NEW SECTION

WAC 296-20-01010 Scope of health care provider network. (1) The rules establish the development, enrollment, and oversight of a network of health care providers approved to treat injured workers. The health care provider network rules apply to care for workers covered by Washington state fund and self-insured employers.

(2) As of January 1, 2013, the following types of health care providers (hereafter providers) must be enrolled in the network with an approved provider agreement to provide and be reimbursed for care to injured workers in Washington state beyond the initial office or emergency room visit:

(a) Medical physicians and surgeons;

(b) Osteopathic physicians and surgeons;

(c) Chiropractic physicians;

(d) Naturopathic physicians;

(e) Podiatric physicians and surgeons;

(f) Dentists;

(g) Optometrists;

(h) Advanced registered nurse practitioners; and

(i) Physician assistants.

(3) The requirement in subsection (2) of this section does not apply to providers who practice exclusively in acute care hospitals or within inpatient settings in the following specialties:

(a) Pathologists;

(b) Consulting radiologists working within a hospital radiology department;

(c) Anesthesiologists or certified registered nurse anesthetists (CRNAs) except anesthesiologists and CRNAs with pain management practices in either hospital-based or ambulatory care settings;

(d) Emergency room providers; or

(e) Hospitalists.

(4) The department may phase implementation of the network to ensure access within all geographic areas. The department may expand the health care provider network scope to include additional providers not listed in subsection (2) of this section, listed in subsection (3) of this section, and to out-of-state providers. For providers outside the scope of the health care provider network rule, the department and self-insured employers may reimburse for treatment beyond the initial office or emergency room visit.

NEW SECTION

WAC 296-20-01020 Health care provider network enrollment. (1) The department or its delegated entity will review the provider's application, supporting documents, and any other information requested or accessed by the department that is relevant to verifying the provider's application, clinical experience or ability to meet or maintain provider network requirements.

(2) The department will notify providers of incomplete applications, including when credentialing information obtained from other sources materially varies from information on the provider application. The provider may submit a supplement to the application with corrections or supporting documents to explain discrepancies within thirty days of the date of the notification from the department. Incomplete applications will be considered withdrawn within forty-five days of notification.

(3) The provider must produce adequate and timely information and timely attestation to support evaluation of the application. The provider must produce information and respond to department requests for information that will help resolve any questions regarding qualifications within the time frames specified in the application or by the department.

(4) The department's medical director or designee is authorized to approve, deny, or further review complete applications consistent with department rules and policies. Providers will be notified in writing of their approval or denial, or that their application is under further review within a reasonable period of time.

(5) Providers who meet the minimum provider network standards, have not been identified for further review, and are in compliance with department rules and policies, will be approved for enrollment into the network.

(6) Enrollment of a provider is effective no earlier than the date of the approved provider application. The department and self-insured employers will not pay for care provided to workers prior to application approval, regardless of whether the application is later approved or denied, except as provided in this subsection.

(7) The department and self-insured employers may pay a provider without an approved application only when:

(a) The provider is outside the scope of the provider network per WAC 296-20-01010; or

(b) The provider is provisionally enrolled by the department after it obtains:

(i) Verification of a current, valid license to practice;

(ii) Verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query; and

(iii) A current and signed application with attestation.

(c) A provider may only be provisionally enrolled once and for no more than sixty calendar days. Providers who have previously

participated in the network are not eligible for provisional enrollment.

NEW SECTION

WAC 296-20-01030 Minimum health care provider network standards. The department will deny an application if a provider does not meet minimum health care provider network standards. To be eligible for enrollment and participation in the provider network, a provider must meet and maintain the following minimum health care provider network standards:

(1) The provider must submit an accurate and complete provider application, including any required supporting documentation and sign without modification, a provider agreement with the department.

(2) The provider must have current professional liability coverage, individually or as a member of a group, through a commercial carrier or provide documentation of self-insurance.

(a) Professional liability coverage must be at least in the amounts of one million dollars per occurrence and three million dollars annual aggregate; or in the amounts otherwise published by the department for the provider type's scope of practice, after notice and opportunity for comment.

(b) Providers in a group practice who are self-insured for professional liability coverage must provide evidence that liabilities in amounts at least equivalent to liability limits in (a) of this subsection are booked on audited financial statements in accordance with generally accepted accounting standards.

(3) The provider must not have had clinical admitting and management privileges denied, limited or terminated for quality of care issues.

(4) The provider must not have been excluded, expelled, terminated, or suspended from any federally or state funded health care programs including, but not limited to, medicare or medicaid programs based on cause or quality of care issues.

(5) The provider must not have made any material misstatement or omission to the department concerning licensure, registration, certification, disciplinary history or any other material matter covered in the application or credentialing materials.

(6) The provider must not have been convicted of a felony or pled guilty or no contest to a felony for a crime including, but not limited to, health care fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of controlled substances.

The department may grant an exception for a felony that the provider has had expunged (vacated criminal conviction) from the provider's record.

(7) The provider must be currently licensed, certified,

accredited or registered according to Washington state laws and rules or in any other jurisdiction where the applicant treats injured workers.

(a) The license, registration or certification must be free of any restrictions, limitations or conditions relating to the provider's clinical practice.

(b) The provider must not have surrendered, voluntarily or involuntarily his or her professional state license in any state while under investigation or due to findings by the state resulting from the provider's acts, omissions, or conduct.

(c) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature or for a case where the restriction, limitation, or condition has been removed.

(8) The provider must have a current Drug Enforcement Administration (DEA) registration, if applicable to the provider's scope of licensure.

(a) The DEA registration must be free of restrictions, limitations or conditions related to the provider's acts, omissions or conduct.

(b) The provider must not have surrendered, voluntarily or involuntarily his or her DEA registration in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct.

(c) The department may grant an exception for any restriction, limitation or condition deemed by the department to be minor or clerical in nature or for a case where the restriction, limitation or condition has been removed.

NEW SECTION

WAC 296-20-01040 Health care provider network continuing requirements. To continue to provide care for workers and be paid for those services, a provider must:

(1) Provide services without unlawful discrimination;

(2) Provide services and bill according to federal and state laws and rules, department rules, policies, and billing instructions;

(3) Maintain material compliance with minimum provider network standards, department credentialing and recredentialing standards, and department's evidence-based coverage decisions and treatment guidelines, policies; and must follow other national treatment guidelines appropriate for their patient;

(4) Inform the department or an applicable delegated credentialing entity of any material changes to the provider's application or agreement within fourteen calendar days including, but not limited to, changes in:

(a) Ownership or business name;

(b) Address or telephone number;

(c) Professionals practicing under the billing provider number;

(d) Any informal or formal disciplinary order, decision, disciplinary action or other action(s), including any criminal action, in any state;

(e) Provider clinical privileges;

(f) Malpractice claims or professional liability coverage;

(5) Retain a current professional state license, registration, certification and/or applicable business license for the service being provided, and update the department of all changes;

(6) Comply with department recredentialing process; and

(7) Comply with the instructions contained in a department action, including documentation of compliance and participation in mentoring, monitoring, or restrictions.

NEW SECTION

WAC 296-20-01050 Health care provider network further review and denial. (1) The department may further review a complete provider application based on information within the application or credentialing information obtained from other sources.

(2) For complete applications requiring further review, the department's medical director or designee has the authority to approve or deny consistent with department rules and policies, and may seek advice, expertise, consultation or recommendations on applications from:

(a) Peer or clinical review individuals or entities;

(b) The industrial insurance medical or chiropractic advisory committee (including a subcommittee);

(c) A department appointed credentialing committee.

(3) The department may deny a provider application during credentialing or recredentialing based on the provider's professional qualifications and practice history including:

(a) The provider fails to meet minimum health care provider network standards;

(b) The provider has been disciplined based on an allegation of sexual misconduct or admitted to sexual misconduct;

(c) The provider is noncompliant with the department of health's or other state health care agency's stipulation to informal disposition (STID), agreed order, or similar licensed restriction;

(d) The provider has any pending statement of charges or notice of proposed disciplinary action or equivalent from any state or governmental professional disciplinary board at the time of application or recredentialing;

(e) The provider is excluded, expelled, terminated, or suspended by medicare, medicaid or any other state or federally

funded health care program;

(f) The provider has a denial, suspension or termination of participation or privileges by any health care institution, insurance plan, facility, or clinic; except where such decision was solely related to broad network or business management changes, instead of an individual determination;

(g) The provider has surrendered, voluntarily or involuntarily, his or her hospital privileges in any state while under investigation or due to findings resulting from the provider's acts, omissions, or conduct;

(h) The provider performs invasive or surgical procedures without:

(i) Clinical admitting and management privileges, in good standing; or

(ii) An inpatient coverage plan with participating practitioner(s), hospitalists, or inpatient service teams for the purpose of admitting patients. Any inpatient coverage plan must be specified by the provider and found to be acceptable by the department.

(i) The provider has significant malpractice claims or professional liability claims (based on materiality to current practice, severity, recency, frequency, or repetition);

(j) The provider has been materially noncompliant with the department's rules, administrative and billing policies, evidence-based coverage decisions and treatment guidelines, and policies and other national treatment guidelines appropriate for their patient (based on severity, recency, frequency, repetition, or any mitigating circumstances);

(k) The provider was or is found to be involved in acts of dishonesty, fraud, deceit or misrepresentation that, in the department's determination, could relate to or impact the provider's professional conduct or the safety or welfare of injured or ill workers;

(l) The provider was or is found to have committed negligence, incompetence, inadequate or inappropriate treatment or lack of appropriate follow-up treatment which results in injury to a worker or creates unreasonable risk that a worker may be harmed (based on severity, recency, frequency, repetition, or any mitigating circumstances);

(m) The provider uses health care providers or health care staff who are unlicensed to practice or who provide health care services outside their recognized scope of practice or the standard of practice in Washington state;

(n) The provider with a history of alcohol or chemical dependency fails to furnish documentation demonstrating that the provider complied or is complying with all conditions limitations, or restrictions to the provider's practice and received or is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice;

(o) The provider has informal licensure actions, conditions, agreements, orders;

(p) The provider has a history of probation, suspension, termination, revocation or a surrendered professional license,

certification, accreditation, or registration listed in the National Provider Data Bank/Healthcare Integrity and Protection Data Bank or any like entity; or by a nationally recognized specialty board; or by a state authority in any jurisdiction including, but not limited to, the Washington state department of health, when such charges involve conduct or behavior as defined under chapter 18.130 RCW, Uniform Disciplinary Act;

(q) The provider engaged in billing fraud or abuse or has a history of other significant billing irregularities;

(r) There are material complaints or allegations demonstrating a pattern of behavior(s) or misrepresentations including, but not limited to incidents, misconduct, or inappropriate prescribing of controlled substances (based on severity, recency, frequency, repetition, or any mitigating circumstances);

(s) The provider has a criminal history which includes, but is not limited to, any criminal charges, criminal investigations, convictions, no contest pleas and guilty pleas; or

(t) A finding of risk of harm pursuant to WAC 296-20-01100.

(4) The department and self-insured employers will not pay for any care to injured workers, other than an initial visit, by a provider whose application has been denied.

NEW SECTION

WAC 296-20-01060 Delegation of credentialing and recredentialing activities. (1) The department may delegate credentialing and recredentialing review activities to the following entities:

(a) Medical and dental group(s) and clinics;

(b) Physician organizations;

(c) Credentials verification organizations (CVOs); or

(d) Other organizations that employ and/or contract with providers.

(2) Any delegation by the department of credentialing or recredentialing review activities will be documented through a written delegation agreement.

(3) The department retains the authority to review, approve, suspend, deny, or terminate any provider who has been credentialed by a delegated entity.

NEW SECTION

WAC 296-20-01070 Waiting periods for reapplying to the network. (1) Providers are not eligible to reapply for enrollment in the network if they have been denied or removed from network participation due to:

(a) A finding of risk of harm, pursuant to WAC 296-20-01100;

(b) Having been excluded, expelled or suspended, other than for convenience, from any federally or state funded programs including, but not limited to, medicare or medicaid programs;

(c) Having been convicted of a felony or pled guilty to a felony for a crime and the felony has not been expunged from the provider's record including, but not limited to, health care fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of controlled substances;

(d) Sexual misconduct as defined in profession specific rules of any state or jurisdiction, including Washington state department of health.

(2) Providers who are denied or removed from the network or terminated for any other reason than those set forth in subsection (1) of this section are not eligible to reapply for enrollment in the network for five years. The department may grant an exception where the reason for denial or removal is related to pending actions or charges which have been resolved or deemed by the department to be minor or clerical in nature.

NEW SECTION

WAC 296-20-01080 Management of the provider network. (1) Appropriate action(s) by the department to monitor quality of care and assure efficient management of the provider network may include, but are not limited to:

(a) Monitoring the provider;

(b) Mentoring the provider;

(c) Restricting payment for services rendered by the provider;

(d) Suspending the provider from the network; or

(e) Removing the provider from the network.

(2) The department must first notify the provider, and may take action in any order or combination, depending on the severity of the issue or risk of harm.

(3) For risk of harm issues, where imminent or actual harm is not life-threatening or substantially disabling, the department may provide an opportunity for the provider to remediate through education or other less severe actions first. Where the department action includes suspension or removal from the network for risk of harm issues, the department may also request expedited hearing and immediate suspension of authority to provide services under RCW 51.52.075.

(4) In taking appropriate action for risk of harm issues, the department will take into account unique mitigating circumstances related to the clinical severity and complexity of the providers' patient population. Unique mitigating circumstances could include practice at a care facility recognized for its receipt of particularly severe cases, such as catastrophic injuries. Duration of disability and/or chronic pain shall not, in and of themselves, be considered uniquely mitigating.

The department may not take action against a provider for risk of harm, if the harm was related to an isolated instance of health care service delivery that was conducted within coverage policies and treatment guidelines established by the department or other evidence-based coverage decisions made by the Washington state health technology committee, or the prescription drug program and appropriate to the patient's specific circumstances.

(5) The department may also terminate a provider network agreement for cause based on the provider's professional qualifications, billing, and practice history including, but not limited to, the following:

(a) The provider fails to maintain the minimum health care provider network standards per WAC 296-20-01030;

(b) The provider fails to comply with health care provider network continuing requirements per WAC 296-20-01040;

(c) The provider engages in action or inaction for which the department may deny an application;

(d) The provider violates the terms of the agreement; or

(e) A finding of risk of harm, pursuant to WAC 296-20-01100 including, but not limited to, prescribing drug therapy in an unsafe manner and/or failure to identify substance abuse/addiction or failure to refer the patient for substance abuse treatment once abuse/addiction is identified.

(6) The department will notify the provider of agreement termination according to the terms of the agreement, identify the reason for agreement termination, and include an effective date of termination. If a provider agreement is terminated for cause, the department or self-insured employer will pay for authorized services provided only up to the date specified in the notice.

NEW SECTION

WAC 296-20-01090 Request for reconsideration of department decision. (1) A provider may request reconsideration of the department's decision to deny enrollment or remove or suspend a provider from the health care provider network. The request for reconsideration must be received by the department within sixty calendar days from the date the department's decision is communicated to the provider.

(2) A provider must:

(a) Specify the department decision(s) that the provider is disputing;

(b) State the basis for disputing the department's decision; and

(c) Include documentation to support the provider's position.

(3) The department may request additional information or documentation. The provider must submit the additional information within thirty calendar days of the date on the department's request.

(4) The department will review the original decision, information supporting the original decision, the provider's reconsideration request and supporting documentation and will notify the provider of the status of its reconsideration decision within ninety days. This is the final department decision, and a provider may appeal pursuant to chapter 51.52 RCW.

NEW SECTION

WAC 296-20-01100 Risk of harm. (1) It is the intent of the department, through authority granted by RCW 51.36.010 to protect workers from physical or psychiatric harm by identifying, and taking appropriate action, including removal of providers from the statewide network, when:

(a) There is **harm**; and

(b) There is a **pattern(s)** of **low quality care**; and

(c) The harm is related to the pattern(s) of low quality care.

(2) It is not the intent of the department to remove or otherwise take action when providers are practicing within department policies and guidelines, or within best practices established or developed by the department, or established in collaboration with its industrial insurance medical and chiropractic advisory committees.

(3) The department may permanently remove a provider from the statewide network or take other appropriate action when that provider's treatment of injured workers exhibits a **pattern or patterns** of conduct of **low quality care** that exposes patients to a risk of physical or psychiatric **harm** or death.

(4) **Harm** is defined as (intended or unintended) physical or psychiatric injury resulting from, or contributed to, by health care services that result in the need for additional monitoring, treatment or hospitalization or that worsens the condition(s), increases disability, or causes death. Harm includes increased, chronic, or prolonged pain or decreased function.

(5) **Pattern or patterns** of low quality care is/are defined as including one or more of the following:

(a) For health services where the department can calculate normative data on frequency, a provider's cases are in the lowest decile (at or below the tenth percentile); or

(b) For health services where the department cannot calculate normative data on frequency, at least twenty percent of requested or conducted services meet the definition of low quality care; or

(c) For health services where department data or scientific literature has reported expected rates of adverse events, a provider's adverse event rates are at least twenty percent above the expected rate; or

(d) A review of a random sample of the provider's cases demonstrates that at least twenty percent of cases do not meet peer matched criteria for acceptable quality; or

(e) Two or more deaths or life-threatening events; or

(f) Provider behavior(s) and/or practices that result in revocation or limitation of hospital privileges or professional licensure sanctions.

(6) **Low quality care in the statewide workers' compensation network is defined as treatments or treatment regimens:**

(a) That have not been shown to be safe or effective or for which it has been shown that the risks of harm exceed the benefits that can reasonably be expected, based on available peer-reviewed scientific studies; or

(b) That uses diagnostic tests or treatment interventions not in compliance with the department's policies, the department's applicable utilization review criteria, or the department's guidelines; or

(c) That includes repeated unsuccessful surgical or other invasive procedures; or

(d) That is outside the provider's scope of practice or training; or

(e) That results in revocation or limitation of hospital privileges or in professional licensure sanctions; or

(f) That fails to include or deliver appropriate and timely health care services as identified in available department guidelines or policies; or

(g) That includes repetitive provision of care that is not curative or rehabilitative per WAC 296-20-01002 for extended periods that does not contribute to recovery, return to work, or claim resolution; or

(h) That includes repeated testing including, but not limited to, routine use of a diagnostic test or procedure by either the provider prescribing or the provider performing the test, when any of the following apply:

(i) The test(s) have been demonstrated to be unsafe or of poor quality; or

(ii) High quality, peer-reviewed scientific studies do not show that the test has the technical capacity (reliable and valid) and accuracy to result in successful clinical outcomes for their intended use (utility); or

(iii) The test is conducted or interpreted in a manner inconsistent with high quality evidence-based clinical practice guidelines; or

(iv) The test is likely to lead to treatment that does not meet department guidelines or policies or is otherwise harmful.