Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Labor & Workforce Development Committee

HB 2431

Brief Description: Addressing claim files and compensation under the industrial insurance laws.

Sponsors: Representatives Reykdal, Appleton, Ladenburg, Green, Ormsby, Moeller and Kenney.

Brief Summary of Bill

- Requires self-insured employers, when issuing payments to workers, to provide notice of the type of benefit and other information, and provides a penalty for failure to comply.
- Requires surveillance or other investigation information to be provided immediately to a worker under certain conditions.
- Requires employer communications with workers' treating medical providers to be provided to workers.
- Requires the Department of Labor & Industries to make a permanent disability determination within 60 days of a worker's request.
- Requires orders that may result in an overpayment or recoupment to include information about the overpayment or recoupment
- Requires payment of attorney's fees and costs when the Board of Industrial Insurance Appeals reverses certain decisions relating to medical issues.
- Defines "claim file" to include electronic information, phone logs, and other information.

Hearing Date: 1/17/12

Staff: Joan Elgee (786-7106).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Background:

Under the state's industrial insurance laws, employers must either insure through the State Fund administered by the Department of Labor and Industries (Department) or, if qualified, may self-insure. Depending on the injury, workers injured in the course of employment receive medical benefits, temporary time-loss benefits including loss of earning power benefits, and vocational rehabilitation benefits, as well as benefits for permanent disabilities.

Self-insurers manage some aspects of injured worker claims, including closing certain types of claims. Self-insurers must maintain records of all payments of compensation and provide to the Director of the Department all information the self-insurer has relating to a disputed claim.

If a worker's representative (e.g., attorney) or the worker requests, the Department or self-insurer must provide a copy of the claim file to the worker. The Department or self-insurer may deny the request of a worker if release is not in the worker's best interests.

Certain payments by the Department or self-insurer may result in an overpayment order. For example, if benefits are paid because of a clerical order, the worker must repay the benefits and recoupment may be made from future benefits.

A worker or attorney may ask the Department or Board of Industrial Insurance Appeals to fix the attorney's fee under specified circumstances. For claim resolution structured settlement agreements, attorney's fees are limited to 15 percent of the total amount to be paid to the worker.

Summary of Bill:

Self-insurer payments and records. When issuing a payment to a worker, a self-insurer must simultaneously provide written notice of the type of benefit or other purpose of the payment. For temporary time-loss payments, the notice must also state the time period the payment covers, the daily rate of payment, and the Department claim number. For payments of temporary partial time-loss, the notice must indicate the full manner in which the payment was calculated. Notice must also be given of any change in the rate of benefits or the value of the worker's earning power and the reason for the change. A self-insurer's failure to comply with the notice requirements subjects the self-insurer to a penalty not to exceed $500. Within 30 days of a request by a worker, the Director of the Department must issue an order determining whether a violation occurred.

The self-insurer's duty to maintain records is modified to include payments to medical providers and other persons. A self-insurer must also keep a record of all requests for payments.

In the event of a disputed claim, or an audit or request by the Department, the self-insurer must provide the worker's claim file to the Department within 15 days.

Investigations. When the department, employer, or employer's representative conducts or a third-party administrator or claims management entity initiates surveillance or other investigation, investigation materials and reports become part of the claim file. Investigation materials and reports must be immediately provided to the worker: 1) if no investigatory activity has taken place for 30 days or the investigation is closed; 2) if information obtained is used for

any claims management decision; or 3) ten days before review of the information by a medical or vocational professional.

Medical information. If an employer, third-party administrator, or claims management entity communicates with a worker's current or former treating medical provider:

- Copies of written communications to a provider must be sent simultaneously to the claimant.
- Copies of reports or other writings received from the provider must be sent to the claimant within five days of receipt.
- The employer must give the claimant at least 14 days notice before a scheduled conversation, and a memorandum of the conversation must be sent to the claimant within five days of the conversation, regardless of the source, any claim of privilege, or attorney work product.

Permanent disability determination if an injured worker requests the Department to issue an order. After an injured worker's condition becomes fixed, the Department must issue an order within 60 days of receipt of the worker's request for the Department to issue a permanent disability determination. If a self-insurer requests a disability determination, the self-insurer must submit the claim file with the request. If an injured worker makes the request, the self-insured employer must submit the claim file to the Department within 15 working days of receiving notice of the request.

Overpayments. Any order which may result in an overpayment being assessed or benefits being recouped must itemize each overpayment or recoupment which may result, including the manner in which the overpayment will be calculated and the amount which will be recouped. If the information is not identified in the order, any subsequent overpayment is deemed waived. The provision does not apply to social security overpayments.

Attorney's fees and costs. If the Board reverses a decision of the Department related to certain medical issues, the Board must fix a reasonable attorney's fee, and the Board must order reimbursement for all reasonable costs of litigation, including witness fees. Fees and costs must be paid by self-insured employers or by the Department for State Fund cases. This provision applies to reversals of Department decisions: 1) denying the reopening of a claim previously resolved with a structured settlement agreement; 2) denying treatment of payment for treatment; or 3) segregating a medical condition as unrelated to the claim.

Definitions. A "claim file" is all documents and information regarding the claim or claimant under the control of the Department, self-insurer or representative, third-party administrator, or claims management entity and includes but is not limited to electronic information, medical treatment records, phone logs, and other specified information. A "third-party administrator" is an entity that contracts to administer claims for self-insured employers. A "claims management entity" is an individual designated by a self-insured employer to administer claims, including self-administered organizations and third-party administrators.

The provisions apply to all claims open after January 1, 2013.

Appropriation: None.

Fiscal Note: Requested on January 13, 2012.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.