Concise Explanatory Statement (CES)

The purpose of this rulemaking is to establish a new statewide medical provider network. This rulemaking includes the following new WAC sections.

NEW SECTIONS

WAC 296-20-01010	Scope of Health Care Provider Network
WAC 296-20-01020	Health Care Provider Network Enrollment
WAC 296-20-01030	Minimum Health Care Provider Network Standards
WAC 296-20-01040	Health Care Provider Network Continuing Requirements
WAC 296-20-01050	Health Care Provider Network Further Review and Denial
WAC 296-20-01060	Delegation of Credentialing and Recredentialing Activities
WAC 296-20-01070	Waiting Periods for Reapplying to the Network
WAC 296-20-01080	Management of the Provider Network
WAC 296-20-01090	Request for Reconsideration of Department Decision
WAC 296-20-01100	Risk of Harm

I. *Reasons for adopting the rule change*:

Substitute Senate Bill 5801 (SSB 5801, Chapter 6, Laws of 2011) amends RCW 51.36.010 and directs the Department of Labor & Industries (Department or L&I) to establish a medical provider network for injured workers of both state fund and self-insured employers and to expand Centers of Occupational Health and Education (COHEs). Rules are necessary to implement the changes. The Department will create and/or amend necessary rules in phases. The initial set of rules is needed for the establishment of the medical provider network.

These rule changes are expected to improve quality of medical services provided to injured and ill workers and reduce long-term disability and associated costs. These new rules enable the Department to establish an open medical network, using common standards for medical providers, while still allowing injured workers to choose their provider. The changes will help return more workers to good health and get them back on the job after an injury.

Additionally, statute requires L&I to seek the input of the Industrial Insurance Medical Advisory Committee (IIMAC) and to form a Provider Network Advisory Group (PNAG). The PNAG includes representatives from business, labor, IIMAC, and the Industrial Insurance Chiropractic Advisory Committee (IICAC).

The Department has developed these rules with the assistance of the PNAG and IIMAC. A subcommittee of IIMAC drafted the risk of harm language, and the full IIMAC, in a public meeting with public comment, refined and approved the language. The PNAG assisted in the development of minimum provider credentialing standards over two public meetings, which included public comments, and provided detailed feedback in one meeting on the overall rules.

The intended date of adoption for this rule is January 3, 2012

The intended effective date for this rule is February 3, 2012.

II. Purpose of the concise explanatory statement:

The purpose of this document is to respond to the oral and written comments, directly related to the proposed rule language, received through the public comment period and public hearings. The public comment period for this rulemaking began November 1, 2011, and ended December 16, 2011.

III. Public hearings:

Three public hearings were held to receive comments from interested parties regarding this rulemaking. The hearings took place on December 8th at SeaTac Airport, December 12th in Tumwater, and December 16th in Spokane; two hearings were held during business hours and one was held in the evening. Each hearing had about ten attendees; three people testified at the first hearing, four testified at the second hearing, and none at the third hearing.

Total Attendance: 31 individuals attended the hearings

- Signed in supporting the proposed rule: 9
- Signed in opposing the proposed rule: 6
- Signed in supporting the proposed rule with minor changes: 9

IV. Summary of comments received directly related to this rulemaking, including Department responses and, where applicable, changes to the rules:

The Department received 39 written comments from provider associations, individual providers, attorneys, a medical device manufacturer, and a labor representative. About 15 submissions, most from organizations, contained detailed comments on sections of the rule, which are responded to in the corresponding section. Six commenters expressed support for the rule, while 20 opposed.

Overall Rule Comments

Comments:

The Department received oral and written comments supporting the rule, with representative comments below.

Creating a Medical Provider Network and expanding the Centers for Occupational Health Education supports our shared goal of injured workers' receiving the best possible care from the beginning of their claims. Access to qualified care providers is a key to meeting this goal. As we build and shape the Medical Provider Network and COHE Expansion, we aim to strike the right balance of rigor around the quality of care without being so restrictive that we exclude quality providers or discourage good providers from applying.

The Provider Network Advisory Group worked to define and outline the important elements necessary to ensure the success of the new provide network. These efforts were developed over six months of consideration. We reviewed and gave consideration to all issues related to these important steps. A consensus was arrived at in proposing what is before you today.

After an initial review, I support the proposal as written. We deal with many claims where the providers that are managing those claims do not use sound objective-based medicine to determine whether or not to accept or extend a claim. And I think that anything that can strengthen the network of providers and ensure that they are credentialed to use objective-based medicine to make those determinations would be an improvement and eventually save the state and employers a great deal of money as well as time.

The Department also received oral and written comments opposing the rule; with representative comments below.

I think that will make it more difficult for injured workers to find treating physicians, and obviously it will limit their choice of doctors that they can choose to treat them. And I think these things are in violation of other aspects of Title 51 and the industrial insurance laws and intent. The L&I system has become increasingly cumbersome and difficult to provide the care that is needed. Any new regulations that decrease due process would be very problematic.

I am quite concerned that if the rules pass as they are written, we are doing a disservice to injured workers throughout the state of Washington, to the medical providers who offer the needed care, and ultimately to the Department of Labor and Industries. If the proposed rules become final, workers will see a vast decrease in the number of medical providers and medical care will suffer. All in all, the entire rule seems to go way beyond what is needed to set up a network of licensed and competent providers of all types.

I am opposed to the new medical network. This takes away the patients right to the provider of their choice; it takes away providers ability to treat injured workers and reduces the quality of care to injured workers. If injured workers are unable to get quality care they will be out of

work longer and finally return with greater disabilities than before. This is bad for industry and workers.

I have grave concerns about L&I, but particularly with self insurers putting together their own provider panels. This network will only cause more issues because the end result is L&I will pick who they want as a doctor to do their bidding or you will not be included. In other words those that will say the injured worker's condition is fixed and stable forcing the injured worker to appeal every denial for treatment.

Please do not allow this WAC to pass. As written it is without due process and allows one person to choose the worker's attending physician.

We believe that doctors should not be automatically terminated from the network for treatment or procedures that are outside the guidelines. We are concerned that individual clinical circumstances and decisions will not be considered in the guideline development and implementation process. The Department rules and guidelines much be more flexible to allow treatment where strictly following Department guidelines is a potential risk of harm to the patient.

Response: The Department agrees that a medical provider network is required by the worker's compensation reform law passed in 2011 and that it supports the goal of injured workers' receiving the best possible care through access to qualified care providers. The draft rules were carefully crafted by Department staff and the newly formed Provider Network Advisory Group that is composed of four physicians, two chiropractors, two business representatives, and two labor representatives. Over the course of six months of discussion, including four public meetings, the advisory group drafted, revised, and finally approved the rules through a consensus process.

The main reasons expressed for opposing the rule include the following four themes, addressed below: decreased access, closed or limited network, self-insured standards, and appeal rights.

1) <u>It will decrease access</u>
   The Department is committed to broad access and recruitment and has proposed an open network with transparent minimum standards. Workers will have their choice of a provider in the network for ongoing care and the network rules include an exception in case adequate coverage within a geographic area is not maintained by the planned January 1, 2013, start date. The Department based the network requirements on common criteria among private and public payers; and further refined them by ensuring they had full support from the advisory group, particularly unanimous support from the six provider representatives. This resulted in generally more favorable criteria to providers, but the Department believes the criteria will ensure and promote quality.

2) <u>The network is limited or inclusion is based on selection by medical director</u>
   The network is open to all providers. The Department encourages all providers to apply. As further described in the subsections below, the Department will approve any provider meeting the minimum standards and continuing requirements. The Department is using an

industry standard and a National Committee for Quality Assurance (NCQA) recommended process to make the enrollment decisions. To ensure the input of a senior clinician, the Medical Director has the final review of these important decisions to ensure they are made following the criteria established in the rule and policy. As noted in the rule, applications requiring further review will also include recommendations of other clinicians based on peer or clinical review; a credentialing committee, or the industrial insurance medical or chiropractic advisory committees.

3) Self-insured employers are not subject to the same standard
Self-insured employers are subject to the same rule. Both the statute creating the medical provider network and the network rules require that the standards apply to workers covered by either the Washington state fund or self-insured employers.

4) Providers can't appeal a decision
There are several opportunities for appeal or review of a decision. The rule includes a process for a provider to request reconsideration of a decision using timelines that are common for review of most Department decisions. The appeal rights that apply to any Department action remain in effect and contain the process for further appeal. These rules do not limit this process. Clarifying language has been added to be explicit that the current appeal process applies.

Rule Change: The Department intends to adopt the medical provider network rules, with clarifying changes as specified, by section, below.

WAC 296-20-01010 Scope of Health Care Provider Network

The Department received oral and written comments related to the scope of the provider network, summarized below.

Comments:

a. *This implementation date in the Rule exceeds the authority of the statute by imposing a drop dead implementation date.*
b. *The Rule should specify that health care providers of a type not listed in this subsection may still treat injured workers under existing Rules.*
c. *There isn't a reference to psychologists in the listing of providers in the network. I'm concerned that it is not listed in the initial phase.*
d. *Disagree with ER physicians' exclusion and ability for them to continue to get paid for follow-up care; and there is a substantial fiscal incentive for ER providers to maintain volume by having worker's comp patients follow up care, but ER providers generally have little training in occupational medicine.*
e. *Change ER Physician to ER Provider.*
f. *Must all doctors performing IME's be in the network to continue to perform IME's?*

Response:

a. The Department disagrees that specifying an implementation date exceeds the authority granted by SSB 5801 to implement a health care provider network. The implementation date is needed for the Department to provide notice on when the network will formally begin and delineate when the requirements will apply.
b. We agree, the rule does specify at (3) and (4) that providers not listed may still be reimbursed for treatment beyond the initial visit.
c. The Department is phasing in the rules, starting with those listed as attending providers, and psychologists are not attending providers. Under (4), L&I will phase in standards for other provider types. Until they are invited to join the network, other provider types can continue to treat injured workers without joining.
d. The Department shares the concern that some providers will not be subject to the same standards, but needs to phase implementation in. The network advisory group discussed adding limitations on the ER exclusion, but could not identify a limitation that would be viable and not unduly restrict emergent care. The Department will monitor this issue.
e. Agreed, the exclusion should be for emergency room providers, not solely ER physicians.
f. The first phase of network standards applies only to attending providers that are providing ongoing treatment, including: physicians, chiropractors, naturopathic physicians, doctors of podiatry, advanced registered nurse practitioners, physician assistants, dentists, and optometrists. L&I will phase in standards for other provider types. An IME doctor would need to apply to the network if they are also providing ongoing treatment as one of the provider types listed above.

Rule Change: The Department made six clarifying changes to this section: five minor wording changes to ensure consistency in terms throughout the rule, and one to clarify the exception for ER providers.

WAC 296-20-01020 Health Care Provider Network Enrollment

The Department received oral and written comments related to the health care provider network enrollment, summarized below.

Comments:

a. *Several commenters requested the Department include a deadline by which applications will be processed by the Department. Based on a sense that this provides fairness and balance because health care providers are required to meet deadlines. Alternatively, a commenter requested adding "within a reasonable time".*
b. *Opposed to the rule because providers must have a DEA registration to be included in the network, and not all providers prescribe.*

c. *Current language refers to the "The Department" will not pay or may pay, but there is no language about self-insurers.*
d. *The Department, not the Department's medical director or designee should be authorized to deny or approve applications.*
e. *Opposed to the requirement for attestation; and provisional enrollment was too vague.*
f. *Requested the Department pay for care prior to application approval; bills from non-network doctors will not be paid after initial visit, but concern expressed if the injured worker is non-English speaking and doesn't know the laws, or doctor doesn't know the new insurance rules and provides treatment, and it is not lawful to bill client.*

Response:

a. The Department's goal is to ensure a robust provider network with timely processing and agrees that including "within a reasonable time" is important. The Department disagrees with comments requesting 30 day timeframes. The current industry standards and NCQA requirements for processing provider applications range from 90 to 120 days; and NCQA requires notification within 60 days after a credentialing committee decision is reached (not after receipt).
b. The Department agrees that not all providers need to have a DEA registration and the current rule requires a current DEA registration only if applicable to the provider's scope of practice.
c. The Department agrees that the medical provider network rules regarding payment to only network providers should apply to both self-insurers and the Department.
d. The Department believes designating the individual within the organization responsible for approving or denying applications, consistent with these rules, improves accountability and transparency, as well as demonstrates consistency with industry best practice. The law and rules specify that the Department will approve any provider meeting the minimum standards and continuing requirements. The Department is using an industry standard and a National Committee for Quality Assurance (NCQA) recommended process to make enrollment decisions. To ensure the input of a senior clinician, the medical director has the final review of these important decisions to ensure they are made following the criteria established in rule and policy. As noted in the rule, applications requiring further review will also include recommendations of other clinicians based on peer or clinical review; a credentialing committee, or the industrial insurance medical or chiropractic advisory committees. The Department disagrees that attestation provisions be removed because standard provider applications require them. The Department disagrees that additional rules are required to describe provisional enrollment, procedural steps and instructions will be included in implementation.
e. The Department disagrees with the request to pay for care prior to an approved application. Paying only network providers is fundamental to the network establishment and goals of ensuring quality care by approved providers. Provisional enrollment and the ability to pay for an initial visit are included to assure timely access for urgent care and first visits, plus ongoing treatment if a provider is not currently in the network.

Rule Change: The Department made four clarifying changes to this section: one editorial correction, one correction to clarify the Department's response time, and two changes to clarify application to both the Department and self-insurers.

WAC 296-20-01030 Minimum Health Care Provider Network Standards

The Department received oral and written comments related to the health care provider network standards, summarized below.

Comments:

a. *Some commenters disagreed with all minimum standards, indicating that no doctors will pass the standards because a doctor has to be perfect, literally perfect without ever a complaint, malpractice claim, investigation (formal or informal); or that they were too broad.*
b. *Some commenters agreed with the requirement to sign the provider contract without modification for reasons of standardization; some requested to review the contract before finalization; and some commenters opposed the requirement to sign without modification.*
c. *Some commenters agreed that language allowing flexibility as professional liability standards and economic circumstances change; while other commenters disagreed that there should be amounts specified or that amounts specified by the Department left an unreasonable degree of authority to the Department in determination of the adequacy of professional liability coverage and may be applied differentially to individual providers.*
d. *One commenter objected to the minimum standard related to limitation of clinical admitting and management privileges.*
e. *Several commenters expressed concern that physicians who have been terminated for convenience from public program such as Medicaid or other program would not meet the minimum health care provider network standards, and would therefore be excluded, but these terminations are not for quality of care or cause issues and they may have no appeal rights.*
f. *Some commenters questioned "material misstatement or omission" as not being defined, or requested that it included intent.*
g. *One commenter objected to the minimum standard related to felony convictions as overly broad and requested it be limited to crimes that could impact care and management of patients, while another requested a time limit.*
h. *One commenter objected to the minimum standard related to licenses being free of restrictions, limitations, or conditions as too broad.*

Response:

a. The Department disagrees that the minimum standards proposed are overly difficult or that no doctors will pass the standards. Most of the minimum standards are based on the statutory provisions which commercial and other public payers currently require

either equivalent or higher standards. The Provider Network Advisory Group carefully considered each minimum standard and all members unanimously supported the proposed standards.

b. The Department agrees that current industry practice and a need for standardization require signing a contract without modification. The Department will make the agreement available to interested stakeholders prior to finalizing, but disagrees that individual change and negotiation is appropriate.
c. Specifying an amount of malpractice insurance is one of the statutory requirements and an industry standard. The ability for the Department to adjust was suggested by the network advisory group to ensure that for certain provider types, a different amount (potentially lower) would be more appropriate, especially where future network phases include ancillary providers. The Department does not intend that the amounts specified would be applied individually and agrees that providing an opportunity to comment prior to any additional specification is appropriate.
d. The Department disagrees that this is overly burdensome and agrees with the Provider Network Advisory Group recommendation.
e. Several commenters expressed concern that physicians who have been terminated for convenience from a public program such as Medicaid or other programs would not meet the minimum health care provider network standards, and would therefore be excluded, but these terminations are not for quality of care or cause issues and they may have no appeal rights.
f. The Department agrees that a technical oversight or omission should not be grounds for denial and included "material" before "misstatement or omission". The Department disagrees that intent must be demonstrated if the misstatement is material. The Provider Network Advisory Group also discussed this issue and recommended the proposed language based on consistency with industry standard and the difficulty in proving intent.
g. The minimum qualification related to criminal history is limited to felony convictions and includes an exception if the applicant has the record expunged. The Provider Network Advisory Group considered felonies, gross misdemeanors, and all crimes related to health care and unanimously agreed that the appropriate level for a minimum standard was a felony. The Department agrees with this decision.
h. The Department disagrees that a minimum standard related to licenses being free of restrictions, limitations, or conditions is too broad. The standard is based on the statutory requirement and consistent with public and commercial payers as well as the network goal of ensuring providers deliver quality care.

Rule Change: The Department made seven clarifying changes to this section: two changes to make terms consistent, one editorial correction, two corrections to clarify the Department's intent to provide opportunity for comment, and two changes to clarify that termination is based on cause.

WAC 296-20-01040 Health Care Provider Network Continuing Requirements

The Department received oral and written comments related to the health care provider network continuing requirements, summarized below.

Comments:

a. *Subsection (2) does not make sense when parsed out – i.e. "Provide services according to … billing instructions. Other commenters requested adding BIIA and Court orders, and medical director coverage decisions if that is not covered by rules and policies.*
b. *Subsection (3) "material compliance" is not defined. Several commenters disagreed with the requirement to maintain compliance with the Department's evidence based coverage decision and treatment guidelines, because they believe they are controversial, not applicable to individual patients and clinical scenarios, or would require a provider to choose between providing care they believe is appropriate and risk network removal. Others requested additional language similar to language in the statute or clarifying the role that individual patient variation and clinical judgment play. One commenter indicated that they were anticipating that there would be something about following best practices guidelines or something alluding to best occupational medicine guidelines and encouraged language related to it. One commenter suggested that Department standards, decisions, policies and guidelines be kept up-to date and in an easily accessible fashion, such as a handbook on a provider page.*
c. *Several commenters requested more time for notification of changes to L&I, generally 30 days.*

Response:

a. The Department agrees that an editorial change is necessary for subsection (2).
b. The Department and Provider Network Advisory Group spent significant time discussing on requirements contained in subsection (3) and the next section for compliance with Department standards, coverage decisions, and treatment guidelines. The statute that the Department is implementing addresses this directly: "Network providers must be required to follow the Department's evidence-based coverage decisions and treatment guidelines, policies and must be expected to follow other national treatment guidelines appropriate for their patient." We agree with the statutory requirement, the provider network advisory group, and comments that a core component of the network's ability to increase quality care is to ensure Department policy and rules, as well as treatment guidelines are followed. We agree that mirroring the statutory language is best to ensure consistency with this legal requirement and addresses the concern that a guideline needs to be appropriate for the patient. The Department will continue to publish guidelines on its website and notify providers affected through list-serves and other mechanisms, including working with provider associations to distribute notice of updates or important changes. The Department is open to additional suggestions on

how best to ensure ongoing communication and network implementation strategies to assure workers receive appropriate high quality care.

c. The Department disagrees that two weeks is insufficient if providers have major changes that could impact their ability to practice or their patients' ability to seek care or communicate with them. A survey of public and private payer requirements ranged from a notification period of "immediate", to 3 days, 7 days, and 10 days. The Department originally proposed 7 days, but agreed to change to 14 days based on discussion and request from the provider network advisory group.

Rule Change: The Department made two clarifying changes to this section: one editorial correction, and one correction to ensure consistency with the statute about applicability of treatment guidelines.

WAC 296-20-01050 Health Care Provider Network Further Review and Denial

The Department received oral and written comments related to the health care provider network review and denial section, summarized below.

Comments:

a. *Subsection (1) includes 'credentialing information obtained from other sources'. Several commenters requested limiting the Department review to confirming what is in the providers application or getting the provider's permission to contact other sources.*
b. *Subsection (2) gives authority specifically to the medical director or designee. Several commenters object because it is too much power for one individual or on the basis that it gives the medical director authority to choose only those providers he/she likes. This will eliminate ability of workers to trust the doctors and will close the system to many. Objective verifiable renewable standards must be established to avoid arbitrary and capricious elimination of attending physicians.*
c. *Subsection (3) – This subsection lists the reasons the dept. may deny a provider application. Some commenters agreed that there can and should be such a list according to the statute while others disagreed with one or more criteria. Some commenters felt that the 'including, but not limited to' language was too broad and left open the possibility that denial could be for no reason.*
d. *Nowhere in this list of minimum standards is the requirement that the provider be credentialed by another health plan which uses NCQA or similar guidelines. This was intended to be the primary requirement for participation in the provider network. Instead, these rules propose setting up an extensive and separate application and credentialing process. This provides broader authority to the Office of the Medical Director than the stakeholders agreed to, and promises to severely limit the pool of providers willing to treat injured workers.*

Remaining comments are specific to each review criteria

e. *Subsection (3)(c)/(d) Doctors with orders issued against them cannot be part of the network, or can be removed or suspended it seems, but what if the Department's allegations and corresponding Order are incorrect and false. Additionally, any pending statement of charges or notice of proposed disciplinary action should be limited to final actions.*
f. *Subsection (3)(e)/(f) – Some commenters objected to any termination being reviewed and others requested including terminations for convenience while others requested; some commenters wanted fewer terms or clarification or terms such as expelled, excluded or terminated. Additionally commenters noted that commercial plans may terminate for business reasons, this could allow a provider's application to be denied if he or she was terminated from an insurance plan without cause. Some commenters were concerned that commercial plans may terminate for business reasons, this could allow a provider's application to be denied if he or she was terminated from an insurance plan without cause.*
g. *Subsection (g) This section should be revised to eliminate the terms "while under investigation for." If allegations were unfounded, a provider's application should not be denied. An alternative approach would be to suspend the review of the application and suspend the 60 day time period until the investigation is completed.*
h. *Subsection (3)(h) Some commenters objected to the alternative of an inpatient coverage plan in place acceptable to the Department.*
i. *Subsection (3)(i) includes "significant malpractice claims" – while it does say based on severity, recency, frequency, or repetition, rules are provided to define terms and put parameters around the assessments. These terms are not defined, and no explanation is provided as to how they will be viewed.*
j. *Subsection (3)(j) There is a concern around treatment flexibility related to following treatment guidelines. The Department's treatment guidelines are intended to be guidelines and there is a concern that doctors should not be automatically terminated from the network for treatment or procedures that are outside the guidelines. Another commenter proposed inserting language to the effect that where the BIIA, or any court, has ordered the worker receive proper and necessary treatment, it shall not disqualify providers.*
k. *Subsection (3)(k)(l) There was a concern that the criteria related to negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow up was too broad; another comment that is was repetitive of malpractice claims; another comment to add "serious" before injury to worker; and a concern about due process.*
l. *Subsection (3)(m) – should require 'knowingly' using an unlicensed provider.*
m. *Subsection (3)(n) concern about the criteria related to a provider with a history of alcohol or chemical dependency; requiring furnishing of documentation; or requiring compliance with any treatment; and what private limitations means.*
n. *Subsection (3)(o) What is an informal licensure action, condition or agreement? Should these always disqualify a provider from the network? Are they likely to be administrative and not related to patient care?*

o. *Subsection (3)(q) the language, 'or has a history of other significant billing irregularities' is too vague and broad. There should be some administrative or court finding that the provider has engaged in billing fraud or abuse.*
p. *Subsection (3)(r) Concern that the subsection on complaints is too vague.*
q. *Subsection (3)(s) Concern that a provider can be denied for any criminal history, is overly broad.*

Response:

a. The Department needs to be able to ensure that applications are complete and will use standard credentialing processes, which includes information obtained from other organizations, or public entities. The Department will ensure that providers have an opportunity to supplement or explain any information prior to a final decision.
b. The Department believes designating the individual within the organization responsible for approving or denying applications, consistent with these rules, improves accountability and transparency, as well as demonstrates consistency with industry best practice. The law and rules specify that the Department, through the medical director, will approve any provider meeting the minimum standards and continuing requirements. The Department is using an industry standard and a National Committee for Quality Assurance (NCQA) recommended process to make enrollment decisions. To ensure the input of a senior clinician, the Medical Director has the final review of these important decisions to ensure they are made following the criteria established in rule and policy. As noted in the rule, applications requiring further review will also include recommendations of other clinicians based on peer or clinical review, a credentialing committee, or the industrial insurance medical or chiropractic advisory committees.
c. The Department agrees with commenters, the statute, and the Provider Network Advisory Group that listing the criteria that trigger additional review is important for transparency and effective maintenance of the network. The Department emphasizes that these will trigger a review and can be considered by the Department, but would not automatically or necessarily require denial. The Department agrees that the language "but not limited to" may leave the criteria overly broad.
d. The Department agrees that credentialing by another entity is encouraged and provides evidence of current compliance with some standards, and will make the provider application process more streamlined, but disagrees that this is required for enrollment in the provider network.

Responses to specific review criteria

e. Subsection (3)(c)/(d) The review criteria do not equal an automatic denial. The language in (c) indicates that the Department can review clinicians who are non-compliant with disciplinary or license restrictions; additionally the Department would review and pending statement of charges. For providers with pending allegations the Department determines are serious enough to warrant denial, a provider may re-apply after the pending charges are resolved.

f. Subsection (3)(e)/(f) – The Department agrees with the current industry standards as well as Provider Network Advisory Group that termination, expulsion, and exclusion are important criteria that would trigger further review. The terms are not further defined because different entities use different terms. The Department further agrees that a provider would not be denied enrollment solely on the basis of a termination that was related to a business management reason of a plan or other organization, and has included an exception for that.
g. The Department agrees that if allegations under investigation are resolved, the provider should be permitted to re-apply and the Department has included an exception to the waiting period for re-application period.
h. The Department agrees with the Provider Network Advisory Group who recommended additional flexibility to the requirement for clinical admitting and management principles. The Department included an alternative option if a provider does not have clinical admitting privileges; and disagrees with comments that the alternative coverage plan should not be reviewed and found acceptable by the Department.
i. The Department agrees that malpractice claims are an important criterion to trigger review and agrees with the Provider Network Advisory Group recommended language that ensures that not every claim would be a reason for denial and further defines significance with the factors the Department will consider.
j. The Department and Provider Network Advisory Group spent significant time discussing requirements contained in subsection (3) and the next section for compliance with Department standards, coverage decisions, and treatment guidelines. The statute that the Department is implementing addresses this directly: "Network providers must be required to follow the Department's evidence-based coverage decisions and treatment guidelines, policies and must be expected to follow other national treatment guidelines appropriate for their patient." We agree with the statutory requirement, the provider network advisory group, and comments that a core component of the network's ability to increase quality care is to ensure Department policy and rules, as well as treatment guidelines are followed. We agree that mirroring the statutory language is best to ensure consistency with this legal requirement and addresses the concern that a guideline needs to be appropriate for the patient. The Department will continue to publish guidelines on its website and notify providers affected through list-serves and other mechanisms, including working with provider associations to distribute notice of updates or important changes. The Department is open to additional suggestions on how best to ensure ongoing communication and network implementation strategies to assure workers receive appropriate high quality care.
k. The Department agrees that the criteria for triggering review is broad; however, such broad criteria are necessary in order to effectively manage a network where each provider can have unique situations. The Department also agrees that adding language related to the factors the Department would rely on in a denial, such as severity, recency, frequency, repetition or any mitigating circumstances is appropriate.
l. The Department disagrees that adding "knowingly" to using an unlicensed provider is appropriate because this is a criteria to trigger a review; such facts may not be know in

advance and fundamental to quality patient care is that providers are licensed and practicing within scope.

m. The Department disagrees that a review criteria related to providers with a history of substance abuse is not appropriate or that the Department should not require documentation of ongoing compliance with any treatment plan because patient care can be compromised. The Department agrees that the words "public and private" should be removed.
n. The Department agrees that informal licensure actions should not always disqualify a provider from participation in the network. The current rule proposal includes this as criteria that would trigger further review rather than a minimal qualification.
o. The Department agrees with the Provider Network Advisory Group and other insurance industry standards that billing fraud or abuse or other significant billing irregularities is included as a criterion for review and disagrees that there must be a court finding first. The Department notes that this is not an automatic trigger for denial and the application would be further reviewed.
p. The Department understands the concern that the broad criteria for material "complaints or allegations demonstrating a pattern of behavior or misrepresentation is broad. The Department agrees with the Provider Network Advisory Group recommendation that added both "material" and a "pattern" to the complaints criteria. The criteria are necessary in order to effectively manage a network where each provider can have unique situations. However, the Department also agrees that adding language related to the factors the Department would rely on in a denial, such as severity, recency, frequency, repetition or any mitigating circumstances is appropriate.
q. The Department agrees that excluding any provider with any criminal history is inappropriate and did not include this criterion in minimum standards; but the Department will further review applicants with a criminal history.

Rule Change: The Department made 11 clarifying changes to this section: two editorial corrections, six corrections to ensure consistency with either other rule or statutory language, one clarification to simplify the text, and two clarifications based on public comment about confusion on Department intent.

WAC 296-20-01060 Delegation of Credentialing and Recredentialing Activities

The Department received oral and written comments related to the health care provider network delegation of credentialing, summarized below.

Comments:

a. *Several commenters were concerned about the delegation of credentialing and recredentialing, either based on lack of statutory authority; concern that such delegation creates different rules or will employ an outside network that make errors with no accountability; that all agreements and the vendor selection process should be open and*

public; that stakeholders envisioned requiring network providers to be credentialed by outside health plans which use NCQA or similar guidelines, not that the Department contract out its own credentialing process; and that delegating to groups that need credentialed would create a conflict of interest for those groups.

Response:

a. There appears to be a misunderstanding about how delegated credentialing (as opposed to enrollment) works. The Department agrees with the commenters that indicate it would be unwise to create separate networks or entities with different rules or no accountability. Delegated credentialing permits an organization, usually a large provider group, to gather and conduct the first round of validation of the individual provider information that is required by the application. These groups are required to follow NCQA or equivalent standards. The organization can also indicate that they believe the individual providers either meet or do not meet the Department standards. Using standardized information collection saves the larger groups' time as they routinely prepare this information for multiple payers and save the Department time in reviewing the applications for completeness. The Department remains responsible for making the decision to enroll into its network, according to its standards.

Rule Change: The Department made one clarifying change based on public comment about confusion of Department intent to emphasize that the authority to approve remains with the Department.

WAC 296-20-01070 Waiting Periods for Reapplying to the Network

The Department received oral and written comments related to the health care provider network waiting periods for reapplication, summarized below.

Comments:

a. *One commenter indicated that ineligibility to reapply for certain reasons was not a waiting period and exceeds statutory authority.*
b. *Several commenters requested clarification that ineligibility would not apply to providers who have been terminated from a state or federal program "for convenience"; or for any felony conviction.*
c. *Several commenters indicated that the length of time for reapplication, five years, seems excessively long or arbitrary.*
d. *One commenter objected to the exception for pending, minor, clerical items; indicating disagreement that pending or minor actions could be used to support denial or removal and that if a catchall is needed, the minimum standards and continuing requirements should be tightened up.*

Response:

a. The Department agrees with the Provider Network Advisory Group that there are certain criteria that would make a provider ineligible and disagrees that these limited criteria are beyond its statutory authority: the statute gives the Department broad authority to effectively manage the network and the rules reflect the statute, where certain criteria, whether in minimum standards or risk of harm include or amount to permanent removal or denial.
b. The Department agrees that clarification is needed to ensure that ineligibility would not apply to providers terminated for convenience from a government health care program.
c. The statute directs the Department to work with the Provider Network Advisory Group on the length of this waiting period. This waiting period was unanimously approved by the provider, business, and labor representatives. The Department disagrees that the reapplication time period is excessively long or arbitrary; the denial or removal process are much more extensive than other public and private health payers, and this time period is adequate to demonstrate that the issues causing denial or removal have been resolved or remediated.
d. The Department disagrees with removing the exception for minor or clerical issues. This was added at the request of Provider Network Advisory Group to ensure the Department had the flexibility to manage certain exceptional cases that might technically meet criteria for denial/removal, but would not meet larger goals to encourage broad access while meeting quality of care standards.

Rule Change: The Department made one clarifying change based on public comment to clarify that the ineligibility period does not apply to terminations for convenience.

WAC 296-20-01080 Management of the Provider Network

The Department received oral and written comments related to the management of the health care provider network, summarized below.

Comments:

a. *One commenter was concerned that the Department had the ability to turn doctors away if they were not meeting "qualify care standard" which the commenter translated to too much time loss; too many work restrictions; too many surgical referrals or MRI referrals and they will be outliers.*
b. *One commenter requested changing the phrase "opportunity for the provider to change" to "opportunity for the provider to remediate."*
c. *One commenter requested changing "shall" instead of "may" regarding provision of education and less severe actions.*
d. *One commenter indicated that classic unique mitigating circumstances should include disability and chronic pain; and that the exclusion is inappropriate because these would*

seem to be the classic mitigating circumstances and/or that prescribing for pain management should follow the new DOH regs, and/or that the rules do not account for difficulties confronted by attending physicians; especially where the problem arises because of the Departments or self-insureds conduct, not because of any inaction by the doctor leads to chronic pain; and limiting appropriate treatment to "curative or rehabilitative" care is inconsistent with the statute.

Response:

a. The Department is focused on its obligation created by statute, which includes "monitor quality of care and assure efficient management of the provider network". The Department disagrees that quality of care is defined as indicated in the comment, or not defined: expectations for quality care are set forth in the network continuing requirements; will be forthcoming in the rules or policies about the voluntary second tier, COHE expansion, and incentives for best practices; and the minimum quality of care threshold, below which a provider could be removed are set forth in the risk of harm section.
b. The Department agrees that changing the language to "remediate" instead of "change" clarifies the intent.
c. The Department disagrees with starting with less severe actions in each case. The Department, as stated in subsection (2) intends to consider the severity of the issue or risk of harm in deciding upon the appropriate action. The Department agrees with the Provider Network Advisory Group discussion and recommendation to preserve flexibility, because requiring a step-wise approach to each case does not afford the Department the flexibility needed to consider the circumstances of each case in order to effectively manage the network.
d. The Department disagrees with commenters that the rules have the effect of not recognizing or discounting disability or chronic pain or other factors that could lead to poor outcomes. The Department agrees, and the rules require, the Department take into account unique mitigating circumstances. Duration of disability and chronic pain are listed as factors that on their own, ("in and of themselves") are not uniquely mitigating. The Department recognizes multiple factors can lead to poor outcomes and prohibits action for isolated incidents, or incidents where other mitigating factors were present.

Rule Change: The Department made eight clarifying changes to this section: seven corrections to ensure consistency with either other rule or statutory language, and one editorial correction based on public comment.

WAC 296-20-01090 Request for Reconsideration of Department Decision

The Department received oral and written comments related to the request for reconsideration of a Department decision, summarized below.

Comments:

a) *Several commenters were concerned regarding due process for providers who are rejected or terminated from the network. They indicated that the proposed rule is unclear about the appeal rights of a health care provider whose request for reconsideration is denied and the appeal rights should be explicitly referred to.*

Response:

a. The Department has consistently indicated and been advised that other statutory provisions, namely appeal rights contained in RCW 51.52 remain unaffected. The Department agrees to clarify explicitly that health care provider network decisions, such as denial or removal, are appealable under RCW 51.52

Rule Change: The Department made one clarifying change to indicate that the health care provider network decisions are subject to appeal under RCW 51.52.

WAC 296-20-01100 Risk of Harm

The Department received oral and written comments related to risk of harm, summarized below.

Comments:

a. *Several commenters indicated that this section was unique and education of these requirements needs to occur to ensure that expectations are clearly communicated and or need to be monitored closely to ensure appropriate application.*
b. *One commenter indicated that "risk of harm" language is a big step toward ensuring that all injured workers receive the best possible medical care.*
c. *One commenter indicated that risk of harm should include treatment or coverage pursuant to a BIIA or Court Order, or the standard of care for the profession because it gives an expectation that there are studies and evidence supporting every clinical decision made by a provider. Most treatment provided to a patient is largely based on "best practices" and doesn't always have high quality scientific validation as safe and effective yet this should not exclude the delivery of such care. Please make language adjustment that reference "if such care has been shown to cause injury or harm, be unsafe or ineffective".*
d. *The dept. should not be calculating its own 'normative data on frequency'. This language would permit the dept. to create its own standards, without any real requirement for evidence, and then use those standards to limit the providers who are available to care for injured workers; using the lowest decile as a factor will eventually eliminate all providers.*

Response:

a. The Department agrees that these changes are unique and represent great progress in working with the health care provider community, including the business and labor community, to ensure that injured workers are receiving high quality medical care and will not be further harmed by treatment. The Department agrees with IIMAC, who over the course of several public meetings, assisted in drafting, and unanimously approved the risk of harm language, the IICAC, who agreed with the risk of harm language; and the Provider Network Advisory Group who also approved this language. The Department agrees that clear communication and ongoing education are critical.
b. The Department agrees that these changes are unique and represent great progress in working with the health care provider community, including the business and labor community, to ensure that injured workers are receiving high quality medical care and will not be further harmed by treatment.
c. The Department disagrees that an explicit exception be added for treatment that is approved or provided pursuant to a BIIA or Court Order. This language was approved by IIMAC and IICAC, and a majority of the provider network advisory group, including all clinicians, agreed that this specific language should not be added. The BIIA and courts are reviewing and deciding on a request for a specific action in an individual case, often where such requests are exceptions. The Department complies with BIIA and court orders with respect to the facts decided in that case. The risk of harm rule already prohibits the Department from taking action based on an isolated incident or case and is focused on factors that demonstrate patterns of low quality care that expose a patient to risk of harm or death. The underlying questions and the relevant determining factors are different; it is inappropriate to use a determination made in a unique case by an external entity applying its own criteria to be a bar or prohibition for the Department to review a set of activities based on the criteria set forth in this rule.
d. The Department disagrees that it will be creating its own standards; the risk of harm rule is carefully constructed to ensure that all three elements (harm, low quality care, and a pattern) must be present and that each of those elements are defined. Establishing a pattern is a key protection for providers, requested by clinicians within IIMAC and IICAC to ensure that a poor health outcome, by itself would not be defined as harm. Requiring data is essential to that pattern, and the Department must use the data it has available; both internal and external. The Department does not intend, and the rules as written do not permit the Department to eliminate providers solely on the basis that the provision of health services is in the lowest decile; such care must also be low quality and related to harm, as defined in the rule.

Rule Change: The Department made no changes to this section.