WAC 296-21-270 Mental health services. (1) The following rule supplements information contained in the fee schedules regarding coverage and reimbursement for mental health services.

(2) Treatment of mental conditions to workers is to be goal directed, time limited, intensive, targeted on specific symptoms and functional status and limited to conditions caused or aggravated by the industrial condition. Specific functional goals of treatment must be identified and treatment must have an emphasis on functional, measurable improvement towards the specific goals.

(3) Mental health services to workers are limited to those provided by psychiatrists, doctoral level psychologists, psychiatric advanced registered nurse practitioners, licensed independent clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and according to department policy. Psychiatrists and psychiatric advanced registered nurse practitioners may prescribe medications while providing concurrent care. For purposes of this rule, the term "mental health services" refers to treatment by psychologists, psychiatric advanced registered nurse practitioners, psychiatrists, licensed independent clinical social workers, licensed marriage and family therapists, and licensed mental health counselors.

(4) Initial evaluation, and subsequent treatment must be authorized by department staff or the self-insurer, as outlined by department policy. The report of initial evaluation, including test results, and treatment plan is to be sent to the worker's attending provider, as well as to the department or self-insurer. A copy of the 60-day narrative reports are to be sent to the department or self-insurer and to the attending provider.

(5)(a) All providers are bound by the medical aid rules in chapter 296-20 WAC. Reporting requirements are defined in chapter 296-20 WAC. In addition, the following are required: Testing results with scores, scales, and profiles; report of raw data sufficient to allow reassessment by a panel or independent medical examiner. Explanation of the numerical scales is required.

(b) Providers must use the edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association designated by the department in the initial evaluation, follow-up evaluations and 60-day narrative reports.

(c) A report to the department or self-insurer will contain, at least, the following elements:

(i) Subjective complaints;

(ii) Objective observations;

(iii) Identification and measurement of target symptoms and functional status;

(iv) Assessment of the worker's condition and goals accomplished in relation to the target symptoms and functional status; and

(v) Plan of care.

(6) The codes, reimbursement levels, and other policies for mental health services are listed in the fee schedules.

(7) When providing mental health services, providers must track and document the worker's functional status using validated instruments such as the World Health Organization Disability Assessment Schedule (WHODAS) or other substantially equivalent validated instruments recommended by the department. A copy of the completed functional assessment instrument must be sent to the attending provider and the department or self-insurer, as required by department policy or treatment guideline.

[Statutory Authority: RCW 34.05.313, 51.04.020, and 51.04.030. WSR 23-22-103, § 296-21-270, filed 10/31/23, effective 1/1/24. Statutory Authority: RCW 51.04.020, 51.04.030, and 51.08.142. WSR 15-19-139, § 296-21-270, filed 9/22/15, effective 10/23/15. Statutory Authority: RCW 51.04.020, 51.04.030. WSR 09-14-104, § 296-21-270, filed 6/30/09, effective 7/31/09. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. WSR 93-16-072, § 296-21-270, filed 8/1/93, effective 9/1/93.]