Concise Explanatory Statement (CES)

This CES refers to comments made in response to proposed phase III rules related to the implementation of the Department of Labor & Industries' (L&I) statewide health care provider network. This provider network was established in Substitute Senate Bill (SSB) 5801 (Chapter 6, Laws of 2011).

WACs Proposed for Amendment

WAC 296-20-01010	Scope of health care provider network
WAC 296-20-01020	Health care provider network enrollment
WAC 296-20-02705	What are treatment and diagnostic guidelines and how are they related to medical coverage decisions?
WAC 296-20-03015	What steps may the department or self-insurer take when concerned about the amount or appropriateness of drugs and medications prescribed to the injured worker?

I. Purpose of this rulemaking:

Why is this rulemaking being adopted?
SSB 5801 directs L&I to establish a statewide health care provider network to treat injured workers and to expand the Centers for Occupational Health and Education (COHEs) in the workers' compensation system. L&I is promulgating necessary rules in phases.

The first phase of rules adopted:
(1) Establishes minimum standards for credentials of health care providers and other requirements for network participation; and
(2) Clarifies what constitutes patterns of risk of physical or psychiatric harm or death that determines when the department may remove a provider from the network.

The second phase of rules adopted clarifies who can treat an injured or ill worker for the initial visit.
(1) The adopted language allows injured and ill workers to see a provider of their choice for the initial visit to start their claims.
(2) The adopted language informs health care providers and workers as to what services may be provided by a nonnetwork provider and when care must be transferred to a network provider.

This third rulemaking phase amends existing department rules that are in conflict with SSB 5801 or require clarification for the successful implementation of the statewide health care provider network. This third rulemaking is necessary so that health care providers, State Fund employers, self-insured employers, and injured and ill workers have a clear understanding of this new health care provider network and their rights and requirements under SSB 5801.

The date of adoption is November 13, 2012.
The effective date for this rule is December 14, 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 a public hearing. The public comment period for this rulemaking began August 21, 2012, and ended September 28, 2012.

III. Public hearing:

A public hearing was held to receive comments from interested parties regarding this rulemaking. The hearing took place on September 28, 2012, at the L&I Tumwater building.

No one testified. Three people signed up in support of the proposed rule language with no changes. These three individuals represented the Washington Occupational Therapy Association and U.S. Healthworks Medical Group.

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

The department received written comments on the rule from four organizations. In general, commenters had concerns about three of the four proposed sections.

General Comments by L&I

SSB 5801 mandated a workgroup of medical providers from the Industrial Insurance Medical Advisory Committee and Industrial Insurance Chiropractic Advisory Committee and business and labor representatives - the Provider Network Advisory Committee (PNAG). L&I has worked closely with PNAG on the content of all three phases of rules related to the establishment and implementation of the statewide health care provider network.

WAC 296-20-01010 Scope of health care provider network

Three written comments were received suggesting changes to the proposed amendments to this WAC.

Comments received: *Several commenters stated that the proposed amendment to establish criteria for network adequacy in WAC 296-20-01010 subsection (4) is too broad and does not take into account any other criteria, other than a non-definition of available network specialists. Several of the commenters further recommend that the department adopt the Office of the Insurance Commissioner "guideline" under WAC 284-43-200 which states, "A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan*

services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205." Similarly, a commenter indicated that the rule does not effectively protect workers' access to care by specialists. The commenter indicated that the rules should ensure that the L&I provider network is adequate, and advocated adopting the Office of the Insurance Commissioner rule.

Summary of the comments:

- *Network definition is too broad and does not take into account any other criteria*
- *The department should adopt Office of Insurance Commissioner rule related to health carrier adequacy, generally and for specialists*

Department Response:

Network definition is too broad and does not take into account any other criteria
The department is committed to broad access and recruitment and has proposed an open network with transparent minimum standards. The network is open to all providers. The department encourages all providers to apply and approves providers meeting the network standards and continuing requirements. The language adopted in WAC 296-20-01010 defines the factors that the Director will consider in establishing or expanding the network. The department agrees that additional criteria may be relevant and had intended that these factors would be minimally considered prior to a decision; and thus will clarify that these are the minimum considerations to be taken into account and add the words "at least".

The department reviewed other criteria for establishing a network and considered factors within the context of its statutory obligations and focus on workplace illness and injury. The department worked closely with the PNAG in proposing the factors. The department disagrees that the factors for consideration are too broad; the proposed measures are specified by amount of providers and geographic distance, and are compared to a baseline taken prior to implementation. The geographic distance for specialists is not applicable because many specialists choose to practice in urban settings.

The department should adopt Office of Insurance Commissioner rule related to health carrier adequacy, generally and for specialists
The department disagrees that Office of the Insurance Commissioner rules related to health carriers are applicable to the department's statutory obligations to establish minimum criteria for providers that treat injured and ill workers. See response above related to specificity.

***Rule change**: 296-20-001010 (4) includes a clarifying change to add the words "at least".*

WAC 296-20-01020 Health Care Provider Network Enrollment

No comments were received suggesting changes to the proposed amendments to this WAC.

***Rule change**: No changes were made to this WAC.*

WAC 296-20-02705 What are treatment and diagnostic guidelines and how are they related to medical coverage decisions?

Five written comments were received suggesting changes to this WAC.

***Comment received:** One commenter stated that the language in this section is vague and does not provide sufficient guidance regarding how L&I guidelines are developed. These need to be evidence-based, need to be supported by valid peer-reviewed data, and should be consistent with national best practice guidelines. At the very least the rule needs to state that the guidelines will be evidence-based and supported by peer reviewed data and studies.*
***Comment received:** One commenter stated that "Network providers are required to follow the department's evidence-based coverage decisions, treatment guidelines, and policies," is an overreach of the agency's authority. Another commenter suggested that this language is troublesome.*
***Comment received:** One commenter stated that the proposed language in WAC 296-20-02705(4) does not reflect the Legislature's intent clearly expressed in SSB 5801 that a physician's independent medical judgment, including with respect to determining the national treatment guidelines appropriate for the physician's patient, be preserved.*
***Comment received:** Another commenter objects to the language in this section because it makes guidelines mandatory for all network providers, thus limiting any opportunities for physicians to innovate and explore better treatment options.*
***Comment received:** One commenter further suggested that language should be added to state that network providers must "materially comply with…evidence-based coverage decisions and treatment guidelines…"*

***Department response**: The proposed amendatory language does not alter the substantive provisions related to development of coverage decisions and guidelines. The department agrees with the commenter that decisions should be based on high quality evidence, as currently stated in this WAC and WACs relating to the Industrial Insurance Medical and Chiropractic Advisory Boards.*

The department disagrees with commenters suggesting the proposed language, which serves to provide notice to network providers of their current statutory obligation to follow department guidelines, is an overreach or should be moderated. This language mirrors the requirement already in statute:

"Network providers must be required to follow the department's evidence-based coverage decisions and treatment guidelines, policies…"

***Rule change**: There were no changes to the adopted rule language based on these comments.*

WAC 296-20-03015 What steps may the department or self-insurer take when concerned about the amount or appropriate of drugs and medications prescribed to the injured worker?

One written comment was received suggesting changes to this WAC.

***Comment received:** One commenter wanted changes to the language that states the department may limit the payment for drugs on a claim to one prescribing provider. This can cause problems on the physician's side when their physician assistant writes the prescription, or if a clinic partner writes a prescription in the absence of the treating provider.*

Several oral comments were received suggesting changes to this WAC.

***Comments received:** Several commenters who participate in the Industrial Insurance Medical Advisory Committee (IIMAC) noted that this WAC was last revised in 1999; that policy changes, medical practice, and clinical evidence have changed subsequent to the rule promulgation. The IIMAC noted that a guideline relating to this topic is currently undergoing final review and substantial update to the substantive portion of this WAC would be needed at adoption. Thus, members of the committee requested that the WAC not be amended at this time.*

***Department response**: The department agrees that revision is likely and a holistic approach to update would be more appropriate.*

***Rule change**: This WAC will not be amended at this time.*