H-4103.1

HOUSE BILL 2918

State of Washington 58th Legislature 2004 Regular Session

By Representatives McMorris, Condotta, Holmquist, Crouse and Woods

Read first time 01/22/2004. Referred to Committee on Commerce & Labor.

AN ACT Relating to improving the competitiveness of Washington's industrial insurance system; amending RCW 51.04.110, 51.16.035, 51.28.010, 51.28.055, 51.28.040, 51.32.160, 51.04.060, 51.32.220, 51.32.225, 51.36.110, 51.36.010, 51.44.010, 51.44.020, 28B.20.458, 51.32.210, 41.06.380, 51.52.050, 51.52.132, 51.52.120, and 51.52.130; reenacting and amending RCW 43.84.092 and 51.52.060; adding new sections to chapter 51.32 RCW; adding a new section to chapter 51.36 RCW; adding a new section to chapter 51.04 RCW; adding a new chapter to Title 51 RCW; creating new sections; repealing RCW 51.16.042; prescribing penalties; providing effective dates; providing an expiration date; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

PART I - ACCOUNTABILITY

Sec. 1. RCW 51.04.110 and 1982 c 109 s 2 are each amended to read as follows:

ADVISORY COMMITTEE. (1) The director shall appoint a workers' compensation advisory committee composed of ten voting and two ex officio members as follows: ((~~Three representing subject workers,~~

~~three representing subject employers, one representing self-insurers, one representing workers of self-insurers, and two ex officio members, without a vote, one of whom shall be the chairman~~))

(a) Three members representing workers of state fund employers;

(b) One member representing workers of self-insurers;

(c) Three members representing state fund employers;

(d) One member representing self-insurers; and

(e) Two ex officio members, without a vote, one of whom shall be the chair of the board of industrial appeals and the other the representative of the department. The member representing the department shall be ((~~chairman. This committee shall conduct a continuing study of any aspects of workers' compensation as the committee shall determine require their consideration. The committee shall report its findings to the department or the board of industrial insurance appeals for such action as deemed appropriate~~)) the chair.

(2) The members of the committee shall be appointed for a term of three years commencing on July 1, 1971 and the terms of the members representing the workers and employers shall be staggered so that the director shall designate one member from each such group initially appointed whose term shall expire on June 30, 1972 and one member from each such group whose term shall expire on June 30, 1973.

(3) The members shall serve without compensation, but shall be entitled to travel expenses as provided in RCW 43.03.050 and 43.03.060 as now existing or hereafter amended. The committee may hire such experts, if any, as it shall require to discharge its duties, and may utilize such personnel and facilities of the department and board of industrial insurance appeals as it shall need without charge. All expenses of this committee shall be paid ((~~by the department~~)) from funds appropriated from the medical aid fund to the department.

PART II - PREMIUMS

Sec. 201. RCW 51.16.035 and 1999 c 7 s 8 are each amended to read as follows:

BASIS OF PREMIUM PAYMENT. (1) The department:

(a) Shall classify all occupations or industries in accordance with their degree of hazard and fix therefor basic rates of premium which

shall be the lowest necessary to maintain actuarial solvency of the accident and medical aid funds in accordance with recognized insurance principles((~~. The department~~));

(b) Shall formulate and adopt rules ((~~and regulations~~)) governing the method of premium calculation and collection and providing for a rating system consistent with this title and with recognized principles of workers' compensation insurance which shall be designed to stimulate and encourage accident prevention and to facilitate premium collection((~~. The department~~)). The basis for premium payment shall be total employer payroll as provided in RCW 51.16.060, except that the department may adopt by rule a basis other than payroll for a specific industry when warranted by industry circumstances; and

(c) May annually, or at such other times as it deems necessary to maintain solvency of the funds, readjust rates in accordance with the rating system to become effective on such dates as the department may designate.

(2) In providing a retrospective rating plan under RCW 51.18.010, the department may consider each individual retrospective rating group as a single employing entity for purposes of dividends or premium discounts.

PART III - APPLICATION FOR COMPENSATION

Sec. 301. RCW 51.28.010 and 2001 c 231 s 1 are each amended to read as follows:

EMPLOYER NOTIFICATION--INJURY. (1) Whenever any accident occurs to any worker it ((~~shall be~~)) is the duty of ((~~such~~)) the worker or someone ((~~in~~)) on his or her behalf to ((~~forthwith~~)) report ((~~such~~)) the accident to his or her employer, superintendent, or supervisor in charge of the work((~~, and~~)) within fourteen days after the accident. A claim for an injury due to an accident that was not timely reported may be allowed only for medical aid benefits under chapter 51.36 RCW.

(2) When an employer receives a notice of an accident as required under subsection (1) of this section, it is the duty of the employer to at once report such accident and the injury resulting therefrom to the department pursuant to RCW 51.28.025 where the worker has received treatment from a physician, has been hospitalized, disabled from work, or has died as the apparent result of such accident and injury.

((~~(2)~~)) (3) Upon receipt of ((~~such~~)) the notice of accident required under RCW 51.28.025, the department shall immediately forward to the worker or his or her beneficiaries or dependents notification, in nontechnical language, of their rights under this title. The notice must specify the worker's right to receive health services from a physician of the worker's choice under RCW 51.36.010, including chiropractic services under RCW 51.36.015, and must list the types of providers authorized to provide these services.

Sec. 302. RCW 51.28.055 and 2003 2nd sp.s. c 2 s 1 are each amended to read as follows:

EMPLOYER NOTIFICATION--OCCUPATIONAL DISEASE. (1) Whenever a physician notifies a worker of the existence of an occupational disease, the worker or someone on his or her behalf must report the existence of the disease to his or her employer, superintendent, or supervisor in charge of the work within fourteen days after the notification. A claim for an occupational disease the existence of which was not timely reported may be allowed only for medical aid benefits under chapter 51.36 RCW.

(2) Except as provided in subsection ((~~(2)~~)) (3) of this section for claims filed for occupational hearing loss, claims for occupational disease or infection to be valid and compensable must be filed within two years following the date the physician notifies the worker ((~~had written notice from a physician: (a)~~)) of the existence of his or her occupational disease((~~, and (b) that a claim for disability benefits may be filed. The notice shall also contain a statement that the worker has two years from the date of the notice to file a claim. The physician shall file the notice with the department. The department shall send a copy to the worker and to the self-insurer if the worker's employer is self-insured~~)). However, a claim is valid if it is filed within two years ((~~from~~)) after the date of death of the worker suffering from an occupational disease.

((~~(2)~~)) (3)(a) Except as provided in (b) of this subsection, to be valid and compensable, claims for hearing loss due to occupational noise exposure must be filed within two years ((~~of~~)) after the date of the worker's last injurious exposure to occupational noise in employment covered under this title or within one year ((~~of~~)) after September 10, 2003, whichever is later.

(b) A claim for hearing loss due to occupational noise exposure that is not timely filed under (a) of this subsection ((~~can only~~)) may be allowed only for medical aid benefits under chapter 51.36 RCW.

((~~(3)~~)) (4) The department may adopt rules to implement this section.

Sec. 303. RCW 51.28.040 and 1977 ex.s. c 199 s 1 are each amended to read as follows:

((~~If change of circumstances warrants an increase or rearrangement of compensation, like application shall be made therefor.~~)) Where the worker's application to reopen a claim has been granted under RCW 51.32.160, compensation and other benefits, if in order, shall be allowed for periods of time up to sixty days prior to the receipt of such application.

Sec. 304. RCW 51.32.160 and 1995 c 253 s 2 are each amended to read as follows:

(1)(a) If aggravation, diminution, or termination of disability takes place, the director may, upon the application of the beneficiary, made within seven years from the date the first closing order becomes final, or at any time upon his or her own motion, readjust the rate of compensation in accordance with the rules in this section provided for the same, or in a proper case terminate the payment: PROVIDED, That the director may, upon application of the worker made at any time, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. The department shall promptly mail a copy of the application to the employer at the employer's last known address as shown by the records of the department.

(b) "Closing order" as used in this section means an order based on factors which include medical recommendation, advice, or examination.

(c) Applications for benefits where the claim has been closed without medical recommendation, advice, or examination are not subject to the seven year limitation of this section. The preceding sentence shall not apply to any closing order issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall, for the purposes of this section only, be deemed issued on July 1, 1985. The time limitation of this section shall be ten years in claims involving loss of vision or function of the eyes.

(d)(i) With respect to an application to reopen a claim filed on or after July 1, 1988, but before the effective date of this section, if an order denying ((~~an~~)) the application to reopen ((~~filed on or after July 1, 1988,~~)) is not issued within ninety days of receipt of such application by the self-insured employer or the department, such application shall be deemed granted. ((~~However,~~))

(ii) With respect to an application to reopen a claim filed on or after the effective date of this section:

(A) The self-insured employer or department, as applicable, must notify the worker by mail at the worker's last known address as shown by department records that the application has been received.

(B) If an order denying or granting the application is not issued within ninety days of mailing notice to the worker of receipt of the application, such application shall be deemed granted.

(iii) For good cause, the department or self-insurer may extend the time for making the final determination on the application filed under (d)(i) or (ii) of this subsection for an additional sixty days.

(2) If a worker receiving a pension for total disability returns to gainful employment for wages, the director may suspend or terminate the rate of compensation established for the disability without producing medical evidence that shows that a diminution of the disability has occurred.

(3) No act done or ordered to be done by the director, or the department prior to the signing and filing in the matter of a written order for such readjustment shall be grounds for such readjustment.

(4) This section does not apply to any claim subject to a final settlement agreement under section 305 of this act which provides that the claim is not subject to reopening under this section.

NEW SECTION. **Sec. 305.** A new section is added to chapter 51.32 RCW to read as follows:

FINAL SETTLEMENT AGREEMENTS AUTHORIZED. (1)(a) A worker and an employer may enter into a final settlement agreement as provided in this section with respect to one or more claims under this title. The final settlement agreement may:

(i) Bind the parties with regard to any or all aspects of a claim, including but not limited to allowance or rejection of a claim,

monetary payment, provision of medical treatment, claim closure, and claim reopening under RCW 51.32.160; and

(ii) Not subject any employer who is not a signatory to the agreement to any responsibility or burden under any claim.

(b) A final settlement agreement entered into under this section must be signed by the employer and the worker and must clearly state that the parties agree to the terms of the final settlement agreement. In a state fund claim, the employer or the worker must file the final settlement agreement with the director. Unless the worker or the employer revokes consent to the agreement, except as provided in subsection (2) or (3) of this section: (i) The final settlement agreement in a state fund case becomes final and binding fourteen days after the agreement is filed with the director; and (ii) in a self-insured case, the final settlement agreement becomes final and binding fourteen days after the agreement is signed.

(c) A self-insured employer and a worker may enter into a final settlement agreement. The agreement must be signed by the employer and the worker.

(d) A final settlement agreement that has become final and binding as provided in this section is binding on the department and on all parties to the agreement as to its terms and the injuries and occupational diseases to which the final settlement applies. A final settlement agreement that has become final and binding is not subject to appeal.

(2)(a) A worker or an employer in a state fund case may revoke consent to the final settlement agreement by providing written notice to the other party and the director within fourteen days of the date the agreement is filed with the director.

(b) A worker or an employer in a self-insured case may revoke consent to the final settlement agreement by providing written notice to the other party within fourteen days of signing the settlement agreement. Unless subsection (3) of this section applies, if no party revokes the agreement as specified in this subsection, the self-insurer must forward the agreement to the department to provide notice to the department of the binding terms of the agreement and for placement of the agreement in the applicable claim files.

(3)(a) If a worker is not represented by legal counsel at the time of signing a final settlement agreement, the department or the self-

insurer, as the case may be, must forward a copy of the signed settlement agreement to the board of industrial insurance appeals with a request for a conference with a settlement officer. Unless the worker or the employer requests a later date, the settlement officer must convene a conference within fourteen days of receipt of the request for the limited purpose of receiving the final settlement agreement of the parties, explaining the benefits generally available under this title, and explaining that a final settlement agreement may alter the benefits payable on a claim. In no event may a settlement officer render legal advice to any party.

(b) The settlement officer may reject a settlement agreement only if the agreement constitutes a gross miscarriage of justice. Within seven days after the conference, the settlement officer shall issue a conference report accepting or rejecting the final settlement agreement. If the settlement agreement is rejected, no further proceedings with regard to the settlement agreement may take place, and the settlement agreement is null and void.

(c) If the settlement officer accepts the agreement and no party revokes the agreement as specified in subsection (2) of this section or (d) of this subsection, the agreement becomes final and binding. If the case involves a self-insurer, the self-insurer shall forward the final and binding agreement to the department to provide notice to the department of the binding terms of the agreement and for placement of the agreement in the applicable claim files.

(d) In cases requiring a conference under this subsection:

(i) The worker or the employer in a state fund case may revoke consent to the agreement by providing written notice to the other party and the department within fourteen days after the conference with the settlement officer.

(ii) If the case involves a self-insurer, the worker or the employer may revoke consent to the agreement by providing written notice to the other party within fourteen days after the conference with the settlement officer.

(4) To the extent the worker is entitled to temporary total disability or permanent total disability benefits while a final settlement agreement is being negotiated, or during the revocation period of an agreement, such benefits shall be paid until the agreement becomes final.

(5)(a) If the parties have provided in a final settlement agreement that a claim or claims are not subject to reopening pursuant to RCW 51.32.160, any application to reopen the claim or claims is of no force or effect and must be denied.

(b)(i) If a worker subject to a final settlement agreement subsequently files a new claim under this title, or an application under RCW 51.32.160 to reopen a claim that is not covered by the settlement agreement, for an injury or occupational disease involving the same or similar diagnosis in the same region of the body or the same or similar mental health diagnosis as the claim or claims covered by the final settlement agreement, any monthly compensation or permanent disability compensation payable to the worker under the subsequent or reopened claim shall be reduced by the monetary compensation paid to the worker under the final settlement agreement.

(ii) Proper and necessary medical treatment under RCW 51.36.010, if indicated, shall be provided to the worker in a new claim or a reopened claim not covered by the final settlement agreement notwithstanding the existence of a prior final settlement agreement in another claim or claims of the worker involving the same or similar diagnosis in the same region of the body or the same or similar mental health diagnosis.

(c) A final settlement agreement in any claim may be used as a defense by any employer if a worker subject to a final settlement agreement files a subsequent new claim or an application to reopen a claim for the same or similar diagnosis in the same region of the body or the same or similar mental health diagnosis.

(d) As used in this subsection, "same or similar diagnosis in the same region of the body or the same or similar mental health diagnosis" shall be broadly construed to prevent excessive or duplicative benefits to the worker or abuse by the worker in filing multiple or repetitious claims for benefits.

Sec. 306. RCW 51.04.060 and 1977 ex.s. c 350 s 3 are each amended to read as follows:

No employer or worker shall exempt himself or herself from the burden or waive the benefits of this title by any contract, agreement, rule or regulation, and any such contract, agreement, rule or regulation shall be pro tanto void. However, this section does not

prohibit final settlement agreements authorized under section 305 of this act.

PART IV - COMPENSATION

Sec. 401. RCW 51.32.220 and 1982 c 63 s 19 are each amended to read as follows:

BENEFIT CALCULATION--SOCIAL SECURITY OFFSET. (1) For persons who are under the age of sixty-five receiving compensation for temporary or permanent total disability pursuant to the provisions of this chapter ((~~51.32 RCW~~)), such compensation shall be reduced by an amount equal to the benefits payable under the federal old-age, survivors, and disability insurance act as now or hereafter amended not to exceed the amount of the reduction established pursuant to 42 USC 424a. However, such reduction shall not apply when the combined compensation provided pursuant to chapter 51.32 RCW and the federal old-age, survivors and disability insurance act is less than the total benefits to which the federal reduction would apply, pursuant to 42 USC 424a. Where any person described in this section refuses to authorize the release of information concerning the amount of benefits payable under said federal act the department's estimate of said amount shall be deemed to be correct unless and until the actual amount is established and no adjustment shall be made for any period of time covered by any such refusal.

(2) For persons who are the age of sixty-five or over receiving compensation for temporary or permanent total disability under this chapter on or after July 1, 2004, such compensation must be reduced by an amount equal to the benefits payable under the disability provisions of the federal old-age, survivors, and disability insurance act not to exceed the amount of the reduction established pursuant to 42 U.S.C. 424a. However, the reduction does not apply when the combined compensation provided under this chapter and the federal old-age, survivors, and disability insurance act is less than the total benefits to which the federal reduction would apply, pursuant to 42 U.S.C. 424a. When a person described in this section refuses to authorize the release of information concerning the amount of benefits payable under the federal act, the department's estimate of the amount is deemed to

be correct unless and until the actual amount is established and no adjustment shall be made for any period of time covered by any such refusal.

(3) Any reduction under subsection (1) or (2) of this section shall be effective the month following the month in which the department or self-insurer is notified by the federal social security administration that the person is receiving disability benefits under the federal old-age, survivors and disability insurance act: PROVIDED, That in the event of an overpayment of benefits the department or self-insurer may not recover more than the overpayments for the six months immediately preceding the date the department or self-insurer notifies the worker that an overpayment has occurred: PROVIDED FURTHER, That upon determining that there has been an overpayment, the department or self-insurer shall immediately notify the person who received the overpayment that he or she shall be required to make repayment pursuant to this section and RCW 51.32.230.

((~~(3)~~)) (4) Recovery of any overpayment must be taken from future temporary or permanent total disability benefits or permanent partial disability benefits provided by this title. In the case of temporary or permanent total disability benefits, the recovery shall not exceed twenty-five percent of the monthly amount due from the department or self-insurer or one-sixth of the total overpayment, whichever is the lesser.

((~~(4)~~)) (5) No reduction may be made unless the worker receives notice of the reduction prior to the month in which the reduction is made.

((~~(5)~~)) (6) In no event shall the reduction reduce total benefits to less than the greater amount the worker may be entitled to under this title or the federal old-age, survivors and disability insurance act.

((~~(6)~~)) (7) The director or self-insurer, pursuant to rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05 RCW, may exercise his discretion to waive, in whole or in part, the amount of any overpayment where the recovery would be against equity and good conscience.

((~~(7)~~)) (8) The amendment in subsection (1) of this section by chapter 63, Laws of 1982 raising the age limit during which the

reduction shall be made from age sixty-two to age sixty-five shall apply with respect to workers whose effective entitlement to total disability compensation begins after January 1, 1983.

Sec. 402. RCW 51.32.225 and 1986 c 59 s 5 are each amended to read as follows:

(1) For persons receiving compensation for temporary or permanent total disability under this title, the compensation shall be reduced by the department to allow an offset for social security retirement benefits payable under the federal social security, old age survivors, and disability insurance act, 42 U.S.C. This reduction shall not apply to any worker who is receiving permanent total disability benefits prior to July 1, 1986.

(2) Reductions for social security retirement benefits under this section shall comply with the procedures in RCW 51.32.220 (1) through ((~~(6)~~)) (7), except those that relate to computation, and with any other procedures established by the department to administer this section.

(3) Any reduction in compensation made under chapter 58, Laws of 1986, shall be made before the reduction established in this section.

PART V - MEDICAL AID

NEW SECTION. **Sec. 501.** MANAGED CARE--DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Complaint" means any dissatisfaction expressed by an injured worker concerning a workers' compensation managed care arrangement.

(2) "Grievance" means a written complaint, other than an application for benefits, filed by the injured worker pursuant to the requirements of the managed care arrangement, expressing dissatisfaction with the refusal of the workers' compensation managed care arrangement to provide health care or dissatisfaction with the health care provided.

(3) "Health care coordinator" means a primary care provider within a provider network who is responsible for managing the health care of an injured worker, including determining other health care providers and health care facilities to which the injured worker will be referred

for evaluation or treatment. A health care coordinator must be a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(4) "Practice parameters and protocols" means the practice parameters and protocols of treatment adopted by the United States agency for healthcare research and quality in effect on January 1, 2003, and any other practice parameters or protocols of treatment applicable under this title that the director adopts by rule or policy.

(5) "Provider network" means a comprehensive panel of health care providers and health care facilities who have contracted directly or indirectly with a self-insurer or the department in accordance with this chapter to provide proper and necessary medical, surgical, and hospital care and services to injured workers as required under chapter 51.36 RCW.

(6) "Service area" means the department-approved geographic area within which the self-insured employer or department is authorized to offer a workers' compensation managed care arrangement.

(7) "Workers' compensation managed care arrangement" means an arrangement under which a health care provider as defined in RCW 48.43.005, a health care facility as defined in RCW 48.43.005, a group of health care providers, a health carrier regulated under chapter 48.20 or 48.21 RCW, a health care service contractor registered under chapter 48.44 RCW, or a health maintenance organization registered under chapter 48.46 RCW has entered into a written agreement directly or indirectly with a self-insured employer or the department to provide and to manage proper and necessary medical, surgical, and hospital care and services to injured workers in accordance with this title.

NEW SECTION. **Sec. 502.** MANAGED CARE AUTHORIZED. (1) Subject to the terms and limitations specified in this chapter, a self-insured employer may furnish to its workers, or the department may furnish to some or all workers covered by the state fund, solely through workers' compensation managed care arrangements such proper and necessary medical, surgical, and hospital care and services for the period of a worker's disability from a covered injury as may be required under chapter 51.36 RCW, and which must be provided in accordance with practice parameters and protocols established under this chapter. If

a self-insured employer or the department elects to deliver the medical benefits required by this title through a method other than a workers' compensation managed care arrangement, the discontinuance of the use of the workers' compensation managed care arrangement shall be without regard to the date of injury.

(2)(a) The department shall authorize a self-insured employer to offer or use a workers' compensation managed care arrangement after:

(i) The self-insurer files a completed application along with the payment of a one thousand dollar application fee;

(ii) The department is satisfied that the self-insurer has the ability to provide quality of care consistent with the prevailing professional standards of care; and

(iii) The self-insurer and its workers' compensation managed care arrangement otherwise meet the requirements of this chapter.

(b) No self-insurer may offer or use a managed care arrangement in this state without department authorization required by this section. The authorization, unless sooner suspended or revoked, automatically expires two years after the date of issuance unless renewed by the self-insurer. The authorization shall be renewed upon application for renewal and payment of a renewal fee of one thousand dollars, provided that the self-insurer is in compliance with this section and any rules adopted hereunder. An application for renewal of the authorization shall be made ninety days before expiration of the authorization on forms provided by the department. The renewal application shall not require the resubmission of any documents previously filed with the department if such documents have remained valid and unchanged since their original filing.

NEW SECTION. **Sec. 503.** MANAGED CARE PLAN OF OPERATION. (1) Before a self-insured employer may be authorized to offer or use a workers' compensation managed care arrangement in this state, the self-insurer's managed care plan of operation must be approved by the department.

(2) A self-insurer must file a proposed managed care plan of operation with the department in a format prescribed by the department. The plan of operation must contain evidence that all covered services are available and accessible, including a demonstration that:

(a) The covered services can be provided with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation must reflect usual practice in the local area. Geographic availability must reflect the usual travel times with the community;

(b) Unless the department determines that insufficient numbers of providers are available, the number of providers in the workers' compensation managed care arrangement service area is sufficient, with respect to current and expected workers to be serviced by the arrangement, either:

(i) By delivery of all required health care services; or

(ii) Through the ability to make appropriate referrals within the provider network;

(c) Written agreements are entered into with providers describing specific responsibilities and prohibiting providers from billing or otherwise seeking reimbursement from or recourse against any injured worker for covered services; and

(d) Emergency care is available twenty-four hours a day and seven days a week.

(3) The proposed managed care plan of operation must include:

(a) A statement or map providing a clear description of the service area;

(b) A description of the grievance procedure to be used;

(c) A description of the quality assurance program that assures that the health care services provided to workers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the medical community. The program shall include, but not be limited to:

(i) A written statement of goals and objectives that stresses health and return-to-work outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers;

(ii) A written statement describing how methodology has been incorporated into an ongoing system for monitoring of care that is individual care oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(iii) Written procedures for taking appropriate remedial action

whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided;

(iv) A written plan, that includes ongoing review, for providing review of physicians and other licensed health care providers;

(v) Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service;

(vi) Adequate methods of peer review and utilization review. The utilization review process shall include a health care facility's precertification mechanism, including, but not limited to, all elective admissions and nonemergency surgeries and adherence to practice parameters and protocols established under this chapter;

(vii) Provisions for resolution of disputes arising between a health care provider and a self-insurer regarding reimbursements and utilization review;

(viii) Availability of process for aggressive health care coordination, as well as a program involving cooperative efforts by the workers, the employer, and the workers' compensation managed care arrangement to promote early return to work for injured workers;

(ix) A provision for the selection of a primary care provider by the employee from among primary providers in the provider network; and

(x) The written information proposed to be used by the self-insurer to comply with (e) of this subsection;

(d) Written procedures to provide the self-insurer with timely medical records and information including, but not limited to, work status, work restrictions, date of maximum medical improvement, permanent impairment ratings, and other information as required, including information demonstrating compliance with the practice parameters and protocols of treatment established under this chapter;

(e) Evidence that appropriate health care providers and administrative staff of the self-insurer's workers' compensation managed care arrangement have received training and education on the provisions of this chapter; the administrative rules that govern the provision of proper and necessary medical, surgical, and hospital care and services to injured workers; and the practice parameters and protocols of treatment established under this chapter;

(f) Written procedures and methods to prevent inappropriate or

excessive treatment that are in accordance with the practice parameters and protocols of treatment established under this chapter;

(g) Written procedures and methods for the management of an injured worker's health care by a health care coordinator including:

(i) The mechanism for assuring that covered employees receive all initial covered services from a primary care provider participating in the provider network, except for emergency care;

(ii) The mechanism for assuring that all continuing covered services be received from the same primary care provider participating in the provider network that provided the initial covered services, except when services from another provider are authorized by the health care coordinator pursuant to (g)(iv) of this subsection;

(iii) The policies and procedures for allowing an employee to change to another provider within the provider network as the authorized treating physician during the course of treatment for a work-related injury in accordance with rules adopted under RCW 51.36.010;

(iv) The process for assuring that all referrals authorized by a health care coordinator, in accordance with the practice parameters and protocols of treatment established under this chapter, are made to the participating network providers, unless proper and necessary medical, surgical, and hospital care and services are not available and accessible to the injured worker in the provider network; and

(v) Assignment of a health care coordinator licensed under chapter 18.71 RCW to manage care by physicians licensed under chapter 18.71 RCW, a health care coordinator licensed under chapter 18.57 RCW to manage care by osteopathic physicians licensed under chapter 18.57 RCW, a health care coordinator licensed under chapter 18.25 RCW to manage care by chiropractors licensed under chapter 18.25 RCW, on an injured worker's request for care by any of the listed providers; and

(h) A description of the use of workers' compensation practice parameters and protocols of treatment for health care services.

(4) A self-insured employer must file any proposed changes to the plan of operation, except for changes in the list of health care providers, with the department before implementing the changes. The changes are considered approved forty-five days after filing unless specifically disapproved by the department within the forty-five day period.

NEW SECTION. **Sec. 504.** (1) Before the department may offer or use a workers' compensation managed care arrangement in this state, the department must develop a managed care plan of operation that meets the requirements of the plan of operation required under section 503 of this act, and must provide a period of at least thirty days for public review and comment before implementing the plan or any changes to the plan, except for changes to the list of health care providers.

(2) The department must develop a plan under which retrospective rating plan employers and retrospective rating plan groups would be authorized to contract for workers' compensation managed care arrangements. The proposal must include the requirements that the retrospective rating plan employer or group must meet to qualify for a workers' compensation managed care arrangement and the responsibilities and rights of both employers and employees under the arrangement. The plan must be developed within one year after the effective date of this section and, thereafter, must be implemented through the adoption of rules.

NEW SECTION. **Sec. 505.** MANAGED CARE--DISCLOSURE. A self-insured employer or the department, as the case may be, must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the workers' compensation managed care arrangement to affected workers, including at least:

(1) A description, including address and telephone number, of the network providers, including primary care physicians, specialty physicians, hospitals, and other health care providers;

(2) A description of the coverage for emergency and urgently needed care provided within and outside the service area;

(3) A description of limitations on referrals; and

(4) A description of the grievance process.

NEW SECTION. **Sec. 506.** MANAGED CARE--GRIEVANCE PROCEDURES. (1) A workers' compensation managed care arrangement must have and use procedures for hearing complaints and resolving written grievances from injured workers and health care providers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures. Procedures provided in this section are in addition to other dispute resolution procedures contained in this title.

(2) The grievance procedures must be described in writing and provided to the affected workers and health care providers.

(3) At the time that the workers' compensation managed care arrangement is implemented, the self-insurer or the department, as the case may be, must provide detailed information to workers and health care providers describing the manner in which a grievance may be filed with the self-insured employer or department.

(4) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have the authority to investigate the issues fully and take corrective action.

(5) If a grievance is found to be valid, corrective action must be taken promptly.

(6) All concerned parties must be notified of the results of a grievance.

NEW SECTION. **Sec. 507.** MANAGED CARE--TREATMENT COMPLYING WITH REQUIREMENTS. (1) Notwithstanding any other provision of this title, when an authorized self-insured employer or the department provides health care through a workers' compensation managed care arrangement under this chapter, those workers who are subject to the arrangement must receive health care services for work-related injuries and diseases as prescribed in the contract, if: (a) The self-insurer or the department, as the case may be, has provided notice to the employees of the arrangement in a manner approved by the department; and (b) the health care services are in accordance with the practice parameters and protocols established under this chapter. In such cases, treatment received outside the workers' compensation managed care arrangement is not compensable, regardless of the purpose of the treatment, including, but not limited to, evaluations, examinations, or diagnostic studies to determine causation between medical findings and a covered injury or occupational disease, the existence or extent of impairments or disabilities, and whether the injured employee has reached maximum medical improvement, unless authorized by the self-insurer or the department, as the case may be, before the treatment date.

(2) When a self-insurer or the department enters into a managed care arrangement under this chapter, the employees who are covered by the provision of such arrangement shall be deemed to have received all

the benefits to which they are entitled pursuant to chapter 51.36 RCW. In addition, the employer and the department shall be deemed to have complied completely with the requirements of such provisions. The provisions governing managed care arrangements shall govern exclusively unless specifically stated otherwise in this title.

NEW SECTION. **Sec. 508.** MANAGED CARE--PENALTIES FOR VIOLATIONS. (1) The director may suspend the authority of a self-insurer to offer a workers' compensation managed care arrangement or may order compliance within sixty days, if the director finds that:

(a) The self-insurer or its managed care contractor is in substantial violation of its contracts;

(b) The self-insurer or its managed care contractor is unable to fulfill its obligations under outstanding managed care arrangement contracts;

(c) The self-insurer or managed care contractor knowingly uses a provider who is furnishing or has furnished health care services without having an existing license or other authority to practice or furnish health care services in this state;

(d) The self-insurer no longer meets the requirements for authorization as originally issued; or

(e) The self-insurer has violated any provision of this chapter or rule or order of the director adopted under this chapter.

(2) Revocation of a self-insurer's authorization under this chapter shall be for a period of two years. After two years, the self-insurer may apply for a new authorization by complying with all requirements applicable to first-time applicants.

(3) Suspension of a self-insurer's authority to offer a workers' compensation managed care arrangement shall be for a period, not to exceed one year, as is fixed by the director. The director shall, in his or her order suspending the authority of a self-insurer to offer workers' compensation managed care, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the self-insurer before reinstatement of its authority. The order of suspension is subject to rescission or modification by further order of the director before the expiration of the suspension period. Reinstatement shall not be made unless requested by the self-insurer.

However, the director shall not grant reinstatement if he or she finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(4) Upon expiration of the suspension period, the self-insurer's authorization shall automatically be reinstated unless the director finds before the expiration that the causes of the suspension have not been rectified or that the self-insurer is otherwise not in compliance with the requirements of this chapter. If not so automatically reinstated, the authorization shall be deemed to have expired as of the end of the suspension period.

(5) If the director finds that one or more grounds exist for the revocation or suspension of an authorization issued under this section, the director may, in lieu of such revocation or suspension, impose a fine upon the self-insurer as follows:

(a) With respect to a nonwillful violation, the fine may not exceed two thousand five hundred dollars for each such violation. A fine may not exceed an aggregate amount of ten thousand dollars for all nonwillful violations arising out of the same action; or

(b) With respect to a knowing and willful violation, the fine may not exceed twenty thousand dollars for each such violation. A fine may not exceed an aggregate amount of one hundred thousand dollars for all knowing and willful violations arising out of the same action.

NEW SECTION. **Sec. 509.** MANAGED CARE RULES. The director shall adopt rules that specify:

(1) Procedures for authorization and examination of workers' compensation managed care arrangements by the department;

(2) Requirements and procedures for authorization of workers' compensation arrangement provider networks and procedures for the department to grant exceptions from accessibility of services;

(3) Requirements and procedures for case management, utilization management, and peer review;

(4) Requirements and procedures for quality assurance and medical records;

(5) Requirements and procedures for dispute resolution in conformance with this chapter;

(6) Requirements and procedures for employee and provider education; and

(7) Requirements and procedures for reporting data regarding grievances, return-to-work outcomes, and provider networks.

Sec. 510. RCW 51.36.110 and 1994 c 154 s 312 are each amended to read as follows:

(1) The director of the department of labor and industries or the director's authorized representative shall have the authority to:

((~~(1)~~)) (a) Conduct audits and investigations of providers of medical, chiropractic, dental, vocational, and other health services furnished to industrially injured workers pursuant to Title 51 RCW to determine whether providers are: (i) Complying with this title and the rules adopted under this title; (ii) engaging in overutilization; (iii) engaging in improper billing practices; and (iv) adhering to practice parameters and protocols of treatment established under this title. In the conduct of such audits or investigations, the director or the director's authorized representatives may examine all records, or portions thereof, including patient records, for which services were rendered by a health services provider and reimbursed by the department, notwithstanding the provisions of any other statute which may make or purport to make such records privileged or confidential: PROVIDED, That no original patient records shall be removed from the premises of the health services provider, and that the disclosure of any records or information obtained under authority of this section by the department of labor and industries is prohibited and constitutes a violation of RCW 42.52.050, unless such disclosure is directly connected to the official duties of the department: AND PROVIDED FURTHER, That the disclosure of patient information as required under this section shall not subject any physician or other health services provider to any liability for breach of any confidential relationships between the provider and the patient: AND PROVIDED FURTHER, That the director or the director's authorized representative shall destroy all copies of patient medical records in their possession upon completion of the audit, investigation, or proceedings;

((~~(2)~~)) (b) Approve or deny applications to participate as a provider of services furnished to industrially injured workers pursuant to Title 51 RCW; and

((~~(3)~~)) (c) Terminate or suspend eligibility to participate as a

provider of services furnished to industrially injured workers pursuant to Title 51 RCW.

(2)(a) If the department finds that a health services provider has improperly billed, overutilized, or failed to comply with rules adopted under this title, including but not limited to practice parameters and protocols established under this title, it must notify the provider of its findings and may determine that the health services provider may not receive payment from the department or self-insured employer, as the case may be, or may impose penalties as provided in RCW 51.48.080.

(b) If a health services provider has received payment from the department or self-insured employer for services that were improperly billed, that constitute overutilization, or that were outside the practice parameters or protocols established under this title, the provider must repay those amounts to the department or self-insurer, as the case may be. The department may assess a penalty of up to five hundred dollars for each overpayment that is not refunded within thirty days after notification of overpayment by the department.

(c) For the purposes of this subsection, "overutilization" means providing an inappropriate health service or level of service to an injured worker, including but not limited to providing treatment in excess of established practice parameters and protocols of treatment established under this title.

NEW SECTION. **Sec. 511.** A new section is added to chapter 51.36 RCW to read as follows:

STANDARDS OF CARE. The following standards of care shall be followed in providing medical care under this title:

(1)(a) Abnormal anatomical findings alone, in the absence of objective relevant medical findings, shall not be an indicator of injury or illness, a justification for the provision of curative or rehabilitative medical care or the assignment of restrictions, or a foundation for limitations.

(b) At all times during evaluation and treatment, the health services provider shall act on the premise that returning to work is an integral part of the treatment plan. The goal of removing all restrictions and limitations as early as appropriate shall be part of the treatment plan on a continuous basis. The assignment of restrictions and limitations shall be reviewed with each patient

examination and upon receipt of new information, such as progress reports from physical therapists and other health services providers. Consideration shall be given to upgrading or removing the restrictions and limitations with each patient examination, based upon the presence or absence of objective relevant medical findings.

(c) Reasonable proper and necessary medical care of injured employees shall in all situations:

(i) Use a high intensity, short duration treatment approach that focuses on early activation and restoration of function whenever possible.

(ii) Include reassessment of the treatment plans, regimes, therapies, prescriptions, and functional limitations or restrictions prescribed by the provider every thirty days.

(iii) Be focused on treatment of the individual employee's specific clinical dysfunction or status and shall not be based upon nondescript diagnostic labels.

(2) All treatment shall be inherently scientifically logical and the evaluation or treatment procedure must match the documented physiologic and clinical problem. Treatment shall match the type, intensity, and duration of service required by the problem identified.

Sec. 512. RCW 51.36.010 and 1986 c 58 s 6 are each amended to read as follows:

CHOICE OF PHYSICIAN. (1) Subject to the limits in this section, upon the occurrence of any injury to a worker entitled to compensation under the provisions of this title, he or she shall receive proper and necessary medical and surgical services at the hands of a physician of his or her own choice, if conveniently located, and proper and necessary hospital care and services during the period of his or her disability from such injury((~~, but the same shall be limited in point of duration as follows:~~)).

(a) The duration of medical and surgical services is limited as provided in this subsection:

(i) In the case of permanent partial disability, services may not ((~~to~~)) extend beyond the date when compensation shall be awarded him or her, except when the worker returned to work before permanent partial disability award is made, in such case services may not ((~~to~~)) extend beyond the time when monthly allowances to him or her shall cease;

(ii) In case of temporary disability services may not ((~~to~~)) extend beyond the time when monthly allowances to him or her shall cease: PROVIDED, That after any injured worker has returned to his or her work his or her medical and surgical treatment may be continued if, and so long as, such continuation is deemed necessary by the supervisor of industrial insurance to be necessary to his or her more complete recovery;

(iii) In case of a permanent total disability services may not ((~~to~~)) extend beyond the date on which a lump sum settlement is made with him or her or he or she is placed upon the permanent pension roll: PROVIDED, HOWEVER, That the supervisor of industrial insurance, solely in his or her discretion, may authorize continued medical and surgical treatment for conditions previously accepted by the department when such medical and surgical treatment is deemed necessary by the supervisor of industrial insurance to protect such worker's life or provide for the administration of medical and therapeutic measures including payment of prescription medications, but not including those controlled substances currently scheduled by the state board of pharmacy as Schedule I, II, III, or IV substances under chapter 69.50 RCW, which are necessary to alleviate continuing pain which results from the industrial injury. In order to authorize such continued treatment the written order of the supervisor of industrial insurance issued in advance of the continuation shall be necessary.

(b) The choice of attending physician is limited as provided in this subsection:

(i) If an injured worker is covered through a workers' compensation managed care arrangement as provided in chapter 51.-- RCW (sections 501 through 509 of this act), the worker must select a primary care provider from among the primary care providers in the provider network as prescribed in the managed care contract; and

(ii) A physician who is not an attending physician may not: (A) Authorize payment of temporary disability compensation; or (B) make ratings regarding the worker's impairment for the purpose of evaluating the worker's disability unless requested by the department or the employer.

(2) The supervisor of industrial insurance, the supervisor's designee, or a self-insurer, in his or her sole discretion, may authorize inoculation or other immunological treatment in cases in

which a work-related activity has resulted in probable exposure of the worker to a potential infectious occupational disease. Authorization of such treatment does not bind the department or self-insurer in any adjudication of a claim by the same worker or the worker's beneficiary for an occupational disease.

NEW SECTION. **Sec. 513.** A new section is added to chapter 51.32 RCW to read as follows:

EMPLOYER CLAIMS ADMINISTRATION AUTHORITY. (1) A state fund employer or retrospective rating plan group that administers its industrial insurance program through an authorized claims administrator may:

(a) Schedule medical examinations and consultations under RCW 51.36.070, using only providers from the department's approved provider list; and

(b) Initiate vocational and other rehabilitation services under RCW 51.32.095, using only providers from the department's approved provider list. Vocational and other rehabilitation services may include job placement services, vocational rehabilitation plans, or other accepted services.

(2) Within one hundred twenty days after the effective date of this section, the department shall adopt rules to implement the specific requirements of this section, including the following:

(a) The rules may require notification to the department before the employer or retrospective rating plan group exercises authority under this section, but the rules must minimize the department's need to respond and must ensure that a failure to respond or a delay in response by the department does not impede the timely administration of the claim.

(b) The rules may not require that: (i) A medical examination be performed by the worker's attending physician or other treating provider; or (ii) a consultation referral be requested from the worker's attending physician or other treating provider before scheduling a provider for a medical examination.

(c) The rules must establish qualifications for authorized claims administrators and require an authorized claims administrator to demonstrate, in a manner satisfactory to the department, a thorough knowledge of the industrial insurance laws, and an expertise in

processing claims as authorized under this section. The rules must also establish procedures for approval and disapproval of authorized claims administrators. This section does not permit the department to establish requirements for authorized claims administrators that exceed the requirements for state fund claims administrators.

(3) This section applies to all claims regardless of the date of injury.

(4) For purposes of this section, "authorized claims administrator" means a person who is approved by the department as meeting the qualifications established by rule under subsection (2)(c) of this section.

PART VI - FUNDS

Sec. 601. RCW 51.44.010 and 1961 c 23 s 51.44.010 are each amended to read as follows:

ACCIDENT FUND. (1) There shall be, in the office of the state treasurer, a fund to be known and designated as the "accident fund((~~.~~))" for the benefit of employers and employees subject to this title. All receipts from premiums owed under RCW 51.16.060 must be deposited in the accident fund. Expenditures from the accident fund may be used only for the payment of compensation, vocational rehabilitation, death benefits, funeral expenses, like benefits for loss sustained on account of injury, disease, or death provided for by this title, administration of this title, and debt service for capital improvements related to the state fund, and may not be used for any other purpose. Only the director or the director's designee may authorize expenditures from the accident fund for such benefits. Consistent with RCW 43.88.180, money in the accident fund may be spent for the administration of this title and debt service for capital improvements related to the state fund only after appropriation.

(2) The legislature declares that it is in the best interest of the state, the employers and employees subject to Title 51 RCW, and the owners and holders of the bonds issued by the state for capital improvements related to the state fund to specify and thereby limit the purposes for which expenditures from the accident fund may be used. It is the intent of the legislature in this section to specify and thereby limit the purposes for which expenditures from the accident fund may be

used. The legislature does not intend to diminish in any way the current obligations of the state or diminish in any way the rights of owners and holders of the bonds issued by the state for capital improvements related to the state fund.

Sec. 602. RCW 51.44.020 and 1961 c 23 s 51.44.020 are each amended to read as follows:

MEDICAL AID FUND. (1) There shall be, in the office of the state treasurer, a fund to be known and designated as the "medical aid fund((~~,~~))" for the benefit of employers and employees subject to this title. All receipts from premiums owed under RCW 51.16.060 must be deposited in the medical aid fund. Expenditures from the medical aid fund may be used only for the payment of medical aid and like benefits for loss sustained on account of injury, disease, or death provided for by this title, administration of this title, and debt service for capital improvements related to the state fund, and may not be used for any other purpose. Only the director or the director's designee may authorize expenditures from the medical aid fund for such benefits. Consistent with RCW 43.88.180, money in the medical aid fund may be spent for the administration of this title and debt service for capital improvements related to the state fund only after appropriation.

(2) The legislature declares that it is in the best interest of the state, the employers and employees subject to Title 51 RCW, and the owners and holders of the bonds issued by the state for capital improvements related to the state fund to specify and thereby limit the purposes for which expenditures from the medical aid fund may be used. It is the intent of the legislature in this section to specify and thereby limit the purposes for which expenditures from the medical aid fund may be used. The legislature does not intend to diminish in any way the current obligations of the state or diminish in any way the rights of owners and holders of the bonds issued by the state for capital improvements related to the state fund.

Sec. 603. RCW 43.84.092 and 2003 c 361 s 602, 2003 c 324 s 1, 2003 c 150 s 2, and 2003 c 48 s 2 are each reenacted and amended to read as follows:

(1) All earnings of investments of surplus balances in the state

treasury shall be deposited to the treasury income account, which account is hereby established in the state treasury.

(2) The treasury income account shall be utilized to pay or receive funds associated with federal programs as required by the federal cash management improvement act of 1990. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for refunds or allocations of interest earnings required by the cash management improvement act. Refunds of interest to the federal treasury required under the cash management improvement act fall under RCW 43.88.180 and shall not require appropriation. The office of financial management shall determine the amounts due to or from the federal government pursuant to the cash management improvement act. The office of financial management may direct transfers of funds between accounts as deemed necessary to implement the provisions of the cash management improvement act, and this subsection. Refunds or allocations shall occur prior to the distributions of earnings set forth in subsection (4) of this section.

(3) Except for the provisions of RCW 43.84.160, the treasury income account may be utilized for the payment of purchased banking services on behalf of treasury funds including, but not limited to, depository, safekeeping, and disbursement functions for the state treasury and affected state agencies. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for payments to financial institutions. Payments shall occur prior to distribution of earnings set forth in subsection (4) of this section.

(4) Monthly, the state treasurer shall distribute the earnings credited to the treasury income account. The state treasurer shall credit the general fund with all the earnings credited to the treasury income account except:

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: <u>The accident account, the accident reserve account, t</u>he capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data

processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the drinking water assistance account, the drinking water assistance administrative account, the drinking water assistance repayment account, the Eastern Washington University capital projects account, the education construction fund, the election account, the emergency reserve fund, The Evergreen State College capital projects account, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the state higher education construction account, the higher education construction account, the highway infrastructure account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the medical aid account, the mobile home park relocation fund, the multimodal transportation account, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the oyster reserve land account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system combined plan 2 and plan 3 account, the public facilities construction loan revolving account beginning July 1, 2004, the public health supplemental account, the public works assistance account, the Puyallup tribal settlement account, the regional transportation investment district account, the resource management cost account, the second injury account, the self-insurers' insolvency trust account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the Tacoma Narrows toll bridge account, the teachers' retirement system plan 1 account, the teachers' retirement system combined plan 2 and plan 3 account, the tobacco prevention and control account, the tobacco settlement account, the transportation infrastructure account, the tuition recovery trust fund, the University of Washington bond

retirement fund, the University of Washington building account, the volunteer fire fighters' and reserve officers' relief and pension principal fund, the volunteer fire fighters' and reserve officers' administrative fund, the Washington fruit express account, the Washington judicial retirement system account, the Washington law enforcement officers' and fire fighters' system plan 1 retirement account, the Washington law enforcement officers' and fire fighters' system plan 2 retirement account, the Washington school employees' retirement system combined plan 2 and 3 account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (4)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

(b) The following accounts and funds shall receive eighty percent of their proportionate share of earnings based upon each account's or fund's average daily balance for the period: The aeronautics account, the aircraft search and rescue account, the county arterial preservation account, the department of licensing services account, the essential rail assistance account, the ferry bond retirement fund, the grade crossing protective fund, the high capacity transportation account, the highway bond retirement fund, the highway safety account, the motor vehicle fund, the motorcycle safety education account, the pilotage account, the public transportation systems account, the Puget Sound capital construction account, the Puget Sound ferry operations account, the recreational vehicle account, the rural arterial trust account, the safety and education account, the special category C account, the state patrol highway account, the transportation 2003 account (nickel account), the transportation equipment fund, the transportation fund, the transportation improvement account, the transportation improvement board bond retirement account, and the urban arterial trust account.

(5) In conformance with Article II, section 37 of the state Constitution, no treasury accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

Sec. 604. RCW 28B.20.458 and 1969 ex.s. c 223 s 28B.20.458 are each amended to read as follows:

The University of Washington may accept and administer loans, grants, funds, or gifts, conditional or otherwise, in furtherance of the objects and purposes of RCW 28B.20.450 through 28B.20.458, from the federal government and from other sources public or private. ((~~For the purpose of securing payment from the accident fund and medical aid fund as funds are required, vouchers shall be presented to the department of labor and industries.~~))

NEW SECTION. **Sec. 605.** RCW 51.16.042 (Occupational and environmental research facility) and 1977 ex.s. c 350 s 25, 1971 ex.s. c 289 s 84, & 1963 c 151 s 2 are each repealed.

PART VII - CLAIMS MANAGEMENT

Sec. 701. RCW 51.32.210 and 1977 ex.s. c 350 s 55 are each amended to read as follows:

(1) Claims of injured workers of employers who have secured the payment of compensation by insuring with the department shall be promptly acted upon by the department. The department must enter an order allowing or denying a claim within ninety days from the date that the claim is filed with the department.

(2) Where temporary disability compensation is payable, the first payment thereof shall be mailed within fourteen days after receipt of the claim at the department's offices in Olympia and shall continue at regular semimonthly intervals. The payment of this or any other benefits under this title, prior to the entry of an order by the department in accordance with RCW 51.52.050 as now or hereafter amended, shall be not considered a binding determination of the obligations of the department under this title. The acceptance of compensation by the worker or his or her beneficiaries prior to such order shall likewise not be considered a binding determination of their rights under this title.

NEW SECTION. **Sec. 702.** A new section is added to chapter 51.32 RCW to read as follows:

The department may purchase services by contract from individuals, nonprofit organizations, or businesses to provide services with respect to any aspect of managing industrial insurance claims filed with the state fund under this title.

Sec. 703. RCW 41.06.380 and 2003 c 363 s 104 are each amended to read as follows:

((~~(1)~~)) Nothing contained in this chapter ((~~shall~~)) prohibits:

(1) Any department, as defined in RCW 41.06.020, from purchasing services by contract with individuals or business entities if such services were regularly purchased by valid contract by such department prior to April 23, 1979: PROVIDED, That no such contract may be executed or renewed if it would have the effect of terminating classified employees or classified employee positions existing at the time of the execution or renewal of the contract.

(2) ((~~Nothing contained in this chapter prohibits~~)) The department of transportation from purchasing construction services or construction engineering services, as those terms are defined in RCW 47.28.241, by contract from qualified private businesses as specified in RCW 47.28.251(2).

(3) The department of labor and industries from purchasing services by contract from individuals, nonprofit organizations, or business entities to provide services with respect to any aspect of managing industrial insurance claims filed with the state fund under Title 51 RCW.

PART VIII - APPEALS

Sec. 801. RCW 51.52.050 and 1987 c 151 s 1 are each amended to read as follows:

SERVICE; BENEFIT PAYMENT PENDING RECONSIDERATION; PROVIDER SUSPENSION PENDING APPEAL. (1) Whenever the department has made any order, decision, or award, it shall promptly serve the worker, beneficiary, employer, or other person affected thereby, with a copy thereof by mail, which shall be addressed to such person at his or her last known address as shown by the records of the department. The

copy, in case the same is a final order, decision, or award, shall bear on the same side of the same page on which is found the amount of the award, a statement, set in black faced type of at least ten point body or size, that such final order, decision, or award shall become final within sixty days from the date the order is communicated to the parties unless a written request for reconsideration is filed with the department of labor and industries, Olympia, or an appeal is filed with the board of industrial insurance appeals, Olympia((~~: PROVIDED, That~~)). However, a department order or decision making demand, whether with or without penalty, for repayment of sums paid to a provider of medical, dental, vocational, or other health services rendered to an industrially injured worker, shall state that such order or decision shall become final within twenty days from the date the order or decision is communicated to the parties unless a written request for reconsideration is filed with the department of labor and industries, Olympia, or an appeal is filed with the board of industrial insurance appeals, Olympia.

(2)(a) Except as provided in section 305 of this act, whenever the department has taken any action or made any decision relating to any phase of the administration of this title the worker, beneficiary, employer, or other person aggrieved thereby may request reconsideration of the department((~~,~~)) or may appeal to the board. If an employer requests reconsideration of a department order in favor of an injured worker, temporary total disability compensation or medical aid benefits granted to the worker by the order under reconsideration are suspended while the reconsideration is pending.

(b) In an appeal before the board, the appellant shall have the burden of proceeding with the evidence to establish a prima facie case for the relief sought in such appeal((~~: PROVIDED, That~~)). However, in an appeal from an order of the department that alleges fraud, the department or self-insured employer shall initially introduce all evidence in its case in chief.

(c) Any ((~~such~~)) person aggrieved by the decision and order of the board may thereafter appeal to the superior court, as prescribed in this chapter.

(3) When a provider files with the board an appeal from an order terminating the provider's authority to provide services related to the treatment of industrially injured workers, the department may petition

the board for an order immediately suspending the provider's eligibility to participate as a provider of services to industrially injured workers under this title pending the final disposition of the appeal by the board. The board shall grant the petition if it determines that there is good cause to believe that workers covered under this title may suffer serious physical or mental harm if the petition is not granted. The board shall expedite the hearing of the department's petition under this subsection.

Sec. 802. RCW 51.52.060 and 1995 c 253 s 1 and 1995 c 199 s 7 are each reenacted and amended to read as follows:

NOTICE OF APPEAL; BENEFIT PAYMENT PENDING APPEAL. (1)(a) Except as otherwise specifically provided in this section, a worker, beneficiary, employer, health services provider, or other person aggrieved by an order, decision, or award of the department must, before he or she appeals to the courts, file with the board and the director, by mail or personally, within sixty days from the day on which a copy of the order, decision, or award was communicated to such person, a notice of appeal to the board. However, a health services provider or other person aggrieved by a department order or decision making demand, whether with or without penalty, solely for repayment of sums paid to a provider of medical, dental, vocational, or other health services rendered to an industrially injured worker must, before he or she appeals to the courts, file with the board and the director, by mail or personally, within twenty days from the day on which a copy of the order or decision was communicated to the health services provider upon whom the department order or decision was served, a notice of appeal to the board.

(b) Failure to file a notice of appeal with both the board and the department shall not be grounds for denying the appeal if the notice of appeal is filed with either the board or the department.

(2) Within ten days of the date on which an appeal has been granted by the board, the board shall notify the other interested parties to the appeal of the receipt of the appeal and shall forward a copy of the notice of appeal to the other interested parties. Within twenty days of the receipt of such notice of the board, the worker or the employer may file with the board a cross-appeal from the order of the department from which the original appeal was taken.

(3) If within the time limited for filing a notice of appeal to the board from an order, decision, or award of the department, the department directs the submission of further evidence or the investigation of any further fact, the time for filing the notice of appeal shall not commence to run until the person has been advised in writing of the final decision of the department in the matter. In the event the department directs the submission of further evidence or the investigation of any further fact, as provided in this section, the department shall render a final order, decision, or award within ninety days from the date further submission of evidence or investigation of further fact is ordered ((~~which time period may be extended by the department for good cause stated in writing to all interested parties for an additional ninety days~~)).

(4) The department, either within the time limited for appeal, or within thirty days after receiving a notice of appeal, may:

(a) Modify, reverse, or change any order, decision, or award; or

(b)(i) Except as provided in (b)(ii) of this subsection, hold an order, decision, or award in abeyance for a period of ninety days ((~~which time period may be extended by the department for good cause stated in writing to all interested parties for an additional ninety days pending further investigation in light of the allegations of the notice of appeal~~)); or

(ii) Hold an order, decision, or award issued under RCW 51.32.160 in abeyance for a period not to exceed ninety days from the date of receipt of an application under RCW 51.32.160. ((~~The department may extend the ninety-day time period for an additional sixty days for good cause.~~

~~For purposes of this subsection, good cause includes delay that results from conduct of the claimant that is subject to sanction under RCW 51.32.110.~~))

The board shall deny the appeal upon the issuance of an order under (b)(i) or (ii) of this subsection holding an earlier order, decision, or award in abeyance, without prejudice to the appellant's right to appeal from any subsequent determinative order issued by the department.

This subsection (4)(b) does not apply to applications deemed granted under RCW 51.32.160.

(5) An employer shall have the right to appeal an application deemed granted under RCW 51.32.160 on the same basis as any other application adjudicated pursuant to that section.

(6) ((~~A provision of this section shall not be deemed to change, alter, or modify the practice or procedure of the department for the payment of awards pending appeal.~~)) If an employer appeals to the board a department order granting temporary total disability compensation or medical aid benefits to a worker, the payment of compensation or medical aid benefits granted to the worker by the order under appeal are suspended while the appeal is pending before the board.

Sec. 803. RCW 51.52.132 and 1965 ex.s. c 63 s 2 are each amended to read as follows:

ATTORNEYS' FEES GENERALLY. ((~~Where the department, the board or the court, pursuant to RCW 51.52.120 or 51.52.130 fixes the attorney's fee, it shall be~~)) (1) It is unlawful for an attorney engaged in the representation of any worker or beneficiary to charge or receive any fee for services rendered in connection with securing benefits under this title in excess of ((~~that~~)) the lesser of:

(a) Twenty percent of the compensation awarded under chapter 51.32 RCW; or

(b) The amount fixed by the department, board, or the court under RCW 51.52.120.

(2) Any person who violates any provision of this section ((~~shall be~~)):

(a) Is guilty of a misdemeanor; and

(b) From the date of conviction under (a) of this subsection, may not engage in the representation for a fee of a worker or beneficiary in connection with securing benefits under this title.

Sec. 804. RCW 51.52.120 and 2003 c 53 s 285 are each amended to read as follows:

ATTORNEYS' FEES--AMOUNT FIXED. (1) ((~~It shall be unlawful for an attorney engaged in the representation of any worker or beneficiary to charge for services in the department any fee in excess of a reasonable fee, of not more than thirty percent of the increase in the award secured by the attorney's services. Such reasonable fee shall be fixed~~

~~by~~)) For services rendered before the department in connection with securing benefits under this title, the director or the director's designee shall fix a reasonable fee, subject to RCW 51.52.132, for services performed by an attorney for ((~~such~~)) a worker or beneficiary, if written application therefor is made by the attorney, worker, or beneficiary within one year from the date the final decision and order of the department is communicated to the party making the application.

(2)(a) If, on appeal to the board, the order, decision, or award of the department is reversed or modified and additional relief is granted to a worker or beneficiary, or in cases where a party other than the worker or beneficiary is the appealing party and the worker's or beneficiary's right to relief is sustained by the board, the board shall fix a reasonable fee, subject to RCW 51.52.132, for the services of ((~~his or her~~)) the worker's or beneficiary's attorney in proceedings before the board if written application therefor is made by the attorney, worker, or beneficiary within one year from the date the final decision and order of the board is communicated to the party making the application.

(b) In fixing the ((~~amount of such attorney's~~)) fee, the board shall take into consideration the fee ((~~allowed~~)), if any, fixed by the director or the director's designee, for the attorney's services before the department, and the board may review the fee fixed by the director or the director's designee.

(3)(a) If, on appeal to the superior or appellate court from the decision and order of the board, the decision and order is reversed or modified and additional relief is granted to a worker or beneficiary, or in cases where a party other than the worker or beneficiary is the appealing party and the worker's or beneficiary's right to relief is sustained, the court shall fix a reasonable fee, subject to RCW 51.52.132, for the services before the court of the worker's or beneficiary's attorney.

(b) In fixing the fee, the court shall take into consideration the fee or fees, if any, fixed by the director or the director's designee or the board for the attorney's services before the department and the board under subsections (1) and (2) of this section.

(4) Any attorney's fee ((~~set~~)) fixed by the ((~~department~~)) director or the director's designee or the board may be reviewed by the superior court upon application of such attorney, worker, or beneficiary. The

department or self-insured employer, as the case may be, shall be served a copy of the application and shall be entitled to appear and take part in the proceedings. ((~~Where the board, pursuant to this section, fixes the attorney's fee, it shall be unlawful for an attorney to charge or receive any fee for services before the board in excess of that fee fixed by the board.~~

~~(3) Any person who violates this section is guilty of a misdemeanor.~~))

Sec. 805. RCW 51.52.130 and 1993 c 122 s 1 are each amended to read as follows:

ATTORNEYS' FEES--PAYMENT BY DEPARTMENT OR SELF-INSURER. ((~~If, on appeal to the superior or appellate court from the decision and order of the board, said decision and order is reversed or modified and additional relief is granted to a worker or beneficiary, or in cases where a party other than the worker or beneficiary is the appealing party and the worker's or beneficiary's right to relief is sustained, a reasonable fee for the services of the worker's or beneficiary's attorney shall be fixed by the court. In fixing the fee the court shall take into consideration the fee or fees, if any, fixed by the director and the board for such attorney's services before the department and the board. If the court finds that the fee fixed by the director or by the board is inadequate for services performed before the department or board, or if the director or the board has fixed no fee for such services, then the court shall fix a fee for the attorney's services before the department, or the board, as the case may be, in addition to the fee fixed for the services in the court.~~)) If, in a worker or beneficiary appeal to the superior or appellate court from the decision and order of the board, the decision and order of the board is reversed or modified and if the accident fund or medical aid fund is affected by the litigation, or if in an appeal by the department or employer the worker or beneficiary's right to relief is sustained, or in an appeal by a worker involving a state fund employer with twenty-five employees or less, in which the department does not appear and defend, and the board order in favor of the employer is sustained, the attorney's fee permitted under RCW 51.52.132 and fixed by the court under RCW 51.52.120, for services before the court only, and the fees of medical and other witnesses and the costs

shall be payable out of the administrative fund of the department. In the case of self-insured employers, the attorney's fee((s)) permitted under RCW 51.52.132 and fixed by the court under RCW 51.52.120, for services before the court only, and the fees of medical and other witnesses and the costs shall be payable directly by the self-insured employer.

PART IX - MISCELLANEOUS

NEW SECTION. **Sec. 901.** A new section is added to chapter 51.04 RCW to read as follows:

RULE MAKING. The department shall adopt rules to implement the specific requirements of this act.

NEW SECTION. **Sec. 902.** EXISTING RESOURCES. The department of labor and industries is required to find sufficient efficiency savings to implement this act within the appropriations provided for administering the industrial insurance program.

NEW SECTION. **Sec. 903.** Sections 501 through 509 of this act constitute a new chapter in Title 51 RCW.

NEW SECTION. **Sec. 904.** CAPTIONS. As used in this act, captions constitute no part of the law.

NEW SECTION. **Sec. 905.** SEVERABILITY CLAUSE. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 906.** Section 703 of this act expires July 1, 2005.

NEW SECTION. **Sec. 907.** EMERGENCY CLAUSE. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately, except for section 603 of

this act which takes effect July 1, 2005, and section 804 of this act which takes effect July 1, 2004.

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