Certification Page
Regular and Emergency Rules

Revised August 2023

☐ **Emergency Rules** *(Complete Sections 1-3 and 5-6)* ☒ **Regular Rules**

1. General Information		
a. Agency/Board Name* Workforce Services, Department of		
b. Agency/Board Address 5221 Yellowstone Rd	c. City Cheyenne	d. Zip Code 82001
e. Name of Agency Liaison Jennifer Martinez	f. Agency Liaison Telephone Number 307-777-6746	
g. Agency Liaison Email Address jennifer.martinez1@wyo.gov	h. Adoption Date 05/22/2024	
i. Program Workers' Compensation Division		
Amended Program Name (*if applicable*):		

* ☐ *By checking this box, the agency is indicating it is exempt from certain sections of the Administrative Procedure Act including public comment period requirements. Please contact the agency for details regarding these rules.*

2. Legislative Enactment For purposes of this Section 2, "new" only applies to regular (non-emergency) rules promulgated in response to a Wyoming legislative enactment not previously addressed in whole or in part by prior rulemaking and does not include rules adopted in response to a federal mandate.

a. Are these non-emergency or regular rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☒ **No.** ☐ **Yes.** If the rules are new, please provide the Legislative Chapter Number and Year Enacted:	Chapter:	Year:

3. Rule Type and Information For purposes of this Section 3, "New" means an emergency or regular rule that has never been previously created.

a. Provide the Chapter Number, Title* and Proposed Action for Each Chapter. *Please use the "Additional Rule Information" form to identify additional rule chapters.*

Chapter Number	Chapter Name	Action
Chapter Number: 10	Chapter Name: Miscellaneous Medical Protocols	☐ New ☒ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
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Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	

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. ☐ **No.** ☐ **Yes.** ■ **N/A**

b. A public hearing was held on the proposed rules. ■ **No.** ☐ **Yes. Please complete the boxes below.**

Date:	Time:	City:	Location:

5. Checklist

a. ■ For regular rules, the Statement of Principal Reasons is attached to this Certification and, in compliance with Tri-State Generation and Transmission Association, Inc. v. Environmental Quality Council, 590 P.2d 1324 (Wyo. 1979), includes a brief statement of the substance or terms of the rule and the basis and purpose of the rule

b. ☐ For emergency rules, the Memorandum to the Governor documenting the emergency, which requires promulgation of these rules without providing notice or an opportunity for a public hearing, is attached to this Certification.

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct. By electronically submitting the emergency or regular rules into the Wyoming Administrative Rules System, the undersigned acknowledges that the Registrar of Rules will review the rules as to form and, if approved, the electronic filing system will electronically notify the Governor's Office, Attorney General's Office, and Legislative Service Office of the approval and electronically provide them with a copy of the complete rule packet on the date approved by the Registrar of Rules. The complete rules packet includes this signed certification page; the Statement of Principal Reasons or, if emergency rules, the Memorandum to the Governor documenting the emergency; and a strike and underscore copy and clean copy of each chapter of rules.

Signature of Authorized Individual	Elizabeth Gagen
Printed Name of Signatory	Elizabeth Gagen, J.D.
Signatory Title	Director
Date of Signature	05/22/2024

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	

State of Wyoming
Department of Workforce Services

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Mark Gordon
Governor

Elizabeth Gagen, J.D.
Director

Statement of Reasons
Workers' Compensation Division
Chapter 10: Miscellaneous Medical Protocols

The existing Section 8(a)(iv), "*Has primary purpose other than enhancing the personal comfort of the injured worker or providing convenience for the injured worker or caregiver*" inadvertently replaced the reference to "*Is not considered to be experimental or investigational,"* which became effective February 7, 2023. This erroneous replacement created a duplication with Section 8(v)(vii) and eliminated a necessary subsection. Therefore, the Division of Workers' Compensation is proposing to remove the duplicative language that currently exists in Section 8(a)(iv) and replace it with prior language in order to ensure the continued appropriate reimbursement for durable medical equipment-related claims.

Mark Gordon
Governor

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Robin Sessions Cooley, J.D.
Director

Elizabeth Gagen, J.D.
Deputy Director

May 22, 2024

Public Comments
Workers' Compensation Division
Chapter 10: Miscellaneous Medical Protocols

On April 1, 2024, the Secretary of State's office reviewed, accepted and posted this proposed rule on their website. The Department of Workforce Services (DWS) issued a press release, posted the proposed rules on social media, and posted a copy on DWS' public website under Public Notices.

DWS provided 49 days for the public to comment on this proposed rule, which expired on May 20, 2024. DWS did receive one question: "Are these requirements specific to a WY Division of Workers' Compensation program or do these requirements also apply to private carriers?"

DWS responded that the rules were specific to the Division and did not apply to *private* insurance carriers. No additional questions or comments were received.

CHAPTER 10

MISCELLANEOUS MEDICAL PROTOCOLS

Section 1. Acupuncture.

(a) The Division shall pay for acupuncture procedures only if the services are performed by a healthcare provider as defined in W.S. § 27-14-102(a)(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.

(i) The Division shall pay for acupuncture procedures performed by Acupuncturists who have been issued a license to practice acupuncture by the Wyoming Board of Acupuncture. The Division will only consider payment to a fully licensed Acupuncturist upon receipt of written orders from the injured worker's treating health care provider specifying the diagnosis and number of sessions or timeframe. To verify licensure go to: http://acupuncture.wyo.gov

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 requirement.

(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.

(ii) Pursuant to 49 CFR Part 40, a covered employer may test for any and all metabolites: including synthetic forms of: Amphetamines; Marijuana (cannabinoids); Cocaine (benzoylecgonine); 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.

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 any specific conditions, or lacks a valid scientific base.

Section 4. Biofeedback. Biofeedback services shall be paid according to Chapter 9, Section 2 of these rules. The following conditions apply:

(a) Individual meets the definition of "injury" under W.S. § 27-14-102(a)(xi); and,

(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;

(e) Treatment can 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 functional gains.

Section 5. Biological or Chemical Exposure Injury. The Division shall pay for the laboratory testing of any specimen collected from the body of an injured worker 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 injured worker 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 injured worker, 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 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 receive 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. The Division shall pay for compound prescription medications per Wyoming Worker' Compensation formulary listed at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/provider-bulletins/, National Drug Code (NDC) and the fee schedule listed in Chapter 9, Section 7 of these rules.

Section 8. Durable Medical Equipment (DME). The limitations in this section are in addition to any other limitation or restrictions that may apply to the Division's rental or purchase of any physical items or apparatus as a benefit under the Act.

(a) The Division will not rent or purchase or provide reimbursement for any physical item or apparatus for use by an injured worker unless there is proof that the item:

(i) Is medically necessary for the documented compensable work injury;

(ii) Is prescribed by a health care provider;

(iii) Is the most cost-effective method of meeting the medical need;

(iv) Is not considered to be experimental or investigational;

(v) Is designed to withstand repeated use in the home;

(vi) Generally is not useful to a person in the absence of an illness or injury;

(vii) Has primary purpose other than enhancing the personal comfort of the injured worker or providing convenience for the injured worker or caregiver;

(viii) Is the type of item that is suitable and commonly provided for home use or mobility under employer provided health insurance coverage, Medicare or Medicaid; and,

(ix) Generally has an expected lifetime of at least three (3) years.

(b) The Division may choose to rent or purchase any physical item or apparatus depending on its assessment as to which option is most reasonable and cost effective.

(c) 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.

(d) An injured worker shall be responsible for reasonable care and maintenance of any physical item or apparatus provided.

(i) The Division may cover needed repairs and maintenance when a professional is required and the services are not covered under warranty within the warranty period.

(ii) Providers shall not bill for equipment, parts, or services covered under manufacturer warranty within the warranty period.

(iii) The Division may require a copy of the warranty from the provider to be submitted upon request.

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 99050. This code 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. 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 devices(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 injured worker'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.

(a) 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 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.

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

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

Section 14. Impairment Ratings-Requirements.

(a) Pursuant to W.S. § 27-14-405(g) 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 instructions and complete all required measurements referencing all tables contained in 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 injured worker 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 injured worker's injury complaints, or to obtain a permanent partial impairment rating of the residual effects attributed to a compensable injury per 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 injured worker'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 healthcare provider as defined in W.S. § 27-14-102(a)(x) and it is in conjunction with other therapy modalities.

Section 17. Nursing Services. No fee under this section shall be allowed by the Division without first reviewing the fee for appropriateness and reasonableness in accordance with its adopted fee schedules.

(a) Home Health Nursing Services

(i) Home Health Nursing Services shall be intermittent, medically necessary, related to the work injury, documented in a plan of treatment, expected to last six (6) months or less, and ordered by a physician.

(ii) Initial prescriptions/orders for home health nursing services shall include the reason for home health skilled nursing, frequency, and duration.

(iii) Face to face visit. All new home health orders shall be accompanied by documentation of a face to face visit having occurred within ninety (90) days prior to the start of home health services.

(iv) Only independent Medicare/Medicaid certified agencies may provide home health nursing care;

(v) Only Certified Nursing Assistants, Licensed Practical Nurses, Licensed Vocational Nurses or Registered Nurses working for a Medicare/Medicaid certified agency can provide home health nursing care;

(vi) If the injured worker's residence is not within a fifty (50) mile radius of a Medicare/Medicaid certified agency, the Division may approve other alternatives such as Private Duty Nursing Services. Any such arrangement must have prior approval from the Division.

(vii) Home Health Nursing Services beyond six (6) consecutive months shall be reviewed by the Division to determine continued medical necessity.

(viii) Private Duty Services/Attendant Care. Private duty services/attendant care for long term daily care at home not being provided by a Home Health Agency, includes but not limited to; personal care for activities of daily living.

(ix) Initial prescriptions/orders for services shall include the reason for private duty services/attendant care, frequency, and duration.

(x) Private duty services/attendant care shall be provided by individuals who are approved by the primary treating health care provider.

(xi) Private duty services/attendant care shall be paid for a maximum of twelve (12) hours per day per provider.

(xii) Private duty services/attendant care required beyond twelve (12) consecutive months shall be reviewed by the Division; every twelve (12) months thereafter to determine continued medical necessity.

(b) Disclaimer of Employment. Persons performing services in the home of an injured worker are not employees of the State of Wyoming. The 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.

(c) Fees. See Chapter 9, Section 3 for specific information on fees for home health nursing, private duty services and attendant care.

(d) Nursing Facility Care Referral Process

(i) A referral for nursing facility placement shall be made by the treating health care provider. The referral shall be communicated to the Division by the treating health care provider and, when possible, the nursing facility, indicating the injured worker's medical needs require admission to or on the premises of a nursing facility. The request shall be reviewed by the Division for relatedness to the work injury and approved by the Director or designated representative. See Chapter 10, Section 28, Special Agreements for additional information on fee schedules and/or payment rates.

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 3, Subsection (gg)). 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) reliable 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 injured worker 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 injured worker's own words,

(v) Medical notes must include a history and physical exam focused relative to injured worker'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 injured worker presenting complaint,

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

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

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

(x) Medical notes must contain an indication of the specifics of the follow-up care plan and include return-to-work expectations.

Section 21. Physical Medicine and Restorative Services.

(a) Chiropractors, physical therapists, physical therapist 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 diagnosis or clinical impression consistent with 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 worker's primary treating health care provider, as defined in Chapter 1, Section 3(mm) of these Rules.

(c) The Division shall monitor claims for services and may require provider to submit a formal written treatment plan or supplemental report detailing the medical necessity, specific goals, number of sessions and timeframes 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 diagnostics studies or consultation may be considered.

(d) The Administrator adopts the *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 at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/treatment-guidelines/

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 Locality Specific Resource Based Value Scale (RBRVS), as adopted in Chapter 9, Section 2 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(o) as amended.

(a) Treatment rendered by a health care provider to a Wyoming Workers' Compensation injured worker 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 rules, regulations and treatment guidelines. Such treatment guidelines shall be predicated on relevant medical literature consistent with 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 website located at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/preauthorization/

(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 Division will inform health care providers when treatment guidelines are expanded or modified, or there are changes in the 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 email. The Provider Request for Preauthorization form can be obtained from the Division or through the internet at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/preauthorization/

(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).

(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, decision 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 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 provider is valid at the time of service.

(b) When medications prescribed for a compensable injury are dispensed on an outpatient basis, the Division will cover a brand name drug with an AB rated generic equivalent only if there is a documented medical necessity 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.

(c) Healthcare providers directly dispensing prescriptions will be paid based on the original manufacturer's NDC code and the Wyoming Fee Schedule for pharmaceuticals as set forth in the *Rules Wyo. Dep't of Workforce Servs., Workers' Com. Div, Ch9,* § 6.

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 the 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 the current eye examination, which results in 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 injured worker'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 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 injured workers 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 injured workers. 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 (6) 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 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 of experience in 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.

Section 32. Spinal Cord Stimulators. The Division shall not authorize payment for any neurostimulator procedures, including spinal cord dorsal stimulators and dorsal root ganglion neuroaugmentation, or any medical or surgical costs related to the placement, revision, or removal of any spinal cord stimulator.

Section 33. Surgical Procedures. Except as otherwise authorized in these Rules, the Division shall not preauthorize payment or reimburse for any surgery, including a minimally invasive surgical procedure, or related costs, unless performed by a board-certified surgeon or a provider eligible for board certification as a surgeon by virtue of education and training. Nothing in this section shall limit the Division's authority to deny payment for investigational or experimental procedures or for procedures not otherwise eligible for payment, including services defined as Experimental Care in these Rules.

CHAPTER 10

MISCELLANEOUS MEDICAL PROTOCOLS

Section 1. Acupuncture.

(a) The Division shall pay for acupuncture procedures only if the services are performed by a healthcare provider as defined in W.S. § 27-14-102(a)(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.

(i) The Division shall pay for acupuncture procedures performed by Acupuncturists who have been issued a license to practice acupuncture by the Wyoming Board of Acupuncture. The Division will only consider payment to a fully licensed Acupuncturist upon receipt of written orders from the injured worker's treating health care provider specifying the diagnosis and number of sessions or timeframe. To verify licensure go to: http://acupuncture.wyo.gov

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 requirement.

(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.

(ii) Pursuant to 49 CFR Part 40, a covered employer may test for any and all metabolites: including synthetic forms of: Amphetamines; Marijuana (cannabinoids); Cocaine (benzoylecgonine); 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.

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 any specific conditions, or lacks a valid scientific base.

Section 4. Biofeedback. Biofeedback services shall be paid according to Chapter 9, Section 2 of these rules. The following conditions apply:

(a) Individual meets the definition of "injury" under W.S. § 27-14-102(a)(xi); and,

(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;

(e) Treatment can 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 functional gains.

Section 5. Biological or Chemical Exposure Injury. The Division shall pay for the laboratory testing of any specimen collected from the body of an injured worker 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 injured worker 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 injured worker, 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 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 receive 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. The Division shall pay for compound prescription medications per Wyoming Worker' Compensation formulary listed at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/provider-bulletins/, National Drug Code (NDC) and the fee schedule listed in Chapter 9, Section 7 of these rules.

Section 8. Durable Medical Equipment (DME). The limitations in this section are in addition to any other limitation or restrictions that may apply to the Division's rental or purchase of any physical items or apparatus as a benefit under the Act.

(a) The Division will not rent or purchase or provide reimbursement for any physical item or apparatus for use by an injured worker unless there is proof that the item:

(i) Is medically necessary for the documented compensable work injury;

(ii) Is prescribed by a health care provider;

(iii) Is the most cost-effective method of meeting the medical need;

(iv) ~~Has primary purpose other than enhancing the personal comfort of the injured worker or providing convenience for the injured worker or caregiver;~~Is not considered to be experimental or investigational;

(v) Is designed to withstand repeated use in the home;

(vi) Generally is not useful to a person in the absence of an illness or injury;

(vii) Has primary purpose other than enhancing the personal comfort of the injured worker or providing convenience for the injured worker or caregiver;

(viii) Is the type of item that is suitable and commonly provided for home use or mobility under employer provided health insurance coverage, Medicare or Medicaid; and,

(ix) Generally has an expected lifetime of at least three (3) years.

(b) The Division may choose to rent or purchase any physical item or apparatus depending on its assessment as to which option is most reasonable and cost effective.

(c) 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.

(d) An injured worker shall be responsible for reasonable care and maintenance of any physical item or apparatus provided.

(i) The Division may cover needed repairs and maintenance when a professional is required and the services are not covered under warranty within the warranty period.

(ii) Providers shall not bill for equipment, parts, or services covered under manufacturer warranty within the warranty period.

(iii) The Division may require a copy of the warranty from the provider to be submitted upon request.

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 99050. This code 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. 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 devices(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 injured worker'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.

(a) 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 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.

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

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

Section 14. Impairment Ratings-Requirements.

(a) Pursuant to W.S. § 27-14-405(g) 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 instructions and complete all required measurements referencing all tables contained in 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 injured worker 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 injured worker's injury complaints, or to obtain a permanent partial impairment rating of the residual effects attributed to a compensable injury per 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 injured worker'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 healthcare provider as defined in W.S. § 27-14-102(a)(x) and it is in conjunction with other therapy modalities.

Section 17. Nursing Services. No fee under this section shall be allowed by the Division without first reviewing the fee for appropriateness and reasonableness in accordance with its adopted fee schedules.

(a) Home Health Nursing Services

(i) Home Health Nursing Services shall be intermittent, medically necessary, related to the work injury, documented in a plan of treatment, expected to last six (6) months or less, and ordered by a physician.

(ii) Initial prescriptions/orders for home health nursing services shall include the reason for home health skilled nursing, frequency, and duration.

(iii) Face to face visit. All new home health orders shall be accompanied by documentation of a face to face visit having occurred within ninety (90) days prior to the start of home health services.

(iv) Only independent Medicare/Medicaid certified agencies may provide home health nursing care;

(v) Only Certified Nursing Assistants, Licensed Practical Nurses, Licensed Vocational Nurses or Registered Nurses working for a Medicare/Medicaid certified agency can provide home health nursing care;

(vi) If the injured worker's residence is not within a fifty (50) mile radius of a Medicare/Medicaid certified agency, the Division may approve other alternatives such as Private Duty Nursing Services. Any such arrangement must have prior approval from the Division.

(vii) Home Health Nursing Services beyond six (6) consecutive months shall be reviewed by the Division to determine continued medical necessity.

(viii) Private Duty Services/Attendant Care. Private duty services/attendant care for long term daily care at home not being provided by a Home Health Agency, includes but not limited to; personal care for activities of daily living.

(ix) Initial prescriptions/orders for services shall include the reason for private duty services/attendant care, frequency, and duration.

(x) Private duty services/attendant care shall be provided by individuals who are approved by the primary treating health care provider.

(xi) Private duty services/attendant care shall be paid for a maximum of twelve (12) hours per day per provider.

(xii) Private duty services/attendant care required beyond twelve (12) consecutive months shall be reviewed by the Division; every twelve (12) months thereafter to determine continued medical necessity.

(b) Disclaimer of Employment. Persons performing services in the home of an injured worker are not employees of the State of Wyoming. The 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.

(c) Fees. See Chapter 9, Section 3 for specific information on fees for home health nursing, private duty services and attendant care.

(d) Nursing Facility Care Referral Process

(i) A referral for nursing facility placement shall be made by the treating health care provider. The referral shall be communicated to the Division by the treating health care provider and, when possible, the nursing facility, indicating the injured worker's medical needs require admission to or on the premises of a nursing facility. The request shall be reviewed by the Division for relatedness to the work injury and approved by the Director or designated representative. See Chapter 10, Section 28, Special Agreements for additional information on fee schedules and/or payment rates.

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 3, Subsection (gg)). 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) reliable 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 injured worker 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 injured worker's own words,

(v) Medical notes must include a history and physical exam focused relative to injured worker'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 injured worker presenting complaint,

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

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

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

(x) Medical notes must contain an indication of the specifics of the follow-up care plan and include return-to-work expectations.

Section 21. Physical Medicine and Restorative Services.

(a) Chiropractors, physical therapists, physical therapist 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 diagnosis or clinical impression consistent with 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 worker's primary treating health care provider, as defined in Chapter 1, Section 3(mm) of these Rules.

(c) The Division shall monitor claims for services and may require provider to submit a formal written treatment plan or supplemental report detailing the medical necessity, specific goals, number of sessions and timeframes 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 diagnostics studies or consultation may be considered.

(d) The Administrator adopts the *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 at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/treatment-guidelines/

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 Locality Specific Resource Based Value Scale (RBRVS), as adopted in Chapter 9, Section 2 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(o) as amended.

(a) Treatment rendered by a health care provider to a Wyoming Workers' Compensation injured worker 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 rules, regulations and treatment guidelines. Such treatment guidelines shall be predicated on relevant medical literature consistent with 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 website located at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/preauthorization/

(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 Division will inform health care providers when treatment guidelines are expanded or modified, or there are changes in the 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 email. The Provider Request for Preauthorization form can be obtained from the Division or through the internet at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/preauthorization/

(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).

(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, decision 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 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 provider is valid at the time of service.

(b) When medications prescribed for a compensable injury are dispensed on an outpatient basis, the Division will cover a brand name drug with an AB rated generic equivalent only if there is a documented medical necessity 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.

(c) Healthcare providers directly dispensing prescriptions will be paid based on the original manufacturer's NDC code and the Wyoming Fee Schedule for pharmaceuticals as set forth in the *Rules Wyo. Dep't of Workforce Servs., Workers' Com. Div, Ch9,* § 6.

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 the 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 the current eye examination, which results in 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 injured worker'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 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 injured workers 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 injured workers. 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 (6) 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 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 of experience in 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.

Section 32. Spinal Cord Stimulators. The Division shall not authorize payment for any neurostimulator procedures, including spinal cord dorsal stimulators and dorsal root ganglion neuroaugmentation, or any medical or surgical costs related to the placement, revision, or removal of any spinal cord stimulator.

Section 33. Surgical Procedures. Except as otherwise authorized in these Rules, the Division shall not preauthorize payment or reimburse for any surgery, including a minimally invasive surgical procedure, or related costs, unless performed by a board-certified surgeon or a provider eligible for board certification as a surgeon by virtue of education and training. Nothing in this section shall limit the Division's authority to deny payment for investigational or

experimental procedures or for procedures not otherwise eligible for payment, including services defined as Experimental Care in these Rules.