AMENDATORY SECTION (Amending WSR 06-06-066, filed 2/28/06, effective 4/1/06)

WAC 296-15-330 Authorization of medical care. What are the requirements for authorization of medical care? Every self-insurer must:

(1) Authorize treatment and pay bills in accordance with Title 51 RCW and the medical aid rules and fee schedules of the state of Washington.

(2) Provide a written explanation of benefits (EOB) to the provider, with a copy to the worker if requested, for each bill adjustment. A written explanation is not required if the adjustment was made solely to conform to the maximum allowable fees as set by the department.

(3) Establish procedures to ensure prompt responses to inquiries regarding authorization decisions and bill adjustments.

(4) Comply with the requirements of the health care provider network. This includes:

(a) Utilizing only those providers approved for the provider network, except when the provider specialty or geographic location is not yet covered by the network;

(b) Providing information to workers about the requirement for providers to be enrolled in the network in order to treat injured workers and information on how a worker can find network providers. This information must be included in publications used by self-insurers to comply with WAC 296-15-400 (2)(a);

(c) Ensuring, when applicable, that only network providers are paid for care after the initial office or emergency room visit; and

(d) Promptly assisting workers who are being treated by a nonnetwork provider to transfer their care to a network provider of their choice; including, at a minimum, notification to the worker within forty-five days of receipt of the first bill from a nonnetwork provider that the provider will not be paid for treatment beyond the initial visit on the claim and information about how to find network providers.