S-3826.2

SENATE BILL 6393

State of Washington 58th Legislature 2004 Regular Session

By Senators Honeyford and T. Sheldon

Read first time 01/19/2004. Referred to Committee on Commerce & Trade.

1 AN ACT Relating to workers' compensation managed care arrangements;
2 amending RCW 51.36.010; adding a new section to chapter 51.36 RCW; and
3 adding a new chapter to Title 51 RCW.

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

5 NEW SECTION. **Sec. 1.** MANAGED CARE--DEFINITIONS. The definitions
6 in this section apply throughout this chapter unless the context
7 clearly requires otherwise.
8 (1) "Complaint" means any dissatisfaction expressed by an injured
9 worker concerning a workers' compensation managed care arrangement.
10 (2) "Grievance" means a written complaint, other than an
11 application for benefits, filed by the injured worker pursuant to the
12 requirements of the managed care arrangement, expressing
13 dissatisfaction with the refusal of the workers' compensation managed
14 care arrangement to provide health care or dissatisfaction with the
15 health care provided.
16 (3) "Health care coordinator" means a primary care provider within
17 a provider network who is responsible for managing the health care of
18 an injured worker, including determining other health care providers
19 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. 2.** 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

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

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

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

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

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

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

28 <u>NEW SECTION.</u> **Sec. 3.** MANAGED CARE PLAN OF OPERATION. (1) Before
29 a self-insured employer may be authorized to offer or use a workers'
30 compensation managed care arrangement in this state, the self-insurer's
31 managed care plan of operation must be approved by the department.

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

36 (a) The covered services can be provided with reasonable promptness
37 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;

1 (iv) A written plan, that includes ongoing review, for providing
2 review of physicians and other licensed health care providers;
3 (v) Appropriate financial incentives to reduce service costs and
4 utilization without sacrificing the quality of service;
5 (vi) Adequate methods of peer review and utilization review. The
6 utilization review process shall include a health care facility's
7 precertification mechanism, including, but not limited to, all elective
8 admissions and nonemergency surgeries and adherence to practice
9 parameters and protocols established under this chapter;
10 (vii) Provisions for resolution of disputes arising between a
11 health care provider and a self-insurer regarding reimbursements and
12 utilization review;
13 (viii) Availability of process for aggressive health care
14 coordination, as well as a program involving cooperative efforts by the
15 workers, the employer, and the workers' compensation managed care
16 arrangement to promote early return to work for injured workers;
17 (ix) A provision for the selection of a primary care provider by
18 the employee from among primary providers in the provider network; and
19 (x) The written information proposed to be used by the self-insurer
20 to comply with (e) of this subsection;
21 (d) Written procedures to provide the self-insurer with timely
22 medical records and information including, but not limited to, work
23 status, work restrictions, date of maximum medical improvement,
24 permanent impairment ratings, and other information as required,
25 including information demonstrating compliance with the practice
26 parameters and protocols of treatment established under this chapter;
27 (e) Evidence that appropriate health care providers and
28 administrative staff of the self-insurer's workers' compensation
29 managed care arrangement have received training and education on the
30 provisions of this chapter; the administrative rules that govern the
31 provision of proper and necessary medical, surgical, and hospital care
32 and services to injured workers; and the practice parameters and
33 protocols of treatment established under this chapter;
34 (f) Written procedures and methods to prevent inappropriate or
35 excessive treatment that are in accordance with the practice parameters
36 and protocols of treatment established under this chapter;
37 (g) Written procedures and methods for the management of an injured
38 worker's health care by a health care coordinator including:

1 (i) The mechanism for assuring that covered employees receive all
2 initial covered services from a primary care provider participating in
3 the provider network, except for emergency care;
4 (ii) The mechanism for assuring that all continuing covered
5 services be received from the same primary care provider participating
6 in the provider network that provided the initial covered services,
7 except when services from another provider are authorized by the health
8 care coordinator pursuant to (g)(iv) of this subsection;
9 (iii) The policies and procedures for allowing an employee to
10 change to another provider within the provider network as the
11 authorized treating physician during the course of treatment for a
12 work-related injury in accordance with rules adopted under RCW
13 51.36.010;
14 (iv) The process for assuring that all referrals authorized by a
15 health care coordinator, in accordance with the practice parameters and
16 protocols of treatment established under this chapter, are made to the
17 participating network providers, unless proper and necessary medical,
18 surgical, and hospital care and services are not available and
19 accessible to the injured worker in the provider network; and
20 (v) Assignment of a health care coordinator licensed under chapter
21 18.71 RCW to manage care by physicians licensed under chapter 18.71
22 RCW, a health care coordinator licensed under chapter 18.57 RCW to
23 manage care by osteopathic physicians licensed under chapter 18.57 RCW,
24 a health care coordinator licensed under chapter 18.25 RCW to manage
25 care by chiropractors licensed under chapter 18.25 RCW, on an injured
26 worker's request for care by any of the listed providers; and
27 (h) A description of the use of workers' compensation practice
28 parameters and protocols of treatment for health care services.
29 (4) A self-insured employer must file any proposed changes to the
30 plan of operation, except for changes in the list of health care
31 providers, with the department before implementing the changes. The
32 changes are considered approved forty-five days after filing unless
33 specifically disapproved by the department within the forty-five day
34 period.

35 NEW SECTION. **Sec. 4.** Before the department may offer or use a
36 workers' compensation managed care arrangement in this state, the
37 department must develop a managed care plan of operation that meets the

requirements of the plan of operation required under section 3 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.

NEW SECTION. **Sec. 5.** 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. 6.** 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. 7.** 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. 8.** 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,

1 the director may, in lieu of such revocation or suspension, impose a
2 fine upon the self-insurer as follows:
3 (a) With respect to a nonwillful violation, the fine may not exceed
4 two thousand five hundred dollars for each such violation. A fine may
5 not exceed an aggregate amount of ten thousand dollars for all
6 nonwillful violations arising out of the same action; or
7 (b) With respect to a knowing and willful violation, the fine may
8 not exceed twenty thousand dollars for each such violation. A fine may
9 not exceed an aggregate amount of one hundred thousand dollars for all
10 knowing and willful violations arising out of the same action.

11 NEW SECTION. **Sec. 9.** MANAGED CARE RULES. The director shall
12 adopt rules that specify:
13 (1) Procedures for authorization and examination of workers'
14 compensation managed care arrangements by the department;
15 (2) Requirements and procedures for authorization of workers'
16 compensation arrangement provider networks and procedures for the
17 department to grant exceptions from accessibility of services;
18 (3) Requirements and procedures for case management, utilization
19 management, and peer review;
20 (4) Requirements and procedures for quality assurance and medical
21 records;
22 (5) Requirements and procedures for dispute resolution in
23 conformance with this chapter;
24 (6) Requirements and procedures for employee and provider
25 education; and
26 (7) Requirements and procedures for reporting data regarding
27 grievances, return-to-work outcomes, and provider networks.

28 NEW SECTION. **Sec. 10.** A new section is added to chapter 51.36 RCW
29 to read as follows:
30 STANDARDS OF CARE. The following standards of care shall be
31 followed in providing medical care under this title:
32 (1)(a) Abnormal anatomical findings alone, in the absence of
33 objective relevant medical findings, shall not be an indicator of
34 injury or illness, a justification for the provision of curative or
35 rehabilitative medical care or the assignment of restrictions, or a
36 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. 11. 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:~~)).

1 (a) The duration of medical and surgical services is limited as
2 provided in this subsection:
3 (i) In the case of permanent partial disability, services may not
4 ((~~to~~)) extend beyond the date when compensation shall be awarded him or
5 her, except when the worker returned to work before permanent partial
6 disability award is made, in such case services may not ((~~to~~)) extend
7 beyond the time when monthly allowances to him or her shall cease;
8 (ii) In case of temporary disability services may not ((~~to~~)) extend
9 beyond the time when monthly allowances to him or her shall cease:
10 PROVIDED, That after any injured worker has returned to his or her work
11 his or her medical and surgical treatment may be continued if, and so
12 long as, such continuation is deemed necessary by the supervisor of
13 industrial insurance to be necessary to his or her more complete
14 recovery;
15 (iii) In case of a permanent total disability services may not
16 ((~~to~~)) extend beyond the date on which a lump sum settlement is made
17 with him or her or he or she is placed upon the permanent pension roll:
18 PROVIDED, HOWEVER, That the supervisor of industrial insurance, solely
19 in his or her discretion, may authorize continued medical and surgical
20 treatment for conditions previously accepted by the department when
21 such medical and surgical treatment is deemed necessary by the
22 supervisor of industrial insurance to protect such worker's life or
23 provide for the administration of medical and therapeutic measures
24 including payment of prescription medications, but not including those
25 controlled substances currently scheduled by the state board of
26 pharmacy as Schedule I, II, III, or IV substances under chapter 69.50
27 RCW, which are necessary to alleviate continuing pain which results
28 from the industrial injury. In order to authorize such continued
29 treatment the written order of the supervisor of industrial insurance
30 issued in advance of the continuation shall be necessary.
31 (b) The choice of attending physician is limited as provided in
32 this subsection:
33 (i) If an injured worker is covered through a workers' compensation
34 managed care arrangement as provided in chapter 51.-- RCW (sections 1
35 through 9 of this act), the worker must select a primary care provider
36 from among the primary care providers in the provider network as
37 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. 12.** Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 13.** Sections 1 through 9 of this act constitute a new chapter in Title 51 RCW.

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