AMENDATORY SECTION (Amending WSR 04-22-085, filed 11/2/04, effective 12/15/04)

WAC 296-14-400 Reopenings for benefits. The director at any time may, upon the workers' application to reopen for aggravation or worsening of condition, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. This provision will not apply to total permanent disability cases, as provision of medical treatment in those cases is limited by RCW 51.36.010.

The seven-year reopening time limitation shall run from the date the first claim closure becomes final and shall apply to all claims regardless of the date of injury. In order for claim closure to become final on claims where closure occurred on or after July 1, 1981, the closure must include documentation of medical recommendation, advice or examination. Such documentation is not required for closing orders issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall for the purposes of this section only, be deemed issued on July 1, 1985.

The director shall, in the exercise of his or her discretion, reopen a claim provided objective evidence of worsening is present and proximately caused by a previously accepted asbestos-related disease.

In order to support a final closure based on medical recommendation or advice the claim file must contain documented information from a doctor, or nurse consultant (departmental) or nurse practitioner. The doctor or nurse practitioner may be in private practice, acting as a member of a consultation group, employed by a firm, corporation, or state agency.

For the purpose of this section, a "doctor" is defined in WAC 296-20-01002.

When a claim has been closed by the department or self-insurer for sixty days or longer, the worker must file a written application to reopen the claim. An informal written request filed without accompanying medical substantiation of worsening of the condition will constitute a request to reopen, but the time for taking action on the request shall not commence until a formal application is filed with the department or self-insurer as the case may be.

A formal application occurs when the worker and doctor complete and file the application for reopening provided by the department. Upon receipt of an informal request without accompanying medical substantiation of worsening of the worker's condition, the department or self-insurer shall promptly provide the necessary application to the worker for completion. For services or provider types where the department has established a provider network, beginning January 1, 2013, medical treatment and

documentation for reopening applications must be completed by network providers.

If, within seven years from the date the first closing order became final, a formal application to reopen is filed which shows by "sufficient medical verification of such disability related to the accepted condition(s)" that benefits are payable, the department, or the self-insurer, pursuant to RCW 51.32.210 and 51.32.190, respectively shall mail the first payment within fourteen days of receiving the formal application to reopen. If the application does not contain sufficient medical verification of disability, the fourteen-day period will begin upon receipt of such verification. If the application to reopen is granted, compensation will be paid pursuant to RCW 51.28.040. If the application to reopen is denied, the worker shall repay such compensation pursuant to RCW 51.32.240.

Applications for reopenings filed on or after July 1, 1988, must be acted upon by the department within ninety days of receipt of the application by the department or the self-insurer. The ninety-day limitation shall not apply if the worker files an appeal or request for reconsideration of the department's denial of the reopening application.

The department may, for good cause, extend the period in which the department must act for an additional sixty days. "Good cause" for such an extension may include, but not be limited to, the following:

(1) Inability to schedule a necessary medical examination within the ninety-day time period;

(2) Failure of the worker to appear for a medical examination;

(3) Lack of clear or convincing evidence to support reopening or denial of the claim without an independent medical examination;

(4) Examination scheduled timely but cannot be conducted and a report received in sufficient time to render a decision prior to the end of the ninety-day time period.

The department shall make a determination regarding "good cause" in a final order as provided in RCW 51.52.050.

The ninety-day limitation will not apply in instances where the previous closing order has not become final.

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-20-015 Who may treat. ((~~(1) In order~~)) To treat workers under the Industrial Insurance Act, a health care provider must qualify as an approved provider under the department's rules. The department must approve the health care provider ((~~through the issuance of a provider number~~)) before the health care provider is eligible for payment for services.

(1) A provider must:

(a) Apply and be enrolled in the provider network per WAC 296-20-01010; or

(b) If the provider network scope in WAC 296-20-01010 is not applicable, apply and obtain a provider account number per WAC 296-20-12401.

(2) If the provider or service is within the scope of the provider network under WAC 296-20-01010:

(a) A nonnetwork provider is not authorized to treat and will not be reimbursed by the department or self-insurer for services other than the initial office or emergency room visit. The following services are considered part of the initial office or emergency room visit:

(i) Services that are bundled with those performed during the initial visit where no additional payment is due (as defined in WAC 296-20-01002); and

(ii) In the case of an injured worker directly hospitalized from an initial emergency room visit, all services related to the industrial injury or illness provided through the hospital discharge.

(b) A nonnetwork provider must refer injured workers to network providers when additional treatment is needed, and must provide timely copies of medical records to the other provider.

((~~(2)~~)) (3) Para-professionals, who are not independently licensed, must practice under the direct supervision of a licensed health care professional whose scope of practice and specialty training includes the service provided by the para-professional. The department may deny direct reimbursement to the para-professional for services rendered, and may instead directly reimburse the licensed and supervising health care professional for covered services. Payment rules for para-professionals may be determined by department policy.

((~~(3)~~)) (4) Procedures and evaluations requiring specialized skills and knowledge will be limited to board certified or board qualified physicians, or osteopathic physicians as specified by the American Medical Association or the American Osteopathic Association.

((~~(4)~~)) (5) The department as a trustee of the medical aid fund has a duty to supervise provision of proper and necessary

medical care that is delivered promptly, efficiently, and economically. The department can deny, revoke, suspend, limit, or impose conditions on a health care provider's authorization to treat workers under the Industrial Insurance Act. Reasons for denying issuance of a provider number or imposing any of the above restrictions include, but are not limited to the following:

(a) Incompetence or negligence, which results in injury to a worker or which creates an unreasonable risk that a worker may be harmed.

(b) The possession, use, prescription for use, or distribution of controlled substances, legend drugs, or addictive, habituating, or dependency-inducing substances in any way other than for therapeutic purposes.

(c) Any temporary or permanent probation, suspension, revocation, or type of limitation of a practitioner's license to practice by any court, board, or administrative agency.

(d) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the provider's profession. The act need not constitute a crime. If a conviction or finding of such an act is reached by a court or other tribunal pursuant to plea, hearing, or trial, a certified copy of the conviction or finding is conclusive evidence of the violation.

(e) The failure to comply with the department's orders, rules, or policies.

(f) The failure, neglect, or refusal to:

(i) Provide records requested by the department pursuant to a health care services review or an audit.

(ii) Submit complete, adequate, and detailed reports or additional reports requested or required by the department regarding the treatment and condition of a worker.

(g) The submission or collusion in the submission of false or misleading reports or bills to any government agency.

(h) Billing a worker for:

(i) Treatment of an industrial condition for which the department has accepted responsibility; or

(ii) The difference between the amount paid by the department under the maximum allowable fee set forth in these rules and any other charge.

(i) Repeated failure to notify the department immediately and prior to burial in any death, where the cause of the death is not definitely known and possibly related to an industrial injury or occupational disease.

(j) Repeated failure to recognize emotional and social factors impeding recovery of a worker who is being treated under the Industrial Insurance Act.

(k) Repeated unreasonable refusal to comply with the recommendations of board certified or qualified specialists who have examined a worker.

(l) Repeated use of:

(i) Treatment of controversial or experimental nature;

(ii) Contraindicated or hazardous treatment; or

(iii) Treatment past stabilization of the industrial condition or after maximum curative improvement has been obtained.

(m) Declaration of mental incompetency by a court or other tribunal.

(n) Failure to comply with the applicable code of professional conduct or ethics.

(o) Failure to inform the department of any disciplinary action issued by order or formal letter taken against the provider's license to practice.

(p) The finding of any peer group review body of reason to take action against the provider's practice privileges.

(q) Misrepresentation or omission of any material information in the application for authorization to treat workers, chapter 51.04 RCW. ((~~(chapter 51.04 RCW.)~~

~~(5)~~)) (6) If the department finds reason to take corrective action, the department may also order one or more of the following:

(a) Recoupment of payments made to the provider, including interest, chapter 51.04 RCW; ((~~(chapter 51.04 RCW.)~~))

(b) Denial or reduction of payment;

(c) Assessment of penalties for each action that falls within the scope of subsection ((~~(4)~~)) (5) (a) through (q) of this section, chapter 51.48 RCW; ((~~(chapter 51.48 RCW.)~~))

(d) Placement of the provider on a prepayment review status requiring the submission of supporting documents prior to payment;

(e) Requirement to satisfactorily complete remedial education courses and/or programs; and

(f) Imposition of other appropriate restrictions or conditions on the provider's privilege to be reimbursed for treating workers under the Industrial Insurance Act.

((~~(6)~~)) (7) The department shall forward a copy of any corrective action taken against a provider to the applicable disciplinary authority.

AMENDATORY SECTION (Amending WSR 08-24-047, filed 11/25/08, effective 12/26/08)

WAC 296-20-025 ((~~Initial~~)) Initiating treatment and ((~~report of accident~~)) submitting a claim for benefits. ((~~It is the responsibility of~~)) (1) Worker's responsibility: The worker ((~~to~~)) must notify the ((~~practitioner~~)) provider when the worker has reason to believe his/her injury or ((~~condition~~)) illness is ((~~industrial in nature. Conversely, if the attending doctor discovers a~~)) work related. If treatment beyond the initial office or emergency room visit is needed, the worker must seek treatment from a network provider.

(2) Provider's responsibility: The provider must notify the worker if he/she identifies an injury, illness, or condition which he/she has reason to believe((~~s to be~~)) is work related ((~~or has reason to believe an injury is work related, he must so notify the worker~~)).

Once such determination is made by either the ((~~claimant~~)) worker or the attending ((~~doctor~~)) provider, a report of ((~~accident~~)) the injury or illness must be filed with the department or self-insurer.

Failure to comply with this responsibility can result in penalties as outlined in RCW 51.48.060.

((~~It is the practitioner's responsibility to~~))

(3) Additional provider responsibilities: The provider must ascertain whether he/she is the first attending ((~~practitioner. If so, he will take the following action:~~

~~(1)~~)) provider and give emergency treatment.

((~~(2)~~)) The first attending provider must immediately complete and forward ((~~the~~)) a report of ((~~accident,~~)) the injury or illness to the department ((~~and the employer~~)) or self-insurer((~~.~~)) and instruct and ((~~give assistance to~~)) assist the injured worker in completing his/her portion of the report of ((~~accident~~)) the injury or illness. In filing a claim, the following information is necessary so there is no delay in adjudication of the claim or payment of compensation.

(a) Complete history of the ((~~industrial~~)) work related accident or exposure.

(b) Complete listing of positive physical findings.

(c) Specific diagnosis with ICD-9-CM, or most current version as updated, code(s) and narrative definition relating to the injury.

(d) Type of treatment rendered.

(e) Known medical, emotional or social conditions which may influence recovery or cause complications.

(f) Estimate time-loss due to the injury or illness.

(4) Initial office and emergency room visit services may be performed by a network or nonnetwork provider. Services that are bundled with those performed during the initial visit (as defined in WAC 296-20-01002), with no additional payment being due, are part of the initial visit.

((~~(3) If~~)) (5) When the ((~~patient remains under his care~~)) worker needs treatment beyond the initial office or emergency room visit, the network provider continues with necessary treatment in accordance with medical aid rules. If the provider is not enrolled in the provider network and the injured worker requires additional treatment, the provider will either:

(a) Apply for the provider network (if eligible) at the time he/she files the worker's report of accident; or

(b) Refer the injured worker to a network provider of the worker's choice.

(6) If the ((~~practitioner~~)) provider is *not* the original attending ((~~doctor~~)) provider, he/she should question the injured worker to determine whether a report of accident has been filed for the injury or condition. If no report of accident has been filed, it should be completed immediately and forwarded to the department or self-insurer, as the case may be, with information as to the name and address of original ((~~practitioner~~)) provider if known, so that he/she may be contacted for information if necessary. A worker must complete a request for transfer as outlined in WAC 296-

20-065 if a report of accident has previously been filed((~~, it is necessary to have the worker complete a request for transfer as outlined in WAC 296-20-065, if~~)) and the provider is not enrolled in the provider network or the worker and ((~~practitioner~~)) provider agree that a change in attending ((~~doctor~~)) provider is desirable.

AMENDATORY SECTION (Amending WSR 93-16-072, filed 8/1/93, effective 9/1/93)

WAC 296-20-065 Transfer of ((~~doctors~~)) providers. For services or provider types where the department has established the provider network, the injured worker must select an attending provider from the provider network for all care beyond the initial visit. If the initial office or emergency room visit was completed with a nonnetwork provider and additional treatment is needed, the worker must transfer care to a network provider and promptly inform the department or self-insurer.

All transfers from one ((~~doctor~~)) network provider to another must be approved by the department or self-insurer. Normally transfers will be allowed only after the worker has been under the care of the attending ((~~doctor~~)) provider for sufficient time for the ((~~doctor~~)) provider to: Complete necessary diagnostic studies, establish an appropriate treatment regimen, and evaluate the efficacy of the therapeutic program.

Under RCW 51.36.010 the worker is entitled to free choice of treating ((~~doctor~~)) provider. Except as provided under subsections (1) through (7) of this section, no reasonable request for transfer to a network provider will be denied. The worker must be advised when and why a transfer is denied.

When a transfer is approved, the new attending ((~~doctor~~)) provider must be provided with a copy of the worker's treatment record by the previous attending ((~~doctor~~)) provider. X rays in the possession of the previous attending ((~~doctor~~)) provider must be immediately forwarded to the new attending ((~~doctor~~)) provider for his or her retention as long as the worker remains under his or her care. Copies of X rays and other records may be provided in lieu of originals.

The department or self-insurer reserves the right to require a worker to select another ((~~doctor~~)) provider or specialist for treatment, under the following conditions:

(1) When more conveniently located ((~~doctors~~)) providers, qualified to provide the necessary treatment, are available.

(2) When the attending ((~~doctor~~)) provider fails to cooperate in observance and compliance with the department rules.

(3) In time loss cases where reasonable progress towards return to work is not shown.

(4) Cases requiring specialized treatment, which the attending ((~~doctor~~)) provider is not qualified to render, or is outside the scope of the attending ((~~doctor's~~)) provider's license to practice.

(5) Where the department or self-insurer finds a transfer of ((~~doctor~~)) provider to be appropriate and has requested the worker to transfer in accordance with this rule, the department or self-insurer may select a new attending ((~~doctor~~)) provider if the worker unreasonably refuses or delays in selecting another attending ((~~doctor~~)) provider.

(6) In cases where the attending ((~~doctor~~)) provider is not qualified to treat each of several accepted conditions. This does not preclude concurrent care where indicated. See WAC 296-20-071.

(7) No transfer will be approved to a consultant or special examiner without the approval of the attending ((~~doctor~~)) provider and the worker.

Transfers will be authorized for the foregoing reasons or where the department or self-insurer in its discretion finds that a transfer is in the best interest of returning the worker to a productive role in society.

When a worker's care is transferred to another ((~~doctor~~)) provider each ((~~doctor~~)) provider must submit a separate bill to the department or self-insurer for their portion of the care. Payment will be made at rates determined by department policy.

AMENDATORY SECTION (Amending WSR 90-04-057, filed 2/2/90, effective 3/5/90)

WAC 296-20-075 Hospitalization. (1) Hospitalization will be paid for proper and necessary medical treatment of the accepted condition(s). The department may develop and implement utilization management criteria which will be used to review inpatient hospital admissions. Reimbursement for hospitalization is limited to proper and necessary care for an accepted condition. Failure to comply with these criteria may result in delayed or reduced reimbursement to the provider as allowed under chapter 51.48 RCW. Ward or semi-private accommodations will be paid, unless the worker's condition requires special care.

(2) Discharge from the hospital shall be at the earliest date possible consistent with proper health care. If additional treatment is needed, discharge planning must include referral to a network provider. If transfer to a convalescent center or nursing home is indicated, prior arrangements should be made with the department or self-insurer. See WAC 296-20-091 for further information. The department may designate those diagnostic and surgical procedures which will be reimbursed only if performed in an outpatient setting. When procedures so designated must be performed in an inpatient setting for reasons of medical necessity, prior authorization must be obtained.

AMENDATORY SECTION (Amending WSR 00-09-078, filed 4/18/00, effective 7/1/00)

WAC 296-20-12401 ((~~Provider~~)) Application process for providers outside the scope of the provider network. For providers or services not subject to the health care provider network requirements, including treatment at the initial office or emergency room visit, a provider must obtain a provider account number from the department.

(1) **How can a provider obtain a provider account number from the department?** In order to receive a provider account number from the department, a provider must:

- Complete a provider application;
- Sign a provider agreement;
- Provide a copy of any practice or other license held;
- Complete, sign and return a Form W-9; and
- Meet the department's provider eligibility requirements as cited in the department's rules.

Notes: A provider account number is required to receive payment from the department, but is not a guarantee of payment for services.
Self-insured employers may have additional requirements for provider status.

(2) **Provider account status definitions.**

- Active - Account information is current and provider is eligible to receive payment.
- Inactive - Account is not eligible to receive payment based on action by the department or at provider request. These accounts can be reactivated.
- Terminated - Account is not eligible to receive payment based on action by the department or at provider request. These accounts can not be reactivated.

(3) **When may the department inactivate a provider account?** The department may inactivate a provider account when:

- There has been no billing activity on the account for eighteen months; or
- The provider requests inactivation; or
- Provider communications are returned due to address changes; or
- The department changes the provider application or application procedures; or
- Provider does not comply with department request to update information.

(4) **When may the department terminate a provider account?** The department may terminate a provider account when:

- The provider is found ineligible to treat per department rules; or
- The provider requests termination; or
- The provider dies or is no longer in active business status.

(5) **How can a provider reactivate a provider account?** To reactivate a provider account, the provider may call or write the department. The department may require the provider to update the provider application and/or agreement or complete other needed forms prior to reactivation. Account reactivation is subject to

department review.

If a provider account has been terminated, a new provider application will be required.