WSR 26-07-054
PROPOSED RULES
DEPARTMENT OF
LABOR AND INDUSTRIES
[Filed March 17, 2026, 8:28 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 25-24-088.

Title of Rule and Other Identifying Information: Medical aid rules: Conversion factors and maximum daily fees. WAC 296-20-135 Conversion factors, under chapter 296-20 WAC, Medical aid rules. WAC 296-23-220 Physical therapy rules and 296-23-230 Occupational therapy rules, under chapter 296-23 WAC, Radiology, radiation therapy, nuclear medicine, pathology, hospital, chiropractic, physical therapy, drugless therapeutics and nursing—Drugless therapeutics, etc.

Hearing Location(s): On April 21, 2026, 3:30 p.m., virtual and telephonic hearing at https://lni-wa-gov.zoom.us/j/85956374855?pwd=ZEbSirwaNIKSvldi0zGRl6Ti5Dtj1M.1, Meeting ID 85956374855, Passcode 980@%FFJ; or join by phone (audio only) 253-215-8782 US (Tacoma), 253-205-0468 US. The hearing will begin at 3:30 p.m. and will continue until all oral comments are received.

Date of Intended Adoption: May 5, 2026.

Submit Written Comments to: Megan Lemon, Department of Labor and Industries (L&I), Insurance Services, Health Services Analysis, P.O. Box 44322, Olympia, WA 98504-4322, email Megan.Lemon@Lni.wa.gov, fax 360-902-4249, beginning March 18, 2026, 8:00 a.m., by April 21, 2026, 5:00 p.m.

Assistance for Persons with Disabilities: Contact Megan Lemon, phone 360-902-5161, fax 360-902-4249, email Megan.Lemon@Lni.wa.gov, by April 14, 2026.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule making will (1) change the conversion factor used to calculate payment for anesthesia services; and (2) change the maximum daily payment for physical and occupational therapy.

WAC 296-20-135 (2) and (3), reduce the resource based relative value scale conversion factor from $58.33 to $57.17 and increase the anesthesia conversion factor from $3.91 to $4.06 per minute.

WAC 296-23-220 and 296-23-230, increase the maximum daily rate for physical and occupational therapy services from $149.45 to $155.04.

Reasons Supporting Proposal: These rules are to be updated to continually follow the established methodologies of L&I and maintain consistency with the health care authority and medicaid purchasing administration. These rules will provide medical aid updates regarding rate setting for professional health care services for injured workers.

Statutory Authority for Adoption: RCW 51.04.020(1) and 51.04.030.

Statute Being Implemented: RCW 51.36.080.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: L&I, governmental.

Name of Agency Personnel Responsible for Drafting: Megan Lemon, Tumwater, Washington, 360-902-5161; Implementation and Enforcement: Brenda Heilman, Tumwater, Washington, 360-902-4997.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply because the content of this rule sets fees and fits within the exception listed in RCW 34.05.328 (5)(b)(vi).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules set or adjust fees under the authority of RCW 19.02.075 or that set or adjust fees or rates pursuant to legislative standards, including fees set or adjusted under the authority of RCW 19.80.045.

Scope of exemption for rule proposal:

Is fully exempt.

March 17, 2026
Joel Sacks
Director

RDS-7015.2

AMENDATORY SECTION (Amending WSR 25-11-075, filed 5/20/25, effective 7/1/25)

WAC 296-20-135 Conversion factors. (1) Conversion factors are used to calculate payment levels for services reimbursed under the Washington resource based relative value scale (RBRVS), and for anesthesia services payable with base and time units.

(2) **Washington RBRVS** services have a conversion factor of ((~~$58.33~~)) $57.17. The fee schedules list the reimbursement levels for these services.

(3) **Anesthesia services** that are paid with base and time units have a conversion factor of ((~~$3.91~~)) $4.06 per minute, which is equivalent to ((~~$58.65~~)) $60.90 per 15 minutes. The base units and payment policies can be found in the fee schedules.

RDS-7028.1

AMENDATORY SECTION (Amending WSR 25-11-075, filed 5/20/25, effective 7/1/25)

WAC 296-23-220 Physical therapy rules. Practitioners should refer to WAC 296-20-010 through 296-20-125 for general information and rules pertaining to the care of workers.

Refer to WAC 296-20-132 and 296-20-135 regarding the use of conversion factors.

All supplies and materials must be billed using HCPCS Level II codes. Refer to chapter 296-21 WAC for additional information. HCPCS codes are listed in the fee schedules.

Refer to chapter 296-20 WAC (WAC 296-20-125) and to the department's billing instructions for additional information.

Physical therapy treatment will be reimbursed only when ordered by the worker's attending doctor and rendered by a licensed physical therapist, a physical therapist assistant serving under the direction of a licensed physical therapist as required in RCW 18.74.180 (3)(a), or a licensed athletic trainer serving under the direction of a licensed physical therapist as required in RCW 18.250.010 (4)(a)(v). In addition, physician assistants may order physical therapy under these rules for the attending doctor. Doctors rendering physical therapy should refer to WAC 296-21-290.

The department or self-insurer will review the quality and medical necessity of physical therapy services provided to workers. Practitioners should refer to WAC 296-20-01002 for the department's rules regarding medical necessity and to WAC 296-20-024 for the department's rules regarding utilization review and quality assurance.

The department or self-insurer will pay for a maximum of one physical therapy visit per day. When multiple treatments (different billing codes) are performed on one day, the department or self-insurer will pay either the sum of the individual fee maximums, the provider's usual and customary charge, or ((~~$149.45~~)) $155.04 whichever is less. These limits will not apply to physical therapy that is rendered as part of a physical capacities evaluation, work hardening program, or pain management program, provided a qualified representative of the department or self-insurer has authorized the service.

The department will publish specific billing instructions, utilization review guidelines, and reporting requirements for physical therapists who render care to workers.

Use of diapulse or similar machines on workers is not authorized. See WAC 296-20-03002 for further information.

A physical therapy progress report must be submitted to the attending doctor and the department or the self-insurer following 12 treatment visits or one month, whichever occurs first. Physical therapy treatment beyond initial 12 treatments will be authorized only upon substantiation of improvement in the worker's condition. An outline of the proposed treatment program, the expected restoration goals, and the expected length of treatment will be required.

Physical therapy services rendered in the home and/or places other than the practitioner's usual and customary office, clinic, or business facilities will be allowed only upon prior authorization by the department or self-insurer.

No inpatient physical therapy treatment will be allowed when such treatment constitutes the only or major treatment received by the worker. See WAC 296-20-030 for further information.

The department may discount maximum fees for treatment performed on a group basis in cases where the treatment provided consists of a nonindividualized course of therapy (e.g., pool therapy; group aerobics; and back classes).

Biofeedback treatment may be rendered on doctor's orders only. The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of a licensed physical therapist. See chapter 296-21 WAC for rules pertaining to conditions authorized and report requirements.

Billing codes and reimbursement levels are listed in the fee schedules.

RDS-7029.1

AMENDATORY SECTION (Amending WSR 25-11-075, filed 5/20/25, effective 7/1/25)

WAC 296-23-230 Occupational therapy rules. Practitioners should refer to WAC 296-20-010 through 296-20-125 for general information and rules pertaining to the care of workers.

Refer to WAC 296-20-132 and 296-20-135 for information regarding the conversion factors.

All supplies and materials must be billed using HCPCS Level II codes, refer to the department's billing instructions for additional information.

Occupational therapy treatment will be reimbursed only when ordered by the worker's attending doctor and rendered by a licensed occupational therapist or an occupational therapist assistant serving under the direction of a licensed occupational therapist. In addition, physician assistants may order occupational therapy under these rules for the attending doctor. Vocational counselors assigned to injured workers by the department or self-insurer may request an occupational therapy evaluation. However, occupational therapy treatment must be ordered by the worker's attending doctor or by the physician assistant.

An occupational therapy progress report must be submitted to the attending doctor and the department or self-insurer following 12 treatment visits or one month, whichever occurs first. Occupational therapy treatment beyond the initial 12 treatments will be authorized only upon substantiation of improvement in the worker's condition. An outline of the proposed treatment program, the expected restoration goals, and the expected length of treatment will be required.

The department or self-insurer will review the quality and medical necessity of occupational therapy services. Practitioners should refer to WAC 296-20-01002 for the department's definition of medically necessary and to WAC 296-20-024 for the department's rules regarding utilization review and quality assurance.

The department will pay for a maximum of one occupational therapy visit per day. When multiple treatments (different billing codes) are performed on one day, the department or self-insurer will pay either the sum of the individual fee maximums, the provider's usual and customary charge, or ((~~$149.45~~)) $155.04 whichever is less. These limits will not apply to occupational therapy which is rendered as part of a physical capacities evaluation, work hardening program, or pain management program, provided a qualified representative of the department or self-insurer has authorized the service.

The department will publish specific billing instructions, utilization review guidelines, and reporting requirements for occupational therapists who render care to workers.

Occupational therapy services rendered in the worker's home and/or places other than the practitioner's usual and customary office, clinic, or business facility will be allowed only upon prior authorization by the department or self-insurer.

No inpatient occupational therapy treatment will be allowed when such treatment constitutes the only or major treatment received by the worker. See WAC 296-20-030 for further information.

The department may discount maximum fees for treatment performed on a group basis in cases where the treatment provided consists of a

nonindividualized course of therapy (e.g., pool therapy; group aerobics; and back classes).

Billing codes, reimbursement levels, and supporting policies for occupational therapy services are listed in the fee schedules.