Department of Labor and Industries
Provider Credentialing and Compliance
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Provider Network Agreement

I (provider) _____ , (**print or type**) agree to abide by the terms of this agreement, which pursuant to RCW 51.36.010 has the force of a contract, and by all applicable federal and Washington State statutes, rules and policies. I understand and agree to the following:

1. **Treatment.** I understand that I am responsible for the quality of care that I provide and will use my best medical judgment in providing that care. I further agree that I will provide services that comply with Washington law, Department of Labor and Industries (Department) rules and policies including medical coverage decisions, and Department treatment guidelines. In additional to general laws and rules about medical treatment, I agree I will provide services that comply with specific laws and rules regarding treatment of injured workers found in: Title 51 RCW (Industrial Insurance Act), WAC 296-20 (Medical Aid Rules), WAC 296-21 (Reimbursement Policies: Psychiatric, Biofeedback, Physical Medicine), 296-23 (Radiology, Radiation Therapy, Nuclear Medicine, Pathology, Hospital, Chiropractic, Physical Therapy, Drugless Therapeutics and Nursing – Drugless Therapeutics, etc.), 296-23A (Hospitals), and 296-23B (Ambulatory Surgery Center Payment). I further agree that I will provide quality care that is respectful, equitable and responsive to diverse cultural health beliefs, practices, preferred languages, and communication needs in accordance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

2. **Opioid Treatment.** I acknowledge I am responsible for understanding the Department opioid treatment guidelines and rules. I agree that if I prescribe opioids to injured workers I will comply with the Guidelines for Prescribing Opioids to Treat Pain in Injured Workers and the Department rules for opioids to treat noncancer pain (WAC 296-20-03030-03085). I understand and agree that should I fail to comply with the Department Guidelines for Prescribing Opioids to Treat Pain in Injured Workers and the Department rules for opioids to treat noncancer pain (WAC 296-20-03030-03085), the Department can immediately terminate this agreement. I further agree that in the event of termination of this agreement under Section 13, I will not prescribe opioids to treat injured workers except for an initial visit or hospital emergency room visit under Chapter 51.36.010(2)(b).

3. **Referrals and Consultations.** I agree to timely refer injured workers for consultations and treatment only to other network providers, as required by rule or when it is in the injured worker's best interest. A list of network providers is available at Find a Doctor.

4. **Billing.** I will bill according to the Department's billing rules and policies and understand that payments will be made according to L&I's Medical Aid Rules and Fees Schedules (MARFS) which were in effect at the time the service was rendered. If my usual and customary fee for any particular service is lower to the general public than listed in the fee schedules, I will bill the Department or Self-Insured employer at the lower rate.

5. **Payment.** I will accept payment from the Department or the Self-Insured Employer as sole and complete payment for covered services. I specifically agree not to bill the patient for any difference between the Department's allowable fee and my usual and customary charge, or to bill injured workers for any treatment of an accepted industrial condition.

6. **Overpayment.** If I receive payment from the Department or from a Self-Insured employer in error or in excess of the amount properly due, I will promptly notify the Department and return such excess amounts to the Department or the Self-Insured Employer.

7. **Underpayment.** If I believe additional funds are due, I will submit a provider request for adjustment form within the timelines specified in the rule or on the remittance advice.

8. **Records/Audits.** I agree to complete and maintain all records to fully justify and disclose the extent of the services or items furnished and bills submitted. I will maintain these records for a minimum of five years. I understand and agree that the Department may audit, review, or investigate services and treatment provided under this agreement. I understand that should I fail to retain, maintain, or provide access to the Department, the Department may recover payments not adequately documented or take other action.

9. **Maintain Standards and Notify Department of Changes.** I meet and will maintain all required licenses, permits, governmental or board authorizations, hospital privileges (if applicable), and Department health care provider standards and notify the Department in writing within 14 days of any change, including a change in practice location or contact information. Department health care provider standards may be found in WAC 296-20-01030 (Minimum Health Care Provider Network Standards) and WAC 296-20-01040 (Health Care Provider Network Continuing Requirements).

10. **Communication and Cooperation.** I agree to cooperate with the Department in the management of its Provider Network and will comply with requests made of me in that regard, including mentoring, monitoring, and additional training. I understand that care for injured workers involves more than the provision of medical treatment and agree to timely communicate with the Department, employers, and others who are involved in administering injured workers' claims. I will timely respond to questions, requests for information or records, and complete and timely file required reports or chart notes, and other forms as requested.

11. **Recredentialing.** I will cooperate with the Department's recredentialing process. I agree to submit my recredentialing application every 3 years or at a different time specified by the Department,

12. **Automatic Renewal.** Upon successful completion of recredentialing, I understand that this agreement will automatically renew unless the Department provides me written notice of material changes to this agreement, provides written notice of non-renewal or termination, or unless I no longer meet minimum standards or I am no longer enrolled in the Department's Provider Network.

13. **Termination.** I understand and agree that the Department may terminate this agreement should I no longer meet the provider network standards in WAC 296-20-01030 (Minimum Standards) and WAC 296-20-01040 (Health Care Provider Network Continuing Requirements), the Department finds Risk of Harm pursuant to WAC 296-20-01100, if I violate a material term of this agreement, or if I am no longer a member of the Department's Provider Network. I understand that I may terminate this agreement at any time without cause upon 90 days written notice to the Department.

14. **Services After Termination**. Upon termination of this agreement, I agree that I will not accept injured workers as new patients after the date I am notified of the termination. I may continue to provide covered services to injured workers who are currently undergoing an active course of treatment until the effective date of termination. Thereafter, regardless of the appeal status and pursuant to WAC 296-20-01080, I will not provide any treatment or services to any injured worker unless it is a life threatening emergency or if I provide treatment in a hospital emergency

room. I acknowledge and agree that the Department will not pay for any service I provide to injured workers after the effective date of termination, unless for a life threatening emergency or treatment I provide in a hospital emergency room.

15. **Protest and Appeals.** If I disagree with or believe a decision, determination or order of the Department is incorrect, regardless if it is related to this agreement, my status in the Department's Provider Network or to the claim of an injured worker who I am treating, I may protest or appeal in writing pursuant to Chapter 51.52. I understand and acknowledge that should I fail to timely protest or appeal a decision, determination or order, that such failure will result in the action, determination or directive contained in the order becoming final and binding.

My signature below indicates that I have fully read this document and voluntarily agree to the terms. Once I sign, this agreement will become effective ONLY upon the Department's approval of my provider application and enrollment into the Department's Provider Network. Upon Department approval, this agreement will supersede any previously signed provider agreement that I may have had with the Department.

Print or Type Name	Signature	Date