Department of Labor and Industries
Provider Accounts and
Credentialing
PO Box 44261
Olympia WA 98504-4261

Fax: 360-902-4563

Provider 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 addition 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. Providers are required to ensure spoken and sign language access according to Title VI of the Civil Rights Acts of 1964 and the Americans with Disabilities Act (ADA). Interpreting for an injured worker or a crime victim is covered by L&I and does not require prior authorization.

   Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. This includes discrimination based on limited English proficiency (LEP) persons. As a result, recipients and sub-recipients of Federal financial assistance are responsible for taking reasonable steps to ensure meaningful access by LEP persons to the recipients' and sub-recipients' programs or activities, including the use of an interpreter. Failure to do so constitutes illegal discrimination and is a violation of an individual's civil rights. Since L&I is the recipient of Federal funding, medical providers and others whom L&I pays are sub-recipients.

2. **Opioid Treatment.** I acknowledge that 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.** If I am a medical provider, I agree to timely refer injured workers for consultations and treatment only to other Medical Network Providers, as required by WAC 296-20-015(2)(a), WAC 296-20-051, and WAC 296-20-065 or when it is in the injured worker's best interest. A list of Medical Network Providers is available at Find a Doctor.

4. **Communication and Cooperation**. I agree to cooperate with the Department in the management of its Medical Provider Network, timely communicate and 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 in a manner that promotes effective claims management 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, review information provided by the Department, and complete and timely file required reports or chart notes, and other forms as requested. I understand that I am required to provide all medical records deemed relevant by the Department under RCW 51.36.060. I understand that if I fail to follow Department rules or deliver care that creates imminent harm to the worker the Department may exercise its authority under WAC 296-20-065 and WAC 296-20-03015.

5. **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. I certify that all services provided are related to the industrial injury, occupational disease, or injury covered by the Crime Victims Act. I understand that Crime Victims compensation is secondary to any public or private insurance the victim may have.

6. **Payment.** I agree to accept payment from the Department, Crime Victims program, or the Self-Insured Employer as sole and complete payment for covered services in accordance with WAC 296-20-010 I specifically agree not to bill the patient for any difference between the Department, Crime Victims, or Self-Insured allowable fee and my usual and customary charge, or to bill injured workers for any treatment of an accepted industrial condition.

7. **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.

8. **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.

9. **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.

10. **Maintain Standards and Notify Department of Changes.** I meet and will maintain all required licenses, permits, certifications, governmental or board authorizations, hospital privileges (if applicable), required insurance, and the Departments health care provider standards, and will notify the Department in writing within 14 days of any change. This includes but not limited to: a change in practice location, or contact information, my provider status, (e.g. Licensing, certification, registration, disciplinary action, limitation to privileges); federal tax information changes; and location, payment or correspondence addresses. 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).

11. **Re-Credentialing**. I understand the Department does continuous monitoring on all providers which includes a background check. If I am a provider in the Medical Provider Network, I agree to provide the Department with my current malpractice insurance certificate, or any other information deemed relevant to provider monitoring in the Medical Provider Network.

12. **Automatic Renewal.** Upon successful completion of re-credentialing, 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 Medical Provider Network.

13. **Termination.** I understand and agree that the Department reserves the right to deny, revoke, suspend or place condition on my authorization to treat a worker or crime victim in accordance with Washington State Law. If I am a Medical Network Provider and I no longer meet the network standards in WAC 296-20-01030 (Minimum Standards) and WAC 296-20-01040 (Health Care Provider Network Continuing Requirements), if 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 Medical 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 through a final Department order, final order of the Board of Industrial Insurance Appeals, final court order, or a settlement or withdrawal agreement, I agree that I will not provide any treatment to injured workers except for an initial office visit or treatment I provide in a hospital emergency room under Chapter 51.36.010(2)(b). I acknowledge and agree that the Department will not pay for services I provide to injured workers after the effective date of termination unless for an initial office visit 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, 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.

I agree to abide by the terms of this agreement and by all applicable federal and Washington State statues, rules, and policies. I have enclosed with my application all required supporting information necessary to establish a provider account, including my current licenses and certifications.

Once I sign, this agreement will become effective ONLY upon the Department's approval of my provider application and/or, my enrollment into the Department's Medical Provider Network. Upon Department approval, this agreement will supersede any previously signed provider agreement that I may have had with the Department.

My signature below indicates that I have fully read this document and voluntarily agree to the terms.

Print or Type Name	Title

Signature	Date

RESET