

Dear Provider:

Thank you for your interest in the Centers of Occupational Health & Education (COHE) Program. This letter describes requirements of participation. Please review, sign, and submit the attached form.

Background

The COHE Program is a partnership between the Department of Labor & Industries (L&I or department), medical, and community resources, aimed at improving injured worker health outcomes. The COHEs are dedicated to expanding community expertise in both occupational health care and disability prevention.

Requirements of a COHE Provider

Attached is the Provider Account Application Supplement that must be approved by L&I in order for you to participate in the COHE.

1. If you intend to bill for COHE services using multiple L&I provider numbers, you must complete this form for each provider number.
2. You must be practicing within one of the designated COHE areas, and cooperating with that COHE to improve outcomes for injured workers in your practice.
3. An incomplete application will not be processed.

Billing Information

COHE Providers are allowed to use special billing codes as outlined in the COHE Fee Schedule which details maximum payment for services linked to quality indicators. All other covered services are outlined in the Medical Aid Rules and Fee Schedule (MARFS). Department approval of this Supplemental Application does not guarantee payment of all services billed by a provider. The department's "General Provider Billing Manual" provides instructions for bill submission. The department will purchase only covered services, provided by covered professionals.

Advanced Registered Nurse Practitioners (ARNP) and Certified Physician Assistants (PA-C) are reimbursed at 90% (WAC 296-23-245 and 296-20-12501) of the physician rates, which also applies to the COHE Fee Schedule. All ARNP and PA-C bills must be submitted under their L&I provider account number, *not the account number of the physician*.

For PA-Cs only

State laws governing PA-C scope of practice remain in effect and are in no way altered by COHE participation (WAC 296-20-01501).

Sincerely,

Provider Accounts

Department of Labor & Industries

***L&I Provider Account Application Supplement
for Attending Providers in the
Center of Occupational Health & Education (COHE) Program***

The provider agrees to:

- 1) complete Initial Orientation covering occupational health best practices, program guidelines and L&I billing requirements,
- 2) participate in Annual Occupational Health Best Practices training,
- 3) comply with the COHE Program policies and best practices as adopted by the department while treating injured workers,
- 4) provide appropriate claim-related treatment information to the department in a timely manner,
- 5) use *COHE Program Fee Schedule*, where applicable,
- 6) authorize COHE Health Services Coordinators to access claims for which you are a treating provider via the department's on-line Claim and Account Center.

A provider will be held to the terms of this application, even though a third party may be involved in billing claims to the department.

The department reserves the right to deny, revoke, suspend, or condition a provider's authorization to participate in the COHE Program 3 months from the date of notification of noncompliance with the terms of this application. All other terms and conditions of a provider's application will remain in full force and effect. The department or the provider may terminate this application at any time by submitting a notice of termination in writing to the local COHE.

Please select your comparison group for performance measures:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Hand Surgery | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Other |

Provider's Statement of Agreement

I, _____ agree to abide by the terms of this application and all
(please print clearly)

applicable federal and Washington State statutes, rules, and policies. My orientation to COHE Best Practices occurred on

_____ by _____
(date) (please print clearly the name of person providing orientation)

L&I Provider Number(s)	Group Number(s), if applicable
Name of Clinic/Group, if applicable	Address
	Email (optional)
Signature	Date