WAC 296-20-01020 Health care provider network enrollment. (1) The department or its delegated entity will review the provider's application, supporting documents, and any other information requested or accessed by the department that is relevant to verifying the provider's application, clinical experience or ability to meet or maintain provider network requirements.

(2) The department will notify providers of incomplete applications, including when credentialing information obtained from other sources materially varies from information on the provider application. The provider may submit a supplement to the application with corrections or supporting documents to explain discrepancies within thirty days of the date of the notification from the department. Incomplete applications will be considered withdrawn within forty-five days of notification.

(3) The provider must produce adequate and timely information and timely attestation to support evaluation of the application. The provider must produce information and respond to department requests for information that will help resolve any questions regarding qualifications within the time frames specified in the application or by the department.

(4) The department's medical director or designee is authorized to approve, deny, or further review complete applications consistent with department rules and policies. Providers will be notified in writing of their approval or denial, or that their application is under further review within a reasonable period of time.

(5) Providers who meet the minimum provider network standards, have not been identified for further review, and are in compliance with department rules and policies, will be approved for enrollment into the network.

(6) Enrollment of a provider is effective no earlier than the date of the approved provider application. The department and self-insured employers will not pay for care provided to workers prior to application approval, regardless of whether the application is later approved or denied, except as provided in subsection (7) of this section.

(7) The department and self-insured employers may pay a provider without an approved application only when:

(a) The provider is outside the scope of the provider network per WAC 296-20-01010; or

(b) The provider is provisionally enrolled by the department after it obtains:

(i) Verification of a current, valid license to practice;

(ii) Verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query; and

(iii) A current and signed application with attestation.

(c) A provider may only be provisionally enrolled once and for no more than sixty calendar days. Providers who have previously participated in the network are not eligible for provisional enrollment.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. WSR 12-23-020, § 296-20-01020, filed 11/13/12, effective 12/14/12; WSR 12-02-058, § 296-20-01020, filed 1/3/12, effective 2/3/12.]