S-3941.1

SENATE BILL 6638

State of Washington 61st Legislature 2010 Regular Session

By Senators Holmquist, Sheldon, King, Honeyford, Hewitt, and Parlette

Read first time 01/19/10. Referred to Committee on Labor, Commerce & Consumer Protection.

1 AN ACT Relating to workers' compensation reform; amending RCW
2 51.36.010, 51.36.080, 51.36.085, 51.08.140, and 51.32.180; adding new
3 sections to chapter 51.04 RCW; adding a new chapter to Title 51 RCW;
4 creating new sections; and providing an effective date.

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

6 NEW SECTION. **Sec. 1.** INTENT. The legislature finds that a
7 fiscally sound industrial insurance system that assures necessary and
8 proper medical care for persons injured at work is integral to the
9 health and economic well-being of workers and the economic welfare of
10 the state. The legislature further finds that reforms are needed to
11 assure the best worker outcomes, including return to work.
12 Improvements are also needed to assure the most efficient and fair
13 system. The legislature intends to make the workers' compensation
14 system more cost-effective by authorizing voluntary medical provider
15 networks and voluntary settlement agreements and by assuring that the
16 workers' compensation system will only be responsible for costs due to
17 workplace injuries.

MEDICAL PROVIDER NETWORKS

NEW SECTION. **Sec. 2.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Association" means an association meeting the criteria under section 3(5) of this act.

(2) "Continuity of care" means the continued provision of treatment under this title by another provider within the network in the event the worker's network provider is no longer able to treat the worker.

(3) "Network" or "medical provider network" means a comprehensive panel of health care providers and facilities that provide appropriate remedial treatment, care, and attendance to injured workers.

(4) "Network sponsor" means: (a) The department and a self-insured employer, when the department or self-insured employer has established or contracted with a medical provider network; and (b) an association, when the association has contracted with a medical provider network. "Network sponsor" includes agents of the department, self-insured employer, and association.

(5) "Service area" means the geographic area approved by the department within which a self-insurer or association is authorized to use a medical provider network.

(6) "Utilization control" means a systematic process of implementing measures that assure overall management and cost containment of services delivered, including compliance with practice parameters and protocols of treatment.

(7) "Utilization review" means the assessment of an injured worker's medical care to assure that it is proper and necessary and of good quality. This assessment typically considers the appropriateness of the place of care, level of care, and the duration, frequency, or quantity of services provided in relation to the accepted condition being treated.

NEW SECTION. **Sec. 3.** AUTHORIZATION FOR MEDICAL PROVIDER NETWORKS. (1) The department or a self-insured employer may establish or contract with a medical provider network to provide medical care to injured workers. An association may contract with a medical provider network approved for a self-insured employer or sponsored by the department to

provide medical care to injured workers employed by some or all association members. A network must meet standards established in this section.

(2) Medical treatment within a network must be available and accessible as follows:

(a) The network must include an adequate number and type of providers to treat common injuries and occupational diseases experienced by workers based on the type of occupation or industry in which the employer is engaged and the geographic area where the workers work;

(b) The network must include physicians primarily engaged in the treatment of occupational injuries and must encourage the integration of occupational and nonoccupational providers;

(c) The number of providers must be sufficient to provide timely delivery of all required medical services and to be able to make appropriate referrals for all required medical services; and

(d) To the extent feasible, all medical treatment must be readily accessible to all injured workers. Services must be provided in a timely manner with respect to geographic area, hours of operation, and after-hours care. The network must consider the needs of rural areas, specifically those in which health facilities are located at least thirty miles apart.

(3) A self-insured employer or an association must file a plan of operation for a network for approval with the department in a format prescribed by the department. The department must maintain a plan for any network established by or under contract with the department. A plan must include:

(a) Evidence that all covered services are available and accessible;

(b) A description, including address and phone number, of the providers, including primary care physicians, specialty care physicians, hospitals, and other providers;

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

(d) A description of limitations on referrals;

(e) A description of the dispute resolution procedure;

(f) A description of the quality assurance program under section 8 of this act;

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

(h) The network's formal organizational structure; and

(i) The written criteria for selection, retention, and removal of providers.

(4) If the department or self-insured employer establishes a medical provider network, the department or self-insured employer, as the case may be, has the exclusive right to determine the provider members of the network. Nothing in this chapter creates any right for a health care provider to contract with a network established by or under contract with the department, a self-insured employer, or an association.

(5) An association must meet the following criteria to contract with a medical provider network:

(a) The association must have been in existence for at least four years;

(b) The association must exist primarily for a purpose other than that of obtaining or offering insurance coverage or insurance-related services;

(c) All employers in the network must be members of the association;

(d) At least fifty percent of the employers who contract with the association for network membership must have been members of the association for one year prior to the association contracting with a network;

(e) All employers in the association who contract with the association for network membership must have an industrial insurance account in good standing with the department; and

(f) The association must maintain an annual membership in the network of at least twenty-five members.

NEW SECTION. **Sec. 4.** APPROVAL OF NETWORK. A self-insured employer and an association must submit a medical provider network plan of operation to the director for approval. The director must approve a network plan meeting the requirements of section 3 of this act. If the director does not act within sixty days of submission of the plan, the network is deemed approved. If the director does not approve the plan, the director must state the reasons for disapproval in writing

1 and transmit the decision to the self-insured employer or association.
2 The self-insured employer or association may submit a new application
3 or request a reevaluation by the director. The director must respond
4 to a request for reevaluation within forty-five days of the request.
5 If the director sustains the decision to disapprove the medical
6 provider network plan, the director must issue an order disapproving
7 the plan. The self-insured employer or association may appeal the
8 decision to disapprove the plan to the board of industrial insurance
9 appeals.

10 NEW SECTION. **Sec. 5.** WORKER OPTION/PROVIDER SELECTION. (1) If
11 the department or employer uses a medical provider network, a worker
12 must select and obtain treatment under this title from a provider
13 within the network unless the worker elects to receive treatment from
14 his or her own primary care provider.
15 (2) A worker may elect to receive initial treatment under this
16 title from his or her own primary care provider if:
17 (a) The employer provides nonoccupational health benefit plan
18 coverage through a health carrier as defined in RCW 48.43.005 or
19 through a self-insured health benefit plan;
20 (b) The primary care provider has previously directed the medical
21 treatment of the worker, and retains the worker's medical records,
22 including his or her medical history;
23 (c) The primary care provider agrees to be designated under this
24 section and agrees to follow the guidelines adopted by the network and
25 other provisions of this title and rules adopted by the department; and
26 (d) The worker has designated in writing to the employer before the
27 date of injury the name of the worker's primary care provider.
28 (3) If a worker who designates his or her own primary care provider
29 requires treatment not available from his or her own primary care
30 provider or the primary care provider refers the worker to another
31 provider, the worker must select a provider from the network.
32 Selection of a network provider must be based on the provider's
33 specialty or recognized expertise in treating the particular injury.
34 (4) If the worker's primary care provider designated under this
35 section is not available to treat the worker's injury because of
36 scheduled or unanticipated periods of unavailability, the worker may be

treated by a provider who is normally assigned to cover that designated provider's patients until the designated provider is available.

(5) If a worker disputes either the diagnosis made or the treatment prescribed by a provider within the network, the worker may seek the opinion of another provider within the network. All transfers of care must be preapproved by the network sponsor.

(6) A network must maintain a written continuity of care policy. The department and an employer using a network must notify injured workers of the policy, including information on the process to request a review under the policy. Upon request, the department or employer must provide a written copy of the policy to an injured worker. This subsection does not require the department or employer to provide for completion of treatment by a provider whose contract with the network has been terminated or not renewed for reasons relating to medical discipline under Title 18 RCW, fraud, or other criminal activity.

(7) For purposes of this section, "primary care provider" means a physician licensed under chapter 18.57 or 18.71 RCW or an advanced registered nurse practitioner licensed under chapter 18.79 RCW providing medical services predominantly for nonoccupational illnesses and injuries.

NEW SECTION. **Sec. 6.** TRANSFER OF CARE. (1) A network sponsor may transfer an injured worker whose occupational injury occurred prior to the effective date of network coverage from a nonnetwork provider to a network provider by providing notice under subsection (3) of this section.

(2) A network sponsor must agree to continued care from the nonnetwork provider when the provider is treating an acute condition that has a duration of fewer than ninety days, a serious chronic condition for up to one year from the date of notice under subsection (3) of this section, or a terminal illness where there is a high probability of death within one year from the date of notice under subsection (3) of this section; or when surgery or other procedures have been authorized by the self-insured employer or department as part of a documented course of treatment and has been recommended and documented by the provider to occur within one hundred eighty days from the effective date for the network coverage.

(3) If a network sponsor transfers the worker's medical treatment to a network provider, the network sponsor must send a certified letter to the worker and a copy of the letter to the worker's current treating provider or providers.

(4) Except for section 5(2) (a) and (d) of this act, a worker who has been notified of a transfer may elect to designate his or her current provider or providers in accordance with section 5 of this act.

NEW SECTION. **Sec. 7.** CERTIFICATION OF PROVIDERS. (1) A provider providing care under contract with a medical provider network established by the department or a self-insured employer must be certified by the network sponsor. A provider providing care under contract with a medical provider network that has contracted with the department, self-insured employer, or association must be certified by the network. Certification must include documentation that the provider has read and is familiar with relevant portions of this title, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance under this chapter.

(2) A network must enter written confidential agreements with providers describing specific responsibilities. Provider compensation may not be structured to achieve a goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

NEW SECTION. **Sec. 8.** TREATMENT GUIDELINES. (1) Medical treatment that is reasonably required to be proper and necessary for the injured worker from the effects of his or her injury is treatment that is based upon the guidelines adopted by the director or self-insured network sponsor. For all injuries not covered by the director's treatment and diagnostic guidelines and rules, authorized treatment must be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community. The guidelines must be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers and must reflect practices that are evidence and scientifically based, nationally recognized, and peer reviewed. The guidelines shall constitute care in accordance with RCW 51.36.010 for all injured workers diagnosed with industrial injuries under this chapter.

1 (2) In the event of a dispute, there is a rebuttable presumption
2 affecting the burden of proof that treatment decisions made in
3 accordance with the director's treatment and diagnostic guidelines and
4 rules, and nationally recognized guidelines adopted by the director or
5 self-insured network sponsor, constitute proper and necessary care.
6 The presumption may be rebutted by a showing of a preponderance of
7 scientific medical evidence establishing that a variance from the
8 guidelines is required for proper and necessary treatment.
9 (3) A medical provider network must maintain a quality assurance
10 program which assures that the health care services provided to workers
11 shall be rendered under reasonable standards of quality of care
12 consistent with the prevailing standards of medical practice in the
13 medical community, the department's treatment and diagnostic guidelines
14 and rules, and nationally recognized treatment guidelines.
15 (4) The quality assurance program must include, but not be limited
16 to:
17 (a) A written statement of goals and objectives that stresses
18 health and return-to-work outcomes as the principal criteria for the
19 evaluation of the quality of care rendered to injured workers;
20 (b) A written statement describing how methodology has been
21 incorporated into an ongoing system for monitoring of care that is
22 individual case-oriented and, when implemented, provides interpretation
23 and analysis of patterns of care rendered to individual patients by
24 individual providers;
25 (c) Written procedures for taking appropriate remedial action
26 whenever, as determined under the quality assurance program,
27 inappropriate or substandard services have been provided or services
28 that should have been provided have not;
29 (d) Appropriate financial incentives to reduce service costs and
30 utilization without sacrificing the quality of service. These
31 incentives may include additional fees to providers who submit their
32 medical reports in a timely fashion and cooperate in facilitating an
33 early return to work with the worker and employer;
34 (e) Adequate methods of peer review and utilization review. The
35 utilization review process must include a health care facilities'
36 precertification mechanism including, but not limited to, all elective
37 admissions and nonemergency surgeries and adherence to practice
38 parameters and protocols established in accordance with this chapter;

(f) Provisions for resolution of disputes between a provider within the network and the network sponsor regarding reimbursements and, consistent with section 10 of this act, utilization review; and

(g) Availability of a process for proactive medical care coordination, as well as programs involving cooperative efforts by the workers, the employer, the department, and the network to promote early return to work for injured workers.

NEW SECTION. **Sec. 9.** UTILIZATION REVIEW. (1) A network sponsor must establish a utilization review process in compliance with this section either directly or through a contract for utilization services. Utilization review is performed at the discretion of the network sponsor. An independent medical examination as authorized in RCW 51.32.110 may be performed before a utilization review.

(2) A network under contract with a network sponsor must employ or designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. The network medical director must ensure that the process for review of requests complies with this section.

(3) Each utilization review process must be governed by written policies and procedures that ensure that treatment decisions are made consistent with the treatment guidelines under section 8 of this act. The policies and procedures must be filed with the department and disclosed to workers, providers, and the public upon request.

(4) The utilization review may be performed by a claims adjuster, nurse case manager, the medical director of the network, or a peer review panel.

(5) The criteria or guidelines used in the utilization review process must be:

(a) Developed with involvement from actively practicing providers;

(b) Consistent with the treatment guidelines of section 8 of this act;

(c) Evaluated at least annually and updated if necessary; and

(d) Disclosed to the provider treating the worker and the worker if used as the basis of a decision involving the worker.

(6) The medical director of the network may request from the provider only the information reasonably necessary to make the determination.

(7) In determining whether to approve, modify, delay, or deny a request by a provider prospectively, retrospectively, or concurrent with the provision of treatment, the following requirements must be met:

(a) Prospective or concurrent decisions must be made in a timely manner appropriate for the worker's condition, not to exceed five working days from the receipt of information reasonably necessary to make the decision, but in no event more than fourteen days from the date of the treatment recommendation by the provider. Retrospective decisions must be communicated to the worker within thirty days of the receipt of information reasonably necessary to make the decision.

(b) If the worker faces an imminent and serious threat to his or her health including but not limited to the potential loss of life, limb, or other major bodily function or adherence to the time frames in (a) of this subsection would be detrimental to the worker's life or health or could jeopardize the worker's ability to regain maximum function, decisions must be made in a timely manner appropriate for the worker's condition, not to exceed seventy-two hours after the receipt of information reasonably necessary to make the decision.

(c) A decision to modify, delay, or deny all or part of the requested treatment must be communicated to the provider initially by telephone or facsimile and to the provider and the worker by mail within twenty-four hours for concurrent review or within two business days for prospective review.

(d) In the case of concurrent review, treatment shall not be discontinued until the worker's primary care provider has been notified of the decision and a care plan has been agreed to by the primary care provider that is appropriate for the medical needs of the worker. Treatment provided during concurrent review must be proper and necessary and a self-insured employer and department are only liable for treatment determined to be proper and necessary.

(e) Decisions to approve treatment must specify the specific treatment approved. Decisions to modify, delay, or deny treatment must include a clear and concise explanation for the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision.

(f) If a decision cannot be made within the time frames in this subsection (7) because the network sponsor has not received all the

information reasonably necessary and requested, the network sponsor must immediately notify the provider and the worker, in writing. The entity must specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably requested, the medical director of the network must make the decision under the timelines in (a), (b), and (c) of this subsection.

(g) The medical director of the network must maintain telephone access for providers to request authorization for treatment.

(8) If medical issues in dispute cannot be resolved at the claims adjuster level, by a nurse case manager, or through an independent medical examination process, only a licensed physician within the network or their peer review panel may modify, delay, or deny requests for authorization of medical treatment.

(9) Disputes regarding treatment decisions must be resolved under section 10 of this act.

NEW SECTION. **Sec. 10.** DISPUTE RESOLUTION. (1) The legislature finds that delays in treatment decisions are not in the best interest of the injured worker. The legislature intends to expedite all disputes related to treatment and intends that all treatment and diagnostic disputes between a worker, network sponsor, and provider are reviewed initially through the network's internal dispute resolution process.

(2) A medical provider network must establish and follow procedures for hearing and resolving complaints from workers and providers regarding treatment decisions under this chapter. The procedures must encourage a settlement of the dispute and must meet the following criteria:

(a) The complaint procedure must be in writing and provided to workers and providers.

(b) Complaints must be considered in a timely manner and must be transmitted to appropriate decision makers with the network who have the authority to fully investigate the issue and take corrective action.

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

(d) All concerned parties must be notified of the results of a complaint.

(3) All decisions on medical treatment must be based on objective medical findings and medical treatment guidelines established by the medical director of the department or nationally recognized treatment guidelines.

(4) If a dispute is not resolved within the network, the dissatisfied party or parties must contact the department's medical director within ten days. The medical director must review the medical file and issue an order and notice within twenty days. Additional examinations may not be ordered by the medical director and other reports may not be required to resolve the issues in dispute.

(5)(a) The department's medical director may contract with one or more entities to secure expert medical advisors to provide peer review or expert medical consultation and opinions in connection with resolving disputes under this chapter, including utilization issues. The director must establish the qualifications of expert medical advisors, which must include training and experience in the state's workers' compensation system and knowledge of and commitment to the practice parameters and protocols established under this chapter. The contract must require an expert medical advisor to provide services in accordance with the timetables set forth in this chapter and to abide by the rules adopted by the department.

(b) An expert medical advisor appointed to review a medical file must have free and complete access to the medical records of the worker.

(6) The parties may appeal the decision of the department's medical director to the board of industrial appeals under RCW 51.36.060. The rebuttable presumption in section 8(2) of this act applies to the board's review of the decision.

Sec. 11. RCW 51.36.010 and 2007 c 134 s 1 are each amended to read as follows:

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 or licensed advanced registered nurse practitioner of his or her own choice, if conveniently located <u>and subject to section</u>

5 of this act, and proper and necessary hospital care and services during the period of his or her disability from such injury. The department for state fund claims shall pay, in accordance with the department's fee schedule, for any alleged injury for which a worker files a claim, any initial prescription drugs provided in relation to that initial visit, without regard to whether the worker's claim for benefits is allowed. In all accepted claims, treatment shall be limited in point of duration as follows:

In the case of permanent partial disability, 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 not to extend beyond the time when monthly allowances to him or her shall cease; in case of temporary disability 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; in case of a permanent total disability 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.

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.

Sec. 12. RCW 51.36.080 and 1998 c 245 s 104 are each amended to read as follows:

(1) <u>Except as provided in subsection (2) of this section, a</u>ll fees and medical charges under this title shall conform to the fee schedule established by the director and shall be paid within sixty days of receipt by the department of a proper billing in the form prescribed by department rule or sixty days after the claim is allowed by final order or judgment, if an otherwise proper billing is received by the department prior to final adjudication of claim allowance. The department shall pay interest at the rate of one percent per month, but at least one dollar per month, whenever the payment period exceeds the applicable sixty-day period on all proper fees and medical charges<u>, except that no interest is due if the provider has not filed required reports to substantiate the charges</u>.

Beginning in fiscal year 1987, interest payments under this subsection may be paid only from funds appropriated to the department for administrative purposes.

Nothing in this section may be construed to require the payment of interest on any billing, fee, or charge if the industrial insurance claim on which the billing, fee, or charge is predicated is ultimately rejected or the billing, fee, or charge is otherwise not allowable.

In establishing fees for medical and other health care services, the director shall consider the director's duty to purchase health care in a prudent, cost-effective manner without unduly restricting access to necessary care by persons entitled to the care. With respect to workers admitted as hospital inpatients on or after July 1, 1987, the director shall pay for inpatient hospital services on the basis of diagnosis-related groups, contracting for services, or other prudent, cost-effective payment method, which the director shall establish by rules adopted in accordance with chapter 34.05 RCW.

(2) <u>If a provider specifically agrees in writing to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs, fees and charges may deviate from</u>

the fee schedule. Procedures warranting deviation include, but are not limited to, the timely scheduling of appointments for injured workers, timely filing of medical reports, participation in return-to-work programs with employers, expediting the reporting of treatments provided to injured workers, and agreeing to continuing education, utilization review, quality assurance, precertification, and case management systems that are designed to provide needed treatment for injured workers.

(3) The director may establish procedures for selectively or randomly auditing the accuracy of fees and medical billings submitted to the department under this title.

Sec. 13. RCW 51.36.085 and 1993 c 159 s 3 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, all fees and medical charges under this title shall conform to regulations promulgated, and the fee schedule established by the director and shall be paid within sixty days of receipt by the self-insured of a proper billing in the form prescribed by department rule or sixty days after the claim is allowed by final order or judgment, if an otherwise proper billing is received by the self-insured prior to final adjudication of claim allowance. The self-insured shall pay interest at the rate of one percent per month, but at least one dollar per month, whenever the payment period exceeds the applicable sixty-day period on all proper fees and medical charges, except that no interest is due if the provider has not filed required reports to substantiate the charges.

(2) If a provider specifically agrees in writing to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs, fees and charges may deviate from the fee schedule. Procedures warranting deviation include, but are not limited to, the timely scheduling of appointments for injured workers, timely filing of medical reports, participation in return-to-work programs with employers, expediting the reporting of treatments provided to injured workers, and agreeing to continuing education, utilization review, quality assurance, precertification, and case management systems that are designed to provide needed treatment for injured workers.

NEW SECTION. **Sec. 14.** RULE MAKING. The director shall adopt rules as follows:

(1) The definition of reasonable geographic area under section 3 of this act;

(2) The form, content, and timing of notices required under section 5 of this act; and

(3) The qualifications of expert medical advisors under section 10 of this act.

NEW SECTION. **Sec. 15.** NOTICES. The department and an employer who uses a medical provider network must notify workers of their rights regarding providers under section 5 (2) and (3) of this act and must notify injured workers of their rights under section 5(5) of this act.

OCCUPATIONAL DISEASE

Sec. 16. RCW 51.08.140 and 1961 c 23 s 51.08.140 are each amended to read as follows:

"Occupational disease" means such disease or infection as arises ((~~naturally and proximately~~)) out of and in the course of the particular employment under ((~~the mandatory or elective adoption provisions of~~)) this title in which the worker is exposed to such disease or infection and which meets all of the following criteria:

(1) The disease or infection is proximately caused by the distinctive conditions under which the work is performed and risk of exposure inherent therein;

(2) The disease or infection arose as a natural incident of the employment-related exposure;

(3) The worker would not have ordinarily been exposed to the disease or infection outside of his or her employment; and

(4) The disease or infection is not an ordinary condition of life to which the general public is exposed without regard to employment.

Sec. 17. RCW 51.32.180 and 1988 c 161 s 5 are each amended to read as follows:

Every worker who suffers disability from an occupational disease arising out of and in the course of the worker's particular employment under the mandatory or elective adoption provisions of this title, or

his or her family and dependents in case of death of the worker from such disease or infection, shall receive the same compensation benefits and medical, surgical and hospital care and treatment as would be paid and provided for a worker injured or killed in employment under this title, except as follows: ((~~(a)~~)) <u>(1)</u> This section and RCW 51.16.040 shall not apply where the last exposure to the hazards of the disease or infection occurred prior to January 1, 1937; and ((~~(b)~~)) <u>(2)</u> for claims filed on or after July 1, 1988, the rate of compensation for occupational diseases shall be established as of the date the disease requires medical treatment or becomes totally or partially disabling, whichever occurs first, and without regard to the date of the contraction of the disease or the date of filing the claim.

VOLUNTARY SETTLEMENTS

<u>NEW SECTION.</u> **Sec. 18.** A new section is added to chapter 51.04 RCW to read as follows:

(1)(a) Notwithstanding RCW 51.04.060 or any other provision of this title, the parties to a claim for benefits may enter into a voluntary settlement agreement at any time as provided in this section with respect to one or more claims for benefits under this title. All voluntary settlement agreements must be approved by the board of industrial insurance appeals. The voluntary 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, vocational services, 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) For purposes of this section, "parties" means:

(i) For a self-insured claim, the worker and the employer; and

(ii) For a state fund claim, the worker, the employer, and the department of labor and industries. If the employer participates in a retrospective rating plan under chapter 51.18 RCW, the retrospective rating group, through its administrator, is also a party.

(c) A voluntary settlement agreement entered into under this section must be signed by the parties or their representatives and must clearly state that the parties understand and agree to the terms of the

voluntary settlement agreement. Unless one of the parties revokes consent to the agreement, as provided in subsection (3) of this section, the voluntary settlement agreement becomes final and binding thirty days after approval of the agreement by the board of industrial insurance appeals.

(d) A voluntary 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 voluntary settlement applies. A voluntary settlement agreement that has become final and binding is not subject to appeal.

(2)(a) If a worker is not represented by an attorney at the time of signing a voluntary settlement agreement, the parties must forward a copy of the signed settlement agreement to the board with a request for a conference with a settlement officer. Unless one of the parties requests a later date, the settlement officer must convene a conference within fourteen days after receipt of the request for the limited purpose of receiving the voluntary settlement agreement of the parties, explaining to the worker the benefits generally available under this title, and explaining that a voluntary settlement agreement may alter the benefits payable on a claim. In no event may a settlement officer render legal advice to any party.

(b) Before approving the settlement agreement, the settlement officer shall ensure that the worker has an adequate understanding of the settlement proposal and its consequences to the worker.

(c) The settlement officer may reject a settlement agreement only if the officer finds the parties have not entered into the agreement knowingly and willingly. Within seven days after the conference, the settlement officer shall issue an order allowing or rejecting the voluntary settlement agreement. There is no appeal from the settlement officer's decision.

(d) If the settlement officer issues an order allowing the voluntary settlement agreement, the order shall be submitted to the board.

(3) If a worker is represented by an attorney at the time of signing a voluntary settlement agreement, the parties may submit the agreement directly to the board without the conference described in this section.

1 (4) Upon receiving the voluntary settlement agreement, the board
2 shall approve the agreement within thirty working days of receipt
3 unless it finds that the parties have not entered into the agreement
4 knowingly and willingly. If the board approves the agreement, it shall
5 provide notice to the department of the binding terms of the agreement
6 and provide for placement of the agreement in the applicable claim
7 files.
8 (5) A party may revoke consent to the voluntary settlement
9 agreement by providing written notice to the other parties and the
10 board within thirty days after the date the agreement is approved by
11 the board.
12 (6) To the extent the worker is found to be entitled to temporary
13 total disability or permanent total disability benefits while a
14 voluntary settlement agreement is being negotiated, or during the
15 revocation period of an agreement, the benefits must be paid until the
16 agreement becomes final.
17 (7) If the parties have provided in a voluntary settlement
18 agreement that a claim is not subject to reopening under RCW 51.32.160,
19 any application to reopen the claim must be denied.

20 NEW SECTION. **Sec. 19.** A new section is added to chapter 51.04 RCW
21 to read as follows:
22 The department must maintain copies of all voluntary settlement
23 agreements entered into between the parties and develop processes under
24 RCW 51.28.070 to furnish copies of such agreements to any party
25 contemplating any subsequent voluntary settlement agreement with the
26 worker on any claim. The department shall also furnish claims
27 histories that include all prior permanent disability awards received
28 by the worker on any claims by body part and category or percentage
29 rating, as applicable. Copies of such agreements and claims histories
30 shall be furnished within ten working days of a written request. An
31 employer may not consider a prior settlement agreement or claims
32 history when making a decision about hiring or the terms or conditions
33 of employment.

34 NEW SECTION. **Sec. 20.** A new section is added to chapter 51.04 RCW
35 to read as follows:
36 If a worker has received a prior award of, or entered into a

1 voluntary settlement for, total or partial permanent disability
2 benefits, it shall be conclusively presumed that the medical condition
3 causing the prior permanent disability exists and is disabling at the
4 time of any subsequent industrial injury or occupational disease.
5 Except in the case of total permanent disability, the accumulation of
6 all permanent disability awards issued with respect to any one part of
7 the body in favor of the worker shall not exceed one hundred percent
8 over the worker's lifetime. When entering into a voluntary settlement
9 agreement under this chapter, the department or self-insured employer
10 may exclude amounts paid to settle claims for prior portions of a
11 worker's permanent total or partial disability.

12 NEW SECTION. **Sec. 21.** Sections 2 through 10 and 15 of this act
13 constitute a new chapter in Title 51 RCW.

14 NEW SECTION. **Sec. 22.** Sections 2 through 15 of this act take
15 effect January 1, 2011.

16 NEW SECTION. **Sec. 23.** If any provision of this act or its
17 application to any person or circumstance is held invalid, the
18 remainder of the act or the application of the provision to other
19 persons or circumstances is not affected.

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