



WASHINGTON  
S T A T E  
CHIROPRACTIC  
ASSOCIATION

December 5, 2011

To: Leah Hole-Curry, JD, Medical Administrator  
Diane Reus, Occupational Nurse Consultant  
Janet Peterson, Health Services Analysis, Program Manager

From: Lori Bielinski, Executive Director and Lobbyist  
Washington State Chiropractic Association

Re: Provider Network Draft Rules

Date: December 1, 2011

On behalf of the Board of Directors of the Washington State Chiropractic Association I provide the following public comment related to the proposed rules for the Medical Provider Network to be implemented by the passage of SSB 5801.

During the 2011 legislative session while SB 5801 was in the legislative process I made many attempts to work with the chairs of the respective committees to provide comment regarding the Medical Provider Networks proposed in SB 5801. The bill was heard in the Labor and Commerce committees, in both chambers, and our comment was not able to be heard in public testimony until the bill reached the Senate where no amendments were accepted.

At that time, with other professions and organizations in support, I sent a letter raising three concerns:

- That self-insurers not be allowed to create their own networks and rules for providers; and
- That the Department should establish a process for provider appeals of department and self-insurer decisions when choosing to deny or remove a provider from the network; and
- Suggested the use of negotiated rule-making as described in RCW 34.05.310

The Department indicated in a letter to me, from Department Director Schurke, that our concern of self-insurer's establishment of additional rules and creation of their own provider network, or sub-network, would require new legislative action. I strongly propose that these Rules include language that would protect providers and injured workers from different, or additional, rules than what applies to State Fund covered workers. Additionally, the language should protect providers from self insured entities that want to have "company doctors" with more stringent limitations on access to particular providers, specific types of providers, and/or services available to injured workers. It is unclear what role self-insured providers will have in determining, reviewing or advising on Network membership. We think this should be clarified in this rule.

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In regard to our second item of concern, provider appeals of department network decisions to remove a provider from the network must continue to allow providers excluded or removed to have the right to formally appeal such decisions. We would like to see specific language in a department response to this concern that all existing avenues of appeal for network inclusion decision will continue, including to the Board of Industrial Insurance Appeals.

As currently written, proposed rule language reads as follows:

**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:

(3) Maintain material compliance with minimum provider network standards, department credentialing and recredentialing standards, and department's evidence based coverage decisions and treatment guidelines;

It appears that providers who deliver care outside of a specific guidelines used by the Department could be removed or not renewed in the provider network. We are concerned that individual clinical circumstances and decisions will not be considered in the guideline development and implementation process. Although current department leadership has acted reasonably in most instances of implementing department guidelines, this language is of grave concern to the WSCA Board for the following reasons:

- It is widely accepted that guidelines are intended as resources for patients and providers to have ready access to high quality information to assist in sorting through diagnostic and treatment options. They are not mandatory practice standards.
- "Material compliance" is not defined in this rule and would likely be subject to interpretation by department provider review staff and the medical director. The criteria by which future department staff determine said compliance is unclear and could be applied in a fashion inconsistent with "material clinical needs" of an individual patient. Even if criteria are clarified, the administrative burden on the provider to challenge such a decision will be high and may discourage quality providers from even participating in the network.
- To date, the department has maintained an irregular process for systematically reviewing and updating its guidelines. New innovations in health care and extenuating clinical circumstances only tangentially related to available evidence at the time of guideline publication are common situations in practice.
- There has long been a tendency by private payers to consider the 'absence of evidence' the same as 'evidence against,' with no consideration given to a successful patient outcome. This lays groundwork for L&I to follow a similar path.

The WSCA recommend either a) clarifying how material compliance practice with department guidelines will be determined, including the role that individual patient variation and clinical circumstance plays into this determination, or b) removing guidelines entirely from this section.

While Labor and Industries acts as an insurer for injured workers, it is critical that the Department understand that the benefits for injured workers have a completely different approach than an insurer in the private market. Injured worker benefits are intended to return the worker to their job, whether completely or with limitations until they recover. Private health insurance benefits are purchased with an established set of benefits and are to treat a covered condition, injury or illness. As both use medical necessity and standards of care as guidelines for treating conditions, illness and injury, the Department has a different threshold of covering services than that of a health insurer working within a benefit limit regardless of the outcome of the patients' condition.

WAC 296-20-01020 and WAC 296-20-01060

(1) The language proposed indicates that the Department or “its delegated entity” will review the provider’s application, supporting documents, and any other information requested...”. We strongly oppose the use of a delegated entity in the credentialing process for the L&I provider network. Chiropractic doctors and other providers regularly experience “outside networks” who operate on behalf of an insurer and who are not held accountable for their errors and poor treatment of providers. Regularly these outside networks make errors with little or no accountability to the provider or the insurer, in this case the Department, leaving providers caught in the middle of the appropriate outcome. It is our opinion that the Department should manage their own network within the rules of the department and its intent for providing an expanded network of qualified providers to injured workers

If the Department deems it appropriate to allow delegation of credentialing and recredentialing activities, then the vendor recruitment process and all written agreements with them should be an open and public process (perhaps using the newly established Provider Network Advisory Committee) for this process.

(1) There does not appear to be a deadline for the applications that are appropriately provided to the Department, yet in (2) there is a deadline of thirty days for those providers who may have discrepancies. There should be reciprocal deadlines for both providers and the Department in processing applications. Therefore, we recommend that the number of days for appropriately submitted and complete applications be thirty days.

(4) In the approval, denial or further review of a providers’ application the Department should notify the provider in writing of the reason for the delay and especially the denial.

(7) b (ii) The reference to verification of five years of malpractice claims or settlements from the carrier, in addition to the National Provider Data Bank and the Healthcare Integrity and Protection Data Bank queries seem redundant. If the NPDP and the HIPDB are verified it seems redundant that the provider must have their malpractice carrier submit data of settlements that do not meet the threshold for reporting to the NPDB and the HIPDB.

WAC 296-20-01030 Minimum health care provider network standards

- (1) In reference to the requirement of submission of a provider application without modification puts a provider in a “take-it-or-leave-it” circumstance. If this language is in the final rule than there should be an opportunity for providers, and their respective associations, to review the proposed contract. It is normal for providers to make adjustments and recommendations to provider agreements that they are expected to sign.
- (2) (a) While the proposed malpractice coverage limits seem consistent with other insurer requirements, it is the provider’s responsibility to maintain the necessary limits of coverage consistent with protecting their license. Malpractice carriers regularly modify their proposed policies consistent with industry standards which should not be the responsibility of the department unless they are accepting the liability for each provider’s actions. Language should be incorporated here that allows for flexibility as professional liability standards and economic circumstances necessitate.
- (4) We recommend that the words “with cause” be added after the words ...”expelled or suspended with cause from any...”.

#### WAC 296-20-01040

This subsection requires a provider to “maintain compliance with minimum provider network standards, department credentialing and recredentialing standards, and department’s evidence based coverage decisions and treatment guidelines”. All minimum provider network standards, department credentialing and recredentialing standards, department’s evidence-based coverage policies, and all treatment guidelines that providers will be held in compliance with should be included with the materials the network provider application and should be maintained and kept up-to-date in an easily accessible fashion, such as a network provider handbook and on a network provider webpage. Language should be included in this section to require the department to meet these obligations, otherwise this requirement should be removed.

- (3) The requirement of 14 days notice for changes with a clinic is unreasonably short. The notice to the Department should not be less than thirty days. It is not unusual for a provider to have a health care issue, a family issue, or a vacation that may be longer than 2 weeks. While locum tenans or other means for addressing patient needs is common, the ability for a substitute to handle a short notice administrative manner such as this is unlikely. Remember that unlike a private carrier’s company policies which may be subject to flexibility in extenuating circumstances, these network rules will carry the force of law and can’t be simply exempted unless specific authority is delineated.

#### WAC 296-20-01050

There is a lengthy list of reasons for termination with the caveat indicating “including but not limited to”. Providers should know what would cause denial from enrollment in the network and should be clearly spelled out.

There are terms in the Rule that seem to mean the same thing but are not defined. Please define “terminated” and “expelled” and be consistent in their use throughout the proposed Rule.

- (3) (f) Health care insurers regularly modify their provider networks for many reasons. Termination from a health plan doesn’t always mean it is related to patient care. This section should be explicit to state “if a provider has been terminated for cause” or “quality care issues”.

Note: there appears to be some lettering and numbering confusion following (3) (i).

#### WAC 296-20-01070

Chiropractic care is not regularly covered as part of the Medicaid benefits for adults however; consistency in the Rule should include the term “for cause” consistent with our comment in WAC 296-20-01050 (3) (f).

#### WAC 296-20-01090

This issue was referenced in the beginning of this letter. As previously stated, the existing appeal and legislative appeal rights should be explicitly referred to in this rule. Please include language that states: “Upon the Departments final decision to deny, remove or renew a provider’s application, a health care provider may appeal the decision of the Department to the Board of Industrial Insurance Appeals as allowed in 51.52 RCW.

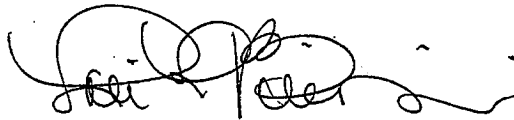
WAC 296-20-01100

Because this section is unique and new to providers treating injured workers, education of these requirements must take place to assure these expectations of the providers are communicated.

- (4) (a) This section is misleading. This language gives an expectation that there are studies and evidence supporting every clinical decision made by a provider. Most every treatment provided to any 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".

Thank you for the opportunity to provide comment on these Rules. If I can be of any assistance I can be reached at 206-878-6055.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori L. Bielinski", with a long, sweeping flourish extending to the right.

Lori L. Bielinski  
Executive Director

Cc: Lorri A. Nichols, DC, WSCA President  
Jim Justin, Governor's Legislative Director