



Certification Page Regular and Emergency Rules

Revised May 2014

Emergency Rules (After completing all of Sections 1 and 2, proceed to Section 5 below)

Regular Rules

1. General Information

a. Agency/Board Name Department of Workforce Services			
b. Agency/Board Address 1510 East Pershing Blvd.		c. City Cheyenne	d. Zip Code 82002
e. Name of Contact Person Marcia J. Price		f. Contact Telephone Number (307) 777-6746	
g. Contact Email Address marcia.price@wyo.gov			h. Adoption Date 8/5/16
i. Program Department of Workforce Services - Workers' Compensation Division			

2. Rule Type and Information: For each chapter listed, indicate if the rule is New, Amended, or Repealed.

If "New," provide the Enrolled Act numbers and years enacted:

c. Provide the Chapter Number, Short Title, and Rule Type of Each Chapter being Created/Amended/Repealed
(Please use the Additional Rule Information form for more than 10 chapters, and attach it to this certification)

Chapter Number:	Chapter Name:	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Amended	<input type="checkbox"/> Repealed
6	Contested Case Proceedings	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10	Miscellaneous Medical Protocols	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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d. The Statement of Reasons is attached to this certification.

e. If applicable, describe the **emergency** which requires promulgation of these rules without providing notice or an opportunity for a public hearing:

3. State Government Notice of Intended Rulemaking

a. Date on which the Notice of Intent containing all of the information required by W.S. 16-3-103(a) was filed with the Secretary of State :	6/5/16
b. Date on which the Notice of Intent and proposed rules in strike and underscore format and a clean copy were provided to the Legislative Service Office :	6/5/16
c. Date on which the Notice of Intent and proposed rules in strike and underscore format and a clean copy were provided to the Attorney General :	6/1/16

4. Public Notice of Intended Rulemaking

a. Notice was mailed 45 days in advance to all persons who made a timely request for advance notice. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
b. A public hearing was held on the proposed rules. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

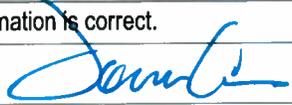
If "Yes:"	Date: 8/1/16	Time: 9:00am	City: Cheyenne	Location: Room 1699 Herschler Bldg.
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5. Final Filing of Rules

a. Date on which the Certification Page with original signatures and final rules were sent to the Attorney General's Office for the Governor's signature :	8/5/16
b. Date on which final rules were sent to the Legislative Service Office :	
c. Date on which a PDF of the final rules was electronically sent to the Secretary of State :	

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct.

Signature of Authorized Individual <i>(Blue ink as per Rules on Rules, Section 7)</i>	
Printed Name of Signatory	John Cox
Signatory Title	Director, Department of Workforce Services (DWS)
Date of Signature	8-11-16

7. Governor's Certification

I have reviewed these rules and determined that they:

1. Are within the scope of the statutory authority delegated to the adopting agency;
2. Appear to be within the scope of the legislative purpose of the statutory authority; and, if emergency rules,
3. Are necessary and that I concur in the finding that they are an emergency.

Therefore, I approve the same.

Governor's Signature	
Date of Signature	

Attorney General: 1. Statement of Reasons; 2. Original Certification Page; 3. Summary of Comments (regular rules); 4. Hard copy of rules: clean and strike/underscore; and 5. Memo to Governor documenting emergency (for emergency rules only).

LSO: 1. Statement of Reasons; 2. Copy of Certification Page; 3. Summary of Comments (regular rules); 4. Hard copy of rules: clean and strike/underscore; 5. Electronic copy of rules (PDFs) emailed to Criss.Carlson@wyoleg.gov: clean and strike/underscore; and 6. Memo to Governor documenting emergency (for emergency rules only).

SOS: 1. PDF of clean copy of rules; and 2. Hard copy of Certification Page as delivered by the AG.

Principal Statement of Reason – WC Chapter 6, Section 2 (Contested Case Proceedings) & WC Chapter 10, Section 16 & Section 25 (Miscellaneous Medical Protocols)

The Workers' Compensation Division is proposing a change in Chapter 6, Section 2, to increase fees for members of the Medical Commission from \$150.00 to \$200.00 per hour. The proposed increase is due to the fact the \$150.00 per hour fee has been in place for approximately fifteen (15) years.

In addition to small edits such as formatting and clarifying certain language, the Workers' Compensation Division is proposing changes to Chapter 10, Section 16 that clarify criteria permitting massage therapy provided upon orders from the treating health care provider. Further, the Division has run into physicians dispensing pharmaceuticals from the physicians' offices and charging a high mark up to dispense those items. To deter these physicians from circumventing the fee schedule, additional language is proposed in Section 25 to clarify that physicians are in fact subject to the fee schedule.

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CHAPTER 6 - CONTESTED CASE PROCEEDINGS

Section 1. Referral for Hearing.

(a) Upon receipt of a request for hearing, the Division shall immediately transmit a copy of the request and a notice of request for hearing to the Office of Administrative Hearings (OAH) or Workers' Compensation Medical Commission as appropriate. For purposes of judicial review of agency inaction under W.S. § 16-3-114(a), the Division is deemed to have denied any timely, written request for a hearing pursuant to W.S. § 27-14-601(k)(iv) when it has failed to transmit a notice of request for hearing within 30 days after receipt of the request.

(i) For purposes of referring contested cases to the Workers' Compensation Medical Commission for hearing, W.S. § 27-14-616(b)(iv), the phrase "medically contested cases" shall include those cases in which the primary issue is:

(A) a claimant's percentage of physical impairment;

(B) whether a claimant is permanently totally disabled;

(C) whether a claimant who has been receiving TTD benefits remains eligible for those benefits under W.S. § 27-14-404(c); or,

(D) any other issue, the resolution of which is primarily dependent upon the evaluation of conflicting evidence as to medical diagnosis, medical prognosis, or the reasonableness and appropriateness of medical care.

Section 2. Establishment of Fees for Members of Medical Commission. Members of the medical commission established pursuant to W.S. § 27-14-616 shall be compensated at the rate of \$200 per hour for their professional services on behalf of the commission, including necessary travel time. In addition, members of the commission shall be reimbursed for necessary travel expenses to the same extent and upon the same conditions as Wyoming State employees are reimbursed under the rules and regulations of the State Auditor.

Section 3. Small Claims. If the Division requests that the matter be resolved as a small claims hearing, the Notice of Referral shall include the following notice:

(a) The Division determines that the amount at issue is less than \$2,000 and does not involve an issue of the compensability of the injury. The Division therefore requests that the matter be resolved as a small claims hearing as provided in W.S. § 27-14-602(b)(i).

(b) The purpose of a small claims hearing is to provide expedited review by a hearing examiner. In a small claims hearing, the Division will not pay a claimant's attorney, nor will the Office of the Attorney General represent the Division.

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(c) If any party objects to a small claims hearing request within 15 days of the notice, the hearing examiner will decide whether a small claims hearing or a contested case hearing is appropriate.

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CHAPTER 10 - MISCELLANEOUS MEDICAL PROTOCOLS

Section 1. Acupuncture. The Division shall pay for acupuncture procedures only if the services are performed by a health care provider as defined in W.S. § 27-14-102(x), who is certified to perform acupuncture. Before the Division will issue any payment for acupuncture services, the health care provider shall submit to the Division proof of certification in acupuncture from an accredited school or a school that is a candidate for accreditation.

Section 2. Alcohol and Drug Testing Protocols.

(a) Nothing in this rule is intended to authorize any employer to test any employee for alcohol or drugs in any manner inconsistent with constitutional, federal or statutory requirements.

(b) Nothing in this rule shall be construed to require an employer to test, or create a legal obligation upon the employer to request an employee to undergo drug or alcohol testing. An employer's decision to post-accident test should be consistent with their substance abuse and testing policy.

(c) All drug and alcohol testing, initial and confirmation, conducted in conjunction with the employer's drug-free workplace policy will be at the employer's expense.

(d) All testing for alcohol and controlled substances will be conducted in accordance with the requirements of 49 CFR Part 40, which procedures are designed to protect the employee and the integrity of the testing process, safeguard the validity of the test results, and ensure those results are attributed to the correct employee.

(i) Pursuant to 49 CFR Part 40, a covered employer may test for Amphetamines; Marijuana (cannabinoids); Cocaine (benzoyllecgonine); Opiates (codeine, morphine, heroin); PCP (phencyclidine); Alcohol; or any controlled substance subsequently subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation. In accordance with these regulations, the following are the cutoff concentrations for initial and confirmation tests:

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All cutoff concentrations are expressed in nanograms per milliliter (ng/mL)

Type of Drug or Metabolite	Initial Test	Confirmation Test
(1) Marijuana Metabolites	50	
(i) Delta-9-tetrahydrocanna-binol-9-carboxylic acid (THC)		15
(2) Cocaine Metabolites (Benzoylecgonine)	300	150
(3) Phencyclidine (PCP)	25	25
(4) Amphetamines	1000	
(i) Amphetamine		500
(ii) Methamphetamine		500 (Specimen must also contain amphetamine at a concentration of greater than or equal to 200 ng/mL.)
(5) Opiate metabolites	2000	
(i) Codeine		2000
(ii) Morphine		2000
(iii) 6-acetylmorphine (6-AM)		10 (Test for 6-AM in the specimen. Conduct this test only when specimen contains morphine at a concentration greater than or equal to 2000 ng/mL.)

Section 3. Alternative Medicine. Except as provided in Section 10 of this Chapter, the Division will not authorize or pay for any alternative medicine treatments, defined as any medical practice or intervention that lacks sufficient documentation for safety or effectiveness against specific conditions, or lacks a valid scientific base.

Section 4. Biofeedback. Biofeedback services shall be paid according to the edition of RVP, as published by Ingenix, Inc., as authored by Relative Value Studies, Inc., as adopted by the Administrator in Chapter 9, Section 2. The following conditions apply and,

(a) individual meets the definition of "injury" under W.S. 27-14-102(a)(xi);

(b) the services must be prescribed by the primary treating health care provider.

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(c) Administration of biofeedback treatment is limited to those practitioners who are certified by the Biofeedback Certification Institute of America.

(d) Practitioners must submit a current copy of their biofeedback certification to the Division of Workers' Compensation. Practitioners are bound by the Wyoming Workers' Compensation Fee Schedule for biofeedback services.

(e) Twelve (12) biofeedback treatments in a ninety-day period will be authorized when the following is presented to the Division:

(i) An evaluation report documenting:

(A) the basis for the injured worker's condition;

(B) the condition's relationship to the work injury;

(C) an evaluation of the injured worker's functional measurable modalities (e.g.), range of motion, uptime, walking tolerance, medication intake, etc.);

(D) an outline of the proposed treatment program; and,

(E) an outline of the expected restoration goals.

(ii) The injured worker's progress must be documented in the medical records to include continued medical necessity, expected number of sessions, and ability to facilitate any further positive functional gains.

(f) No biofeedback treatments beyond the twelve (12) in subsection (d) will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (e.g., range of motion, uptime, walking tolerance, medication intake) and after a file review by and on the advice of the Division's medical consultant.

(g) With the Division's medical consultant's review, up to an additional six (6) sessions in a 30-day period may be authorized. All documentation requirements apply to the additional authorized sessions.

Section 5. Biological or Chemical Exposure Injury. The Division shall pay for the laboratory testing of any specimen collected from the body of an employee in order to determine his exposure to biological or chemical agents in covered employment, if such tests are ordered by the treating health care provider.

(a) If medical emergency response personnel determine that an employee should be treated in a hospital emergency room, the Division will pay for ambulance transportation from the place of exposure to the nearest hospital.

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(b) The Division shall pay for hospitalization of the employee, subsequent to his receipt of treatment in an emergency room, if it is determined by the treating physician that in-patient confinement is necessary to establish the existence and extent of exposure, and to diagnose the effects of the exposure.

(i) Except to the extent expressly provided, nothing in this section shall relieve a worker of the burden to prove the elements of an "injury" as defined by W.S. § 27-14-102(a)(xi).

Section 6. Blood-borne Pathogen Testing and Prophylactic Care.

(a) Benefits for human blood-borne pathogen testing and prophylactic care under W.S. § 27-14-501(a) shall be limited to the cost of reasonable and necessary initial and follow-up testing and reasonable and necessary prophylactic treatment. Benefits under this section shall be available only to workers reasonably believed to have incurred a potentially significant exposure.

(b) Nothing in this section shall limit benefits for testing and prophylactic care to any particular covered occupation or group of covered occupations included in the definition of "injury" under W.S. § 27-14-102(a)(xi) and prescribing reasonable prophylactic medical treatment during the disease's latency period.

(c) Except to the extent expressly provided, nothing in this section shall relieve a worker of the burden to prove the elements of an "injury" as defined by W.S. § 27-14-102(a)(xi).

(d) Nothing in this subsection shall limit benefits for an exposure to a disease that has resulted in an "injury" as defined in W.S. § 27-14-102(a)(xi).

(e) The Division will follow current recommendations of the Centers for Disease Control and Prevention for post-exposure prophylaxis.

Section 7. Compound Prescription Medications.

(a) The Division shall pay for compound prescription medications only if:

(i) a current prescription for the medication was written by the primary treating health care provider;

(ii) the pharmacist submits an itemization for all ingredients, and quantities used in the compounding process.

(b) All services involved in the administration or delivery of compounded medications shall be billed under the appropriate CPT codes.

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(c) If compounded medications are billed through a third party, the third party must supply the Division with the information required in subsection (a).

Section 8. DME Repair or Replacement. Requests for repair or replacement of equipment purchased by the Division shall be reviewed on an individual case-by-case basis. Approval will be dependent upon evidence the equipment was used in a safe and appropriate manner and, due to normal wear and tear, needs to be repaired or replaced. Evidence of improper use or abuse of equipment may warrant denial of the repair or replacement of the equipment.

Section 9. Emergency or After Office Hours Care. Emergency or necessary after office hours care performed in a non-emergency room setting shall be coded 99054 or 99058. These codes shall be paid in addition to other services provided during the same visit. Emergency department services shall be billed using the appropriate CPT codes.

Section 10. Experimental Care. Experimental care is defined as any device, drug, procedure or test used in the delivery of medical, pharmaceutical, surgical or therapeutic services that are not customary and considered investigational, unusual, controversial and/or obsolete. The Division will neither authorize nor pay for these services.

Section 11. Functional Capacity Evaluation. A functional capacity evaluation can be requested by the Division, the health care provider, or the employer to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. The functional capacity evaluation must be performed by a licensed physical therapist or occupational therapist credentialed or experienced in performing functional capacity evaluations, or a licensed medical doctor who practices rehabilitation medicine or physiatry and is credentialed or experienced in performing functional capacity evaluations. The functional capacity evaluation must have objective components which measure the validity of the test results.

Section 12. Hearing Aids. If it has been determined through medical examination and testing that an injured worker incurred a hearing impairment as a result of a compensable injury, the Division shall pay for examinations and testing of the ear(s), and the purchase of hearing aid device(s) approved by the Food and Drug Administration (FDA), and respective supplies, in order to restore the injured worker's hearing as close to pre-injury status as possible.

(a) A hearing test must be performed, and the results submitted to the Division, in order to substantiate the existence of a compensable hearing loss and to establish a base line from which to measure any potential increase in hearing impairment in the future.

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(b) The Division shall pay for a replacement hearing aid only if the treating physician submits a written report to the Division, specifying that a new hearing aid is required due to an increase in hearing impairment which is directly related to the compensable injury. The report must include the results of a current hearing test, which evidences an increase in hearing impairment over the base line, or the results of the last hearing test on file with the Division.

(c) If the Division verifies that an employee's pre-existing hearing aid, not his hearing, was damaged or destroyed as a result of a work-related accident, the Division shall pay for one comparable replacement hearing aid.

(i) The Division will not pay for a cochlear implant, tympanoplasty, or other similar surgery as a replacement for a damaged or destroyed hearing aid device.

(ii) The Division will not pay for a subsequent replacement hearing aid if the first replacement hearing aid was lost, stolen, or broken.

Section 13. Home and Vehicle Modifications. Workers who have experienced a catastrophic injury may be eligible for home and vehicle modifications. Catastrophic injuries include, but are not limited to paralysis, quadriplegia, severe head trauma, amputation and multiple traumas. Requests for home or vehicle modifications will be reviewed by Division staff to determine if the home or vehicle modification meets the injured worker's needs for safety, mobility, and activities of daily living. Only one residence and one current vehicle of a catastrophically injured worker will be modified. Modifications must be reasonable and appropriate for the injured worker's actual functional disability and level of care.

(i) A home modification is defined as a physical structural change to an injured worker's permanent residence. If the injured worker does not own the property of his residence, he must obtain and submit to the Division written permission for structural modification and proof of ownership from the property owner before modifications will be considered.

(A) The Division will not pay for any structural modifications performed prior to the Division giving written consent.

(B) The Division will not pay to restore the modified structure to its original condition when the injured worker ceases to reside on the property.

(i) Modifications can be done at the time a home is being built, but the Division shall only pay for the cost difference between a standard home structure and the modified structure. The modifications must be in compliance with accessibility standards.

(ii) The Division will not purchase any real estate or new or used motor vehicle for the injured worker.

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Section 14. Impairment Ratings-Requirements.

- (a) Any physician determining permanent physical impairment shall:
- (i) have a current, active, and unrestricted license to practice medicine, issued by a state medical board; and
 - (ii) use the most recent edition of the *American Medical Association's Guide to the Evaluation of Permanent Impairment*; and
 - (iii) use the instructions and complete all required measurements referencing all tables contained in the most current editions of the *American Medical Association's Guide to the Evaluation of Permanent Impairment*. The Division requires impairment ratings to be submitted in the same format as the forms contained within that publication.

Section 15. Independent Medical Evaluation. The Division may require an employee to submit to an Independent Medical Evaluation by a non- treating health care provider for the purpose of obtaining a second opinion regarding the diagnosis, prognosis or treatment of an employee's injury complaints, or to obtain a permanent partial impairment rating of the residual affects attributed to a compensable injury. W.S. § 27-14-401(f). The evaluation may include: review of medical records, diagnostic studies, or other relevant materials; examination of the injured worker; consultations with other health care providers or Division representatives; and, any technical preparation by office staff.

(a) The Division may request a non-treating health care provider to conduct a paper review of an injured worker's medical records for the purpose of obtaining a second opinion regarding the diagnosis, prognosis, or treatment of an employee's injury complaints. When conducting a paper review, the health care provider conducting the review will be paid at the same rate as a physician who performed an Independent Medical Evaluation for the Division.

Section 16. Massage Therapy. Massage therapy treatment will be permitted when given by a massage practitioner upon written orders from the injured worker's treating health care provider. Massage therapy treatment must be under the direct supervision of a health care provider as defined in W.S. § 27-14-102(a)(x) and it is in conjunction with other therapy modalities.

Section 17. Nursing Services.

(a) Private Nursing or Nursing Home Care. Medical and hospital care includes nursing home care and necessary private nursing including non-professional home nursing services.

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(i) Nursing home care and home nursing services shall be paid only if prescribed in advance by the primary treating health care provider, who explains in detail the need and states the expected period of time such services will be required.

(b) Home nursing services shall be paid for a maximum of 12 hours per day per provider.

(c) Home nursing services required beyond 12 consecutive months shall be reviewed by the Division every 12 months thereafter to determine continued medical necessity.

(d) Disclaimer of Employment. Persons performing nursing services in the home of an injured worker are not employees of the State of Wyoming. The home nursing care provider or the provider's employer shall retain all responsibility for the payment of any and all federal income tax, state or federal unemployment insurance, state or federal social security premiums, and workers' compensation premiums that may be due.

(e) Initial prescriptions for home nursing services written after October 1, 1996, the following will apply:

(i) only independent Medicare/Medicaid certified agencies may provide in-home nursing care;

(ii) only Certified Nurses Assistants, Licensed Practical Nurses, Licensed Vocational Nurses or Registered Nurses working for a Medicare/Medicaid certified agency can provide in-home nursing care;

(iii) if the injured worker's residence is not within a 50 mile radius of a Medicare/Medicaid certified agency, the Division may approve other alternatives. Any such arrangement must have prior approval from the Division.

Section 18. Nutritional Supplements. The Division shall reimburse nutritional supplements, vitamins, and non-prescription drugs recommended by the treating health care provider, only if FDA approved and the supporting medical records document severe clinical dietary problems attributed to the compensable injury.

Section 19. Off-label use of Medical Services. Medications, treatments, procedures or other medical services used for other than the approved Food and Drug Administration (FDA) indications. These services should be medically necessary, i.e., have a reasonable expectation of cure or significant relief of a condition consistent with any applicable treatment parameter (Rules and Regulations Chapter 1, Section 4, Subsection (a)). The Health Care Provider must document in the medical record the off-label use is medically necessary, and will submit to the Division a comprehensive review of the medical literature. This review will include at least two (2) good prospective,

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randomized, placebo-controlled, double-blind trial. The Division will consider the quality of the evidence and determine medical necessity.

Section 20. Payment for Medical Services and Professional Fees.

(a) Claims for medical services provided to an employee for a compensable injury, and any associated fees charged by professionals, will be denied if they fail to comply with the following standards for content of medical records:

- (i) If handwritten medical notes must be legible to anyone reading them,
- (ii) If handwritten notes are illegible, medical notes must be typewritten,
- (iii) Medical notes must include date of patient visit,
- (iv) Medical notes must specify the reason for the encounter/visit and be described using the patient's own words,
- (v) Medical notes must include a history and physical exam focused relative to patient's complaint to include a description of the findings of the examine relating to the reason for the complaint.
- (vi) Medical notes must specify the diagnosis relative to the patient presenting complaint,
- (vii) Medical notes must delineate a course of treatment consistent with the diagnosis,
- (viii) The studies ordered of the patient must pertain to the complaint being addressed,
- (ix) Medical notes must delineate the education instruction to the patient,
- (x) Medical notes must contain an indication of the specifics of the follow-up care plan.

Section 21. Physical Medicine and Restorative Services.

(a) Chiropractors, physical therapists, physical therapists assistants, occupational therapists, and occupational therapist assistants may perform treatment modalities in the management of soft tissue injuries for the progressive development of strength and mobility, and to improve functional outcomes. An initial evaluation should

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document the diagnoses or clinical impression consistent with the presenting complaint(s) and the results of the examination and diagnostic procedures conducted. Subsequent visits performed require documentation of measured, objective, significant findings.

(b) The Division shall pay physical therapy and occupational therapy services only if they are provided pursuant to a prescription from the injured employee's primary treating health care provider, as defined in Chapter 1, Section 4(a) of these Rules.

(c) The Division shall monitor claims for services and may require the provider to submit a formal written treatment plan or supplemental report detailing the medical necessity, specific goals, number of sessions and time frames for review and authorization to continue the service. If the injured worker is not responding within the recommended duration periods, per the assessment of the provider, other treatment interventions, further diagnostic studies or consultation may be considered.

(i) The Administrator adopts the most current editions of *Rehabilitation Therapy Utilization Guidelines For The Care And Treatment of Injured Workers* and *Chiropractic Utilization Guidelines For The Care And Treatment Of Injured Workers*, which will be used by the Division in its evaluation and payment of physical therapy and chiropractic claims. These guidelines are available under separate cover through the Division.

Section 22. Podiatry Treatment. Fees for services of a podiatrist will be limited to those allowed for minor surgery under the General Surgery section of the edition of *Relative Values for Physicians*, as published by Ingenix, Inc., as authored by Relative Value Studies, Inc., as adopted in Chapter 9, Section 1 of these Rules.

Section 23. Preauthorization. The Division pursuant to its rules and regulations may issue a determination of preauthorization for an injured worker's nonemergency hospitalization, surgery or other specific medical care. W.S. § 27-14-601 as amended.

(a) Treatment rendered by a health care provider to a Wyoming workers' compensation claimant for injuries, will be professionally reviewed and preauthorized on issues of whether proposed treatment is reasonable, medically necessary and in compliance with the Division's case management and treatment guidelines. Such treatment guidelines shall be predicated on relevant medical literature consistent with current evidence-based medicine, or insurance industry standards or practices, or the guidance of the Medical Commission, and shall be available upon request. Policy establishing treatment guidelines shall be available in written format and also maintained on the Division's Internet web site located at www.wyomingworkforce.org.

(b) The Division will institute procedures of preauthorization and utilization review. Policy outlining the description, medical definitions, and a required list of treatments to be preauthorized shall be developed, implemented and maintained.

(c) The Preauthorization program shall be updated and revised through

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expansion and/or enhancement. The Division will inform Health Care Providers when treatment guidelines are expanded or modified, or there are changes in division policy or procedures.

(d) The Preauthorization Process

(i) Health Care Provider notification to the Division.

(A) The Health Care Provider must complete the request for preauthorization review form in writing, in advance of the injured worker receiving treatment for hospitalizations, surgeries or health care requiring preauthorization and submit it to the Division by fax, mail, or e-mail. The Provider Request for Preauthorization form can be obtained from the Division or through the Internet at: www.wyomingworkforce.org.

(B) Concurrent with submission of the Provider Request for Preauthorization, the Health Care Provider must supply relevant clinical information. This will include chart notes that document the injured worker's history, physical examination findings, diagnostic test results, treatment plan, and prognosis.

(ii) The Division will make a determination to authorize or deny treatment as requested per the preauthorization review form, pursuant to the procedures outlined in W.S. 27-14-601(k).

(iii) Notice of a final determination issued by the Division under this subsection shall include a statement of reasons and notice of the right to a hearing.

(iv) Any interested party may request a hearing before a hearing examiner on the final determination of the Division by filing a written request for hearing with the Division within fifteen (15) days after the date the notice of the final determination was mailed by the Division.

(v) Upon receipt of a request for hearing, the Division shall immediately provide notice of the request to the appropriate hearing authority as determined pursuant to W.S 27-14-616.

(vi) If timely written request for hearing is not filed, the final determination by the Division pursuant to this subsection shall not be subject to further administrative or judicial review.

(e) The Administrator or the Administrator's designee will make medical coverage decisions to ensure quality of care and prompt treatment of injured workers. Medical coverage policies and procedures will include, but are not limited to, decisions on health care services, hospitalizations, surgical procedures, medical care, pharmaceuticals, rehabilitative modalities, devices, diagnostic tests, ambulatory services, and supplies rendered for the purpose of diagnosis, treatment or prognosis.

Section 24. Pregnancy Tests. The Division shall pay for a pregnancy test

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only if it is ordered by an injured worker's treating health care provider to rule out pregnancy prior to performing a procedure or treatment considered potentially harmful to a fetus.

Section 25. Prescribed Drugs and Pharmacy Services.

(a) The Division shall pay for prescription and over-the-counter medications only if a prescription, written by the treating care provider is valid at the time of service.

(b) When medications prescribed for a compensable injury are dispensed on an out-patient basis, the Division will cover a brand name drug with an AB rated generic equivalent only if there is a documented medical necessity for utilization of the brand name. Prior authorization may be required for a brand name drug with an AB rated generic equivalent with the exception of certain drugs to be determined by the Division, to include specific anticonvulsant medications. The prescribing physician must provide the Division with medical justification for brand name medications, excluding anticonvulsants prescribed specifically for seizure control secondary to work injury.

(i) An injured worker may choose to pay the difference between the generic and the name brand product, in which case the Division shall pay only the wholesale generic price or substitute equivalent plus a dispensing fee.

(c) Healthcare providers directly dispensing prescriptions will be paid the same as retail pharmacies, based on the original manufacturer's NDC code and the Wyoming Fee Schedule.

Section 26. Prescription Lenses. If it has been determined through medical examination and testing that an injured worker incurred a visual impairment as a result of a compensable injury, the Division shall pay for examinations and testing of the eye(s), and the purchase of prescription lenses to restore the injured worker's vision as close to pre-injury status as possible.

(a) A vision test must be performed, and the results submitted to the Division, in order to substantiate the existence of a compensable vision loss and to establish a baseline from which to measure any potential increase in visual impairment in the future.

(b) The Division shall pay for the replacement of prescription lenses only if the treating physician, ophthalmologist, or optometrist submits a written report to the Division which specifies that new lenses are required due to an increase in visual impairment which is directly related to the compensable injury. The report must include the results of a current eye examination, which evidences an increase in visual impairment over the baseline, or the results of the last eye examination on file with the Division.

(c) If the Division verifies that an employee's prescription lenses and or frames, not his vision, were damaged or destroyed as a result of a work-related accident, the Division shall only pay for one replacement of prescription lenses and or frames and associated examination costs.

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(i) The Division will not pay for cosmetic refractive procedures, or other laser type surgery as a replacement for damaged or destroyed prescription lenses.

Section 27. Smoking Cessation.

(a) Tobacco Cessation products, including varenicline (Chantix), nicotine patches, gum and lozenges, and bupropion (generic Zyban), will be covered for appropriate clients undergoing a surgical procedure (including spinal fusion surgery), suffering from an orthopedic fracture or break, or with a wound in which healing may be negatively affected by smoking.

(b) A maximum coverage period of six (6) months will be approved for designated therapies.

Section 28. Special Agreements. The Division may enter into special agreements for services provided by, or under the direction of, licensed providers authorized to treat Wyoming claimants. Special agreements may be made for services not covered under the fee schedules adopted by the Division, and may include multi-disciplinary or interdisciplinary programs, pain management, work hardening, and physical conditioning, rehabilitation programs, and long-term nursing care. The Division shall establish payment rates for special agreements based on individual cases and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and other criteria to ensure injured workers receive good quality and effective services at a reasonable cost. The Division may terminate special agreements and programs upon 30 days written notice to the provider.

Section 29. Therapeutic Injections. Therapeutic injections such as trigger point injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks shall be compensable only if administered to anatomical sites where they are reasonably calculated to treat the compensable injury. Prior to the first injection, the health care provider shall document in the injured worker's medical record the medical necessity for the injections, other active modalities, and instructions for the injured worker's home exercise plan. If additional injections are indicated, the prescribing health care provider shall provide subsequent documentation indicating the medical necessity and continued need for service in the injured worker's medical record. Payment for injections shall be based upon the appropriate CPT code. The Division will not pay for injections beyond a period of six consecutive months unless the health care provider certifies the medical necessity and need for additional injections in the injured worker's medical record.

Section 30. Third Party Payments. No fee shall be paid to a third party unless the place of service or point of sale is identified on each bill.

Section 31. Vocational Evaluation. The Division may require an injured worker to participate in a vocational evaluation to determine his future employment

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potential, after he has applied for a permanent award, including permanent partial disability, loss of earnings for injuries occurring before July 1, 1994, and permanent total disability.

(a) A vocational evaluation must be performed by a qualified vocational evaluator.

(i) An evaluator is considered qualified if he possesses: a B.A. or B.S. degree and three years experience completing vocational evaluations; a Master's degree in Vocational Rehabilitation; or national certification as a vocational evaluator (CVE).

(b) The vocational evaluation report must be submitted in the format determined by the Division.

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CHAPTER 10 - MISCELLANEOUS MEDICAL PROTOCOLS

Section 1. Acupuncture. The Division shall pay for acupuncture procedures only if the services are performed by a health care provider as defined in W.S. § 27-14- 102(x), who is certified to perform acupuncture. Before the Division will issue any payment for acupuncture services, the health care provider shall submit to the Division proof of certification in acupuncture from an accredited school or a school that is a candidate for accreditation.

Section 2. Alcohol and Drug Testing Protocols.

(a) Nothing in this rule is intended to authorize any employer to test any employee for alcohol or drugs in any manner inconsistent with constitutional, federal or statutory requirements.

(b) Nothing in this rule shall be construed to require an employer to test, or create a legal obligation upon the employer to request an employee to undergo drug or alcohol testing. An employer's decision to post-accident test should be consistent with their substance abuse and testing policy.

(c) All drug and alcohol testing, initial and confirmation, conducted in conjunction with the employer's drug-free workplace policy will be at the employer's expense.

~~(i) All testing for alcohol and controlled substances will be conducted in accordance with the requirements of 49 CFR Part 40, which procedures are designed to protect the employee and the integrity of the testing process, safeguard the validity of the test results, and ensure those results are attributed to the correct employee.~~

~~(A) Pursuant to 49 CFR Part 40, a covered employer may test for Amphetamines; Marijuana (cannabinoids); Cocaine (benzoyllecgonine); Opiates (codeine, morphine, heroin); PCP (phencyclidine); Alcohol; or any controlled substance subsequently subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation. In accordance with these regulations, the following are the cutoff concentrations for initial and confirmation tests:~~

(d) All testing for alcohol and controlled substances will be conducted in accordance with the requirements of 49 CFR Part 40, which procedures are designed to protect the employee and the integrity of the testing process, safeguard the validity of the test results, and ensure those results are attributed to the correct employee.

(i) Pursuant to 49 CFR Part 40, a covered employer may test for Amphetamines; Marijuana (cannabinoids); Cocaine (benzoyllecgonine); Opiates (codeine, morphine, heroin); PCP (phencyclidine); Alcohol; or any controlled substance subsequently subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation. In accordance with these regulations, the following are

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the cutoff concentrations for initial and confirmation tests:

All cutoff concentrations are expressed in nanograms per milliliter (ng/mL)

Type of Drug or Metabolite	Initial Test	Confirmation Test
(1) Marijuana Metabolites	50	
(i) Delta-9-tetrahydrocanna-binol-9-carboxylic acid (THC)		15
(2) Cocaine Metabolites (Benzoylecgonine)	300	150
(3) Phencyclidine (PCP)	25	25
(4) Amphetamines	1000	
(i) Amphetamine		500
(ii) Methamphetamine		500 (Specimen must also contain amphetamine at a concentration of greater than or equal to 200 ng/mL.)
(5) Opiate metabolites	2000	
(i) Codeine		2000
(ii) Morphine		2000
(iii) 6-acetylmorphine (6-AM)		10 (Test for 6-AM in the specimen. Conduct this test only when specimen contains morphine at a concentration greater than or equal to 2000 ng/mL.)

Section 3. Alternative Medicine. Except as provided in Section 10 of this Chapter, the Division will not authorize or pay for any alternative medicine treatments, defined as any medical practice or intervention that lacks sufficient documentation for safety or effectiveness against specific conditions, or lacks a valid scientific base.

Section 4. Biofeedback. Biofeedback services shall be paid according to the edition of RVP, as published by Ingenix, Inc., as authored by Relative Value Studies, Inc., as adopted by the Administrator in Chapter 9, Section 2. The following conditions apply:

- (a) individual meets the definition of “injury” under W.S. 27-14-102(a)(xi);
- and,

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(b) the services must be prescribed by the primary treating health care provider;

(c) Administration of biofeedback treatment is limited to those practitioners who are certified by the Biofeedback Certification Institute of America.

(d) Practitioners must submit a current copy of their biofeedback certification to the Division of Workers' Compensation. Practitioners are bound by the Wyoming Workers' Compensation Fee Schedule for biofeedback services.

(e) Twelve (12) biofeedback treatments in a ninety-day period will be authorized when the following is presented to the Division:

(i) An evaluation report documenting:

(A) the basis for the injured worker's condition;

(B) the condition's relationship to the work injury;

(C) an evaluation of the injured worker's functional measurable modalities (e.g., range of motion, uptime, walking tolerance, medication intake, etc.);

(D) an outline of the proposed treatment program; and,

(E) an outline of the expected restoration goals.

(ii) The injured worker's progress must be documented in the medical records to include continued medical necessity, expected number of sessions, and ability to facilitate any further positive functional gains.

(f) No biofeedback treatments beyond the twelve (12) in subsection (d) will be authorized or paid for without substantiation of evidence of improvement in measurable, functional modalities (e.g., range of motion, uptime, walking tolerance, medication intake) ~~and:~~ and after a file review by and on the advice of the Division's medical consultant.

(g) With the Division's medical consultant's review, up to an additional six (6) sessions in a 30-day period may be authorized. All documentation requirements apply to the additional authorized sessions.

Section 5. Biological or Chemical Exposure Injury. The Division shall pay for the laboratory testing of any specimen collected from the body of an employee in order to determine his exposure to biological or chemical agents in covered employment, if such tests are ordered by the treating health care provider.

(a) If medical emergency response personnel determine that an employee

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should be treated in a hospital emergency room, the Division will pay for ambulance transportation from the place of exposure to the nearest hospital.

(b) The Division shall pay for hospitalization of the employee, subsequent to his receipt of treatment in an emergency room, if it is determined by the treating physician that in-patient confinement is necessary to establish the existence and extent of exposure, and to diagnose the effects of the exposure.

(i) Except to the extent expressly provided, nothing in this section shall relieve a worker of the burden to prove the elements of an "injury" as defined by W.S. § 27-14-102(a)(xi).

Section 6. Blood-borne Pathogen Testing and Prophylactic Care.

(a) Benefits for human blood-borne pathogen testing and prophylactic care under W.S. § 27-14-501(a) shall be limited to the cost of reasonable and necessary initial and follow-up testing and reasonable and necessary prophylactic treatment. Benefits under this section shall be available only to workers reasonably believed to have incurred a potentially significant exposure. ~~Nothing in this section shall limit benefits for testing and prophylactic care to any particular covered occupation or group of covered occupations.~~

~~(b) Benefits for testing shall be limited to procedures reasonably necessary to assist in:~~

- ~~(i) ruling out the presence of such a disease;~~
- ~~(ii) diagnosing the disease, if it is present;~~
- ~~(iii) identifying and testing the source of the significant exposure;~~
- ~~(iv) proving or disproving that the worker's disease, if present, meets the definition of "injury" under W.S. § 27-14-102(a)(xi); and,~~
- ~~(v) prescribing reasonable prophylactic medical treatment during the disease's latency period.~~

(b) Nothing in this section shall limit benefits for testing and prophylactic care to any particular covered occupation or group of covered occupations included in the definition of "injury" under W.S. § 27-14-102(a)(xi) and prescribing reasonable prophylactic medical treatment during the disease's latency period.

(c) Except to the extent expressly provided, nothing in this section shall relieve a worker of the burden to prove the elements of an "injury" as defined by W.S. § 27-14-102(a)(xi).

(d) Nothing in this subsection shall limit benefits for an exposure to a disease that has resulted in an "injury" as defined in W.S. § 27-14-102(a)(xi).

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(e) The Division will follow current recommendations of the Centers for Disease Control and Prevention for post-exposure prophylaxis.

Section 7. Compound Prescription Medications.

(a) The Division shall pay for compound prescription medications only if:

(i) a current prescription for the medication was written by the primary treating health care provider;

(ii) the pharmacist submits an itemization for all ingredients, and quantities used in the compounding process.

(b) All services involved in the administration or delivery of compounded medications shall be billed under the appropriate CPT codes.

(c) If compounded medications are billed through a third party, the third party must supply the Division with the information required in subsection (a).

Section 8. DME Repair or Replacement. Requests for repair or replacement of equipment purchased by the Division shall be reviewed on an individual case-by-case basis. Approval will be dependent upon evidence the equipment was used in a safe and appropriate manner and, due to normal wear and tear, needs to be repaired or replaced. Evidence of improper use or abuse of equipment may warrant denial of the repair or replacement of the equipment.

Section 9. Emergency or After Office Hours Care. Emergency or necessary after office hours care performed in a non-emergency room setting shall be coded 99054 or 99058. These codes shall be paid in addition to other services provided during the same visit. Emergency department services shall be billed using the appropriate CPT codes.

Section 10. Experimental Care. Experimental care is defined as any device, drug, procedure or test used in the delivery of medical, pharmaceutical, surgical or therapeutic services that are not customary and considered investigational, unusual, controversial and/or obsolete. The Division will neither authorize nor pay for these services.

Section 11. Functional Capacity Evaluation. A functional capacity evaluation can be requested by the Division, the health care provider, or the employer to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. The functional capacity evaluation must be performed by a licensed physical therapist or occupational therapist credentialed or experienced in performing functional capacity evaluations, or a licensed medical doctor who practices rehabilitation medicine or psychiatry and is credentialed or

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experienced in performing functional capacity evaluations. The functional capacity evaluation must have objective components which measure the validity of the test results.

Section 12. Hearing Aids. If it has been determined through medical examination and testing that an injured worker incurred a hearing impairment as a result of a compensable injury, the Division shall pay for examinations and testing of the ear(s), and the purchase of hearing aid device(s) approved by the Food and Drug Administration (FDA), and respective supplies, in order to restore the injured worker's hearing as close to pre-injury status as possible.

(a) A hearing test must be performed, and the results submitted to the Division, in order to substantiate the existence of a compensable hearing loss and to establish a base line from which to measure any potential increase in hearing impairment in the future.

(b) The Division shall pay for a replacement hearing aid only if the treating physician submits a written report to the Division, specifying that a new hearing aid is required due to an increase in hearing impairment which is directly related to the compensable injury. The report must include the results of a current hearing test, which evidences an increase in hearing impairment over the base line, or the results of the last hearing test on file with the Division.

(c) If the Division verifies that an employee's pre-existing hearing aid, not his hearing, was damaged or destroyed as a result of a work-related accident, the Division shall pay for one comparable replacement hearing aid.

(i) The Division will not pay for a cochlear implant, tympanoplasty, or other similar surgery as a replacement for a damaged or destroyed hearing aid device.

(ii) The Division will not pay for a subsequent replacement hearing aid if the first replacement hearing aid was lost, stolen, or broken.

Section 13. Home and Vehicle Modifications. Workers who have experienced a catastrophic injury may be eligible for home and vehicle modifications. Catastrophic injuries include, but are not limited to paralysis, quadriplegia, severe head trauma, amputation and multiple traumas. Requests for home or vehicle modifications will be reviewed by Division staff to determine if the home or vehicle modification meets the injured worker's needs for safety, mobility, and activities of daily living. Only one residence and one current vehicle of a catastrophically injured worker will be modified. Modifications must be reasonable and appropriate for the injured worker's actual functional disability and level of care.

(i) A home modification is defined as a physical structural change to an injured worker's permanent residence. If the injured worker does not own the property of his residence, he must obtain and submit to the Division written permission for structural modification and proof of ownership from the property owner before modifications will be considered.

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(A) The Division will not pay for any structural modifications performed prior to the Division giving written consent.

(B) The Division will not pay to restore the modified structure to its original condition when the injured worker ceases to reside on the property.

(i) Modifications can be done at the time a home is being built, but the Division shall only pay for the cost difference between a standard home structure and the modified structure. The modifications must be in compliance with accessibility standards.

(ii) The Division will not purchase any real estate or new or used motor vehicle for the injured worker.

Section 14. Impairment Ratings-Requirements.

(a) Any physician determining permanent physical impairment shall:

(i) have a current, active, and unrestricted license to practice medicine, issued by a state medical board; and

(ii) use the most recent edition of the *American Medical Association's Guide to the Evaluation of Permanent Impairment*; and

(iii) use the instructions and complete all required measurements referencing all tables contained in the most current editions of the *American Medical Association's Guide to the Evaluation of Permanent Impairment*. The Division requires impairment ratings to be submitted in the same format as the forms contained within that publication.

Section 15. Independent Medical Evaluation. The Division may require an employee to submit to an Independent Medical Evaluation by a non- treating health care provider for the purpose of obtaining a second opinion regarding the diagnosis, prognosis or treatment of an employee's injury complaints, or to obtain a permanent partial impairment rating of the residual affects attributed to a compensable injury. W.S. § 27-14-401(f). The evaluation may include: review of medical records, diagnostic studies, or other relevant materials; examination of the injured worker; consultations with other health care providers or Division representatives; and, any technical preparation by office staff.

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(a) The Division may request a non-treating health care provider to conduct a paper review of an injured worker's medical records for the purpose of obtaining a second opinion regarding the diagnosis, prognosis, or treatment of an employee's injury complaints. When conducting a paper review, the health care provider conducting the review will be paid at the same rate as a physician who performed an Independent Medical Evaluation for the Division.

Section 16. Massage Therapy. Massage therapy treatment will be permitted when given by a massage practitioner upon written orders from the injured worker's treating health care provider. Massage therapy treatment must be under the direct supervision of a health care provider as defined in W.S. § 27-14-102(a)(x) and it is in conjunction with other therapy modalities.

Section 17. Nursing Services.

(a) Private Nursing or Nursing Home Care. Medical and hospital care includes nursing home care and necessary private nursing including non-professional home nursing services.

(i) Nursing home care and home nursing services shall be paid only if prescribed in advance by the primary treating health care provider, who explains in detail the need and states the expected period of time such services will be required.

(b) Home nursing services shall be paid for a maximum of 12 hours per day per provider.

(c) Home nursing services required beyond 12 consecutive months shall be reviewed by the Division every 12 months thereafter to determine continued medical necessity.

(d) Disclaimer of Employment. Persons performing nursing services in the home of an injured worker are not employees of the State of Wyoming. The home nursing care provider or the provider's employer shall retain all responsibility for the payment of any and all federal income tax, state or federal unemployment insurance, state or federal social security premiums, and workers' compensation premiums that may be due.

(e) Initial prescriptions for home nursing services written after October 1, 1996, the following will apply:

(i) only independent Medicare/Medicaid certified agencies may provide in-home nursing care;

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(ii) only Certified Nurses Assistants, Licensed Practical Nurses, Licensed Vocational Nurses or Registered Nurses working for a Medicare/Medicaid certified agency can provide in-home nursing care;

(iii) if the injured worker's residence is not within a 50 mile radius of a Medicare/Medicaid certified agency, the Division may approve other alternatives. Any such arrangement must have prior approval from the Division.

Section 18. Nutritional Supplements. The Division shall reimburse nutritional supplements, vitamins, and non-prescription drugs recommended by the treating health care provider, only if FDA approved and the supporting medical records document severe clinical dietary problems attributed to the compensable injury.

Section 19. Off-label use of Medical Services. Medications, treatments, procedures or other medical services used for other than the approved Food and Drug Administration (FDA) indications. These services should be medically necessary, i.e., have a reasonable expectation of cure or significant relief of a condition consistent with any applicable treatment parameter (Rules and Regulations Chapter 1, Section 4, Subsection (a)). The Health Care Provider must document in the medical record the off-label use is medically necessary, and will submit to the Division a comprehensive review of the medical literature. This review will include at least ~~one~~ **two (2)** good prospective, randomized, placebo-controlled, double-blind trial. The Division will consider the quality of the evidence and determine medical necessity.

Section 20. Payment for Medical Services and Professional Fees.

(a) Claims for medical services provided to an employee for a compensable injury, and any associated fees charged by professionals, will be denied if: they fail to comply with the following standards for content of medical records:

(i) If handwritten medical notes must be legible to anyone reading them.

(ii) If handwritten notes are illegible, medical notes must be typewritten,

(iii) Medical notes must include date of patient visit,

(iv) Medical notes must specify the reason for the encounter/visit and be described using the patient's own words.

(v) Medical notes must include a history and physical exam focused relative to patient's complaint to include a description of the findings of the examine relating to the reason for the complaint,

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(vi) Medical notes must specify the diagnosis relative to the patient presenting complaint,

(vii) Medical notes must delineate a course of treatment consistent with the diagnosis,

(viii) The studies ordered of the patient must pertain to the complaint being addressed,

(ix) Medical notes must delineate the education instruction to the patient,

(x) Medical notes must contain an indication of the specifics of the follow-up care plan.

Section 21. Physical Medicine and Restorative Services.

(a) Chiropractors, physical therapists, physical therapists assistants, occupational therapists, and occupational therapist assistants may perform treatment modalities in the management of soft tissue injuries for the progressive development of strength and mobility, and to improve functional outcomes. An initial evaluation should document the diagnoses or clinical impression consistent with the presenting complaint(s) and the results of the examination and diagnostic procedures conducted. Subsequent visits performed require documentation of measured, objective, significant findings.

(b) The Division shall pay physical therapy and occupational therapy services only if they are provided pursuant to a prescription from the injured employee's primary treating health care provider, as defined in Chapter 1, Section 4(a) of these Rules.

(c) The Division shall monitor claims for services and may require the provider to submit a formal written treatment plan or supplemental report detailing the medical necessity, specific goals, number of sessions and time frames for review and authorization to continue the service. If the injured worker is not responding within the recommended duration periods, per the assessment of the provider, other treatment interventions, further diagnostic studies or consultation may be considered.

(i) The Administrator adopts the most current editions of ~~Rehabilitation Therapy Utilization Guidelines For The Care And Treatment of Injured Workers~~ *Rehabilitation Therapy Utilization Guidelines For The Care And Treatment of Injured Workers* and ~~the Chiropractic Utilization Guidelines For The Care And Treatment Of Injured Workers~~ *Chiropractic Utilization Guidelines For The Care And Treatment Of Injured Workers*, which will be used by the Division in its evaluation and payment of physical therapy and chiropractic claims. These guidelines are available under separate cover through the Division.

Section 22. Podiatry Treatment. Fees for services of a podiatrist will be

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limited to those allowed for minor surgery under the General Surgery section of the edition of *Relative Values for Physicians*, as published by Ingenix, Inc., as authored by Relative Value Studies, Inc., as adopted in Chapter 9, Section 1 of these Rules.

Section 23. Preauthorization. The Division pursuant to its rules and regulations may issue a determination of preauthorization for an injured worker's nonemergency hospitalization, surgery or other specific medical care. W.S. § 27-14-601 as amended.

(a) Treatment rendered by a health care provider to a Wyoming workers' compensation claimant for injuries, will be professionally reviewed and preauthorized on issues of whether proposed treatment is reasonable, medically necessary and in compliance with the Division's case management and treatment guidelines. Such treatment guidelines shall be predicated on relevant medical literature consistent with current evidence-based medicine, or insurance industry standards or practices, or the guidance of the Medical Commission, and shall be available upon request. Policy establishing treatment guidelines shall be available in written format and also maintained on the Division's Internet web site located at <http://doe.wyo.gov> www.wyomingworkforce.org.

(b) The Division will institute procedures of preauthorization and utilization review. Policy outlining the description, medical definitions, and a required list of treatments to be preauthorized shall be developed, implemented and maintained.

(c) The Preauthorization program shall be updated and revised through expansion and/or enhancement. The Division will inform Health Care Providers when treatment guidelines are expanded or modified, or there are changes in division policy or procedures.

(d) The Preauthorization Process

(i) Health Care Provider notification to the Division.

(A) The Health Care Provider must complete the request for preauthorization review form in writing, in advance of the injured worker receiving treatment for hospitalizations, surgeries or health care requiring preauthorization and submit it to the Division by fax, mail, or e-mail. The Provider Request for Preauthorization form can be obtained from the Division or through the Internet at: <http://doe.wyo.gov> www.wyomingworkforce.org.

(B) Concurrent with submission of the Provider Request for Preauthorization, the Health Care Provider must supply relevant clinical information. This will include chart notes that document the injured worker's history, physical examination findings, diagnostic test results, treatment plan, and prognosis.

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(ii) The Division will make a determination to authorize or deny treatment as requested per the preauthorization review form, pursuant to the procedures outlined in W.S. 27-14-601(k).

(iii) Notice of a final determination issued by the Division under this subsection shall include a statement of reasons and notice of the right to a hearing.

(iv) Any interested party may request a hearing before a hearing examiner on the final determination of the Division by filing a written request for hearing with the Division within fifteen (15) days after the date the notice of the final determination was mailed by the Division.

(v) Upon receipt of a request for hearing, the Division shall immediately provide notice of the request to the appropriate hearing authority as determined pursuant to W.S. 27-14-616.

(vi) If timely written request for hearing is not filed, the final determination by the Division pursuant to this subsection shall not be subject to further administrative or judicial review.

(e) The Administrator or the Administrator's designee will make medical coverage decisions to ensure quality of care and prompt treatment of injured workers. Medical coverage policies and procedures will include, but are not limited to, decisions on health care services, hospitalizations, surgical procedures, medical care, pharmaceuticals, rehabilitative modalities, devices, diagnostic tests, ambulatory services, and supplies rendered for the purpose of diagnosis, treatment or prognosis.

Section 24. Pregnancy Tests. The Division shall pay for a pregnancy test only if it is ordered by an injured worker's treating health care provider to rule out pregnancy prior to performing a procedure or treatment considered potentially harmful to a fetus.

Section 25. Prescribed Drugs and Pharmacy Services.

(a) The Division shall pay for prescription and over-the-counter medications only if a prescription, written by the treating care provider is valid at the time of service.

(b) When medications prescribed for a compensable injury are dispensed on an out-patient basis, the Division will cover a brand name drug with an AB rated generic equivalent only if there is a documented medical necessity for utilization of the brand name. Prior authorization may be required for a brand name drug with an AB rated generic equivalent with the exception of certain drugs to be determined by the Division, to include specific anticonvulsant medications. The prescribing physician must provide

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the Division with medical justification for brand name medications, excluding anticonvulsants prescribed specifically for seizure control secondary to work injury.

(i) An injured worker may choose to pay the difference between the generic and the name brand product, in which case the Division shall pay only the wholesale generic price or substitute equivalent plus a dispensing fee.

(c) Healthcare providers directly dispensing prescriptions will be paid the same as retail pharmacies, based on the original manufacturer's NDC code and the Wyoming Fee Schedule.

Section 26. Prescription Lenses. If it has been determined through medical examination and testing that an injured worker incurred a visual impairment as a result of a compensable injury, the Division shall pay for examinations and testing of the eye(s), and the purchase of prescription lenses to restore the injured worker's vision as close to pre-injury status as possible.

(a) A vision test must be performed, and the results submitted to the Division, in order to substantiate the existence of a compensable vision loss and to establish a baseline from which to measure any potential increase in visual impairment in the future.

(b) The Division shall pay for the replacement of prescription lenses only if the treating physician, ophthalmologist, or optometrist submits a written report to the Division which specifies that new lenses are required due to an increase in visual impairment which is directly related to the compensable injury. The report must include the results of a current eye examination, which evidences an increase in visual impairment over the baseline, or the results of the last eye examination on file with the Division.

(c) If the Division verifies that an employee's prescription lenses and or frames, not his vision, were damaged or destroyed as a result of a work-related accident, the Division shall only pay for one replacement of prescription lenses and or frames and associated examination costs.

(i) The Division will not pay for cosmetic refractive procedures, or other laser type surgery as a replacement for damaged or destroyed prescription lenses.

Section 27. Smoking Cessation.

(a) Tobacco Cessation products, including varenicline (Chantix), nicotine patches, gum and lozenges, and bupropion (generic Zyban), will be covered for appropriate clients undergoing a surgical procedure (including spinal fusion surgery), suffering from an orthopedic fracture or break, or with a wound in which healing may be negatively affected by smoking.

(b) A maximum coverage period of six (6) months will be approved for designated therapies.

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Section 28. Special Agreements. The Division may enter into special agreements for services provided by, or under the direction of, licensed providers authorized to treat Wyoming claimants. Special agreements may be made for services not covered under the fee schedules adopted by the Division, and may include multi-disciplinary or interdisciplinary programs, pain management, work hardening, and physical conditioning, rehabilitation programs, and long-term nursing care. The Division shall establish payment rates for special agreements based on individual cases and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and other criteria to ensure injured workers receive good quality and effective services at a reasonable cost. The Division may terminate special agreements and programs upon 30 days written notice to the provider.

Section 29. Therapeutic Injections. Therapeutic injections such as trigger point injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks shall be compensable only if administered to anatomical sites where they are reasonably calculated to treat the compensable injury. Prior to the first injection, the health care provider shall document in the injured worker's medical record the medical necessity for the injections, other active modalities, and instructions for the injured worker's home exercise plan. If additional injections are indicated, the prescribing health care provider shall provide subsequent documentation indicating the medical necessity and continued need for service in the injured worker's medical record. Payment for injections shall be based upon the appropriate CPT code. The Division will not pay for injections beyond a period of six consecutive months unless the health care provider certifies the medical necessity and need for additional injections in the injured worker's medical record.

Section 30. Third Party Payments. No fee shall be paid to a third party unless the place of service or point of sale is identified on each bill.

Section 31. Vocational Evaluation. The Division may require an injured worker to participate in a vocational evaluation to determine his future employment potential, after he has applied for a permanent award, including permanent partial disability, loss of earnings for injuries occurring before July 1, 1994, and permanent total disability.

(a) A vocational evaluation must be performed by a qualified vocational evaluator.

(i) An evaluator is considered qualified if he possesses: a B.A. or B.S. degree and three years experience completing vocational evaluations; a Master's degree in Vocational Rehabilitation; or national certification as a vocational evaluator (CVE).

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(b) The vocational evaluation report must be submitted in the format determined by the Division.