your most RECENT job and work BACKWARDS.

Employer's business name			Employment dates: From (mo/yr)	To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name			Employment dates: From (mo/yr)	To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name			Employment dates: From (mo/yr)	To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name			Employment dates: From (mo/yr)	To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name			Employment dates: From (mo/yr)	To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Dept of Labor & Industries
PO Box 44291
Olympia WA 98504-4291

I certify that the information is true and correct to the best of my knowledge.

Date: Signature:

APPENDIX

I

Mailing Addresses, Web Sites, and Phone Numbers

This appendix summarizes the various addresses mentioned in other parts of this handbook. A few of the less commonly used addresses (for example, complaints about discrimination) are given in earlier sections. Please refer to the index if you wish to find more information about any these topics.

1. **CMS 1500 Bills to:**
   Labor & Industries
   PO 44269
   Olympia WA 98504-4269
   www.LNI.wa.gov/ClaimsIns/Providers/Billing/

2. **UB-92 Bills to:**
   Labor & Industries
   PO 44266
   Olympia WA 98504-4266
   www.LNI.wa.gov/ClaimsIns/Providers/Billing/

3. **Adjustments, Retraining, Job Modification, Home Nursing Care, and using the Miscellaneous Form**
   Labor & Industries
   PO 44267
   Olympia WA 98504-4267
   www.LNI.wa.gov/ClaimsIns/Providers/Billing/

4. **Pharmacy Bills to:**
   Labor & Industries
   PO 44268
   Olympia WA 98504-4268
   www.LNI.wa.gov/ClaimsIns/Providers/Billing/

5. **Refunds: (attach a copy of the remittance advise)**
   Labor & Industries
   PO 44835
   Olympia WA 98504-4835
   www.LNI.wa.gov/ClaimsIns/Providers/Billing/

6. **Electronic Billing Info:**
   Labor & Industries
   PO 44264
   Olympia WA 98504-4264
   360-902-6511
   www.ProviderElectronicBilling.LNI.wa.gov

7. **Accident Reports (State Fund Only) to:**
   Labor & Industries
   PO 44299
   Olympia WA 98504-4291
   www.LNI.wa.gov/ClaimsIns/Providers/Billing/

8. **Progress Notes, chart notes, 60-day reports (State Fund Only) to:**
   Labor & Industries
   Records Section
   PO Box 44291
   Olympia WA 98504-4291
   http://www.lni.wa.gov/ClaimsInsurance/ProviderPay/ClaimBilling/

9. **IME Complaints to:**
   IME Project Manager
   Labor & Industries
   PO 44322
   Olympia WA 98504-4322
   http://www.lni.wa.gov/ClaimsIns/FraudComp/Complaints/AboutIME

10. **To View and Print Forms or Publications:**
    www.LNI.wa.gov/IPUB/or to order:
    Warehouse
    Labor & Industries
    PO 44843
    Olympia WA 98504-4843

11. **To Obtain Provider Bulletins:**
    www.LNI.wa.gov/claimsIns/Providers/billing/provbulletins/
    or
    Labor & Industries
    PO 44322
    Olympia WA 98504-4322
    800-848-0811 or 360-902-6799

12. **To Apply for a Provider Number:**
    Labor & Industries
    PO Box 44261
    Olympia WA 98504-4261
    360-902-5140
    www.LNI.wa.gov/ClaimsIns/Providers/Become/

13. **To Appeal Denial of a Provider Number:**
    Labor & Industries
    PO Box 44263
    Olympia WA 98504-4263

14. **Internet addresses:**
    L&I home page: www.LNI.wa.gov
    Claim and Account Center: www.ClaimInfo.LNI.wa.gov
    Drug Policies: www.TreatmentGuidelines.LNI.wa.gov/
    Find a Law or Rule: www.LNI.wa.gov/LawRule/
    Medical Coverage Decisions:
    www.LNI.wa.gov/ClaimsInsurance/Providers/TreatmentGuidelines/Covered/default.asp
    Medical Treatment Guidelines: www.TreatmentGuidelines.LNI.wa.gov/
    Medical Treatment Publications: www.LNI.wa.gov/ClaimsIns/Providers/FormPub/
    Medical Utilization Review: www.TreatmentGuidelines.LNI.wa.gov/
    Technology Assessment Program for Medical Devices: www.TreatmentGuidelines.LNI.wa.gov/

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Updates and Additions to the *Attending Doctor's Handbook*, October 2012

Section	Page	Title	Comments
4	45	Provider Bulletins	Provider Bulletins are temporary communications to announce changes to law, rules, policies and coverage decisions. They're available at **www.ProviderBulletins.Lni.wa.gov**. The information in these bulletins is then rolled into payment policies to permanently convey the information within the Medical Aid Rules and Fee Schedules at **www.FeeSchedules.Lni.wa.gov**.
5	46	Impairment Ratings	A revised *Medical Examiners' Handbook* is available online. Go to **www.IMEs.Lni.wa.gov** and click on *Medical Examiners' Handbook*. Take the related online CME activity and receive 3 hours of Category 1 CME credit. Link from the Web page above or go to **www.CMECredits.Lni.wa.gov**. Find an approved medical examiner at **https://fortress.wa.gov/lni/imets/**. Locate chiropractic and other consultants at **www.FindADoc.Lni.wa.gov**. Click on "Search for L&I providers" and then choose "advanced search." Fill in "located near." Then, under "provider types and specialties," choose the category that applies.
6	49	Billing for Services (State Fund)	The Medical Aid Rules and Fee Schedule at **www.FeeSchedules.Lni.wa.gov** has a new, easier format and a quick fee look up tool. Electronic bill submission is a free and secure way to submit or adjust bills and assure faster payment. Receive remittances through Secure Access Washington (SAW). **www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/Electronic**. Check bill and claim status at the online Claim & Account Center for free at **www.ClaimInfo.Lni.wa.gov**. ICD 9 references are generic and apply to future versions of ICD (ICD 10 was recently estimated to be implemented nationally on 10/1/2014.) See the billing workshop schedule in Washington State: **www.Lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/Workshop**. If you need assistance with State Fund billing issues, call 1-800-848-0811 or contact a Provider Account Representative: ■ ProviderFeedback@Lni.wa.gov. ■ Billing: 360-902-6513. ■ General issues: 360-902-6680.
Appendix C	60	General Reference Materials	Shows upcoming courses and seminars, new educational and reference materials, and CME opportunities. Go to: **www.Lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/Courses**. ■ Online self assessments to receive CME credits: **www.CMECredits.Lni.wa.gov**. ■ *Attending Providers' Return to Work Desk Reference*: **www.Lni.wa.gov/FormPub/Detail.asp?DocID=1492**. ■ *Medical Examiners' Handbook*: **www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/IME/MedHandbook**.

Quick Reference Guide to L&I Services

For State Fund and Self-Insured Workers' Compensation Claims

Topic	Contact
Returning Patients to Work	
Stay at Work Program	**www.StayAtWork.Lni.wa.gov** 1-866-406-2482
Rehabilitation Consultants in Claim Units: State Fund	**www.Lni.wa.gov/ClaimsIns/Voc/ContactUs**
Authorization for Services	
For in-patient and out-patient services, advanced imaging (MRI), and PT or OT utilization review	**www.Lni.wa.gov/ClaimsIns/Providers/AuthRef** 1-800-541-2894
For: ■ Chemical dependency treatment. ■ Home care, skilled nursing facility or discharge planning. ■ Home or vehicle modifications. ■ IV antibiotics. ■ Mental health treatment. ■ Multidisciplinary Chronic Pain Management—Structured Intensive Multidisciplinary Program (SIMP). ■ Office visits beyond 20 visits, or occur more than 60 days after the first date you treated the worker. ■ Opioids for chronic, non-cancer pain. ■ Outpatient surgery.	See the summary of these authorization requirements on Page 2 of the Medical Aid Rules and Fee Schedules: **www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2012/MARFS/Chapter2**. Look up authorization requirements by procedure code: **www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched**.
Billing	
State Fund Electronic Billing (Free online billing form and printable instructions)	**www.ElectronicBilling.Lni.wa.gov**. Click on "Direct Entry" for how to submit direct entry billing. Instructions (PDF file): **www.Lni.wa.gov/ClaimsIns/Files/Providers/SAWPEBInstr.pdf**. 360-902-6511 ebulni@Lni.wa.gov
Billing Questions: State Fund	Overview: **www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI**. 360-902-6680 ProviderFeedback@Lni.wa.gov Provider Hotline: **www.Lni.wa.gov/ClaimsIns/Providers/AuthRef/ProvHotline.asp**. 1-800-848-0811 General Billing Manual: **www.Lni.wa.gov/FormPub/Detail.asp?DocID=2148**. 360-902-6513 Fee Schedules and Payment Policies: **www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched**. Billing Workshops: **www.Lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/Workshop**.

Quick Reference Guide to L&I Services *(Continued)*

For State Fund and Self-Insured Workers' Compensation Claims

Topic	Contact
Claims	
Claim & Account Center: State Fund	**www.ClaimInfo.Lni.wa.gov** 360-902-5999 (for help signing up for this online service)
Guidelines	
Medical Treatment Guidelines	**www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/TreatGuide** and then click on "Treatment Guidelines."
Advanced Imaging Guidelines	**www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/TreatGuide** and then click on "Advanced Imaging Guidelines."
Payment Policies ■ Modifications–Home, Job and Vehicle ■ Obesity Treatment ■ Other Medical Services	**www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched** and then click on the year of service, and then click on "Billing and Payment Policies."
Impairment Ratings/IMEs	
Overview	**www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/IME**
Medical Examiners' Handbook	**www.Lni.wa.gov/IPUB/252-001-000.pdf**
Medical Issues	
Home Modifications	**www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ProviderIndex/homeMod**
Job Modifications	**www.Lni.wa.gov/ClaimsIns/Voc/BackToWork/JobMod**
Payment Policies ■ Modifications–Home, Job and Vehicle ■ Obesity Treatment ■ Other Medical Services	**www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched** and then click on the year of service, and then click on "Billing and Payment Policies."
Workplace Conditions	
Workplace Safety Concerns	**www.Lni.wa.gov/Safety/Basics/Complaint** 1-800-423-7233
Workplace Safety Education and Research	**www.Lni.wa.gov/Safety** 1-800-423-7233
Minimum Wage, Meals and Rest Breaks, Minor Workers	**www.Lni.wa.gov/Workplacerights** 1-866-219-7321
Provider Education	
CME and CE Self-Assessment Examinations	**www.CMECredits.Lni.wa.gov**
Billing Workshops	**www.Lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/Workshop**
Courses and Seminars	**www.Lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/Courses**
Online Videos & Tools	**www.Lni.wa.gov/ClaimsIns/Providers/WorkshopTrain/Courses** and click on "Library of Online CME, Videos & Tools."

ABOUT THIS PUBLICATION

This October 2012 update edition of the *Attending Doctor's Handbook* contains selected updates to the March 2005 edition. New or updated information is located inside the front and back covers of the book, and in the center "insert." Pages i through 90 have not changed.

See "About the October 2012 Update Edition" at the front of the book for more about the changes.

The *Attending Doctor's Handbook* was first published in 1993.