H-3438.1

HOUSE BILL 2431

State of Washington 62nd Legislature 2012 Regular Session

By Representatives Reykdal, Appleton, Ladenburg, Green, Ormsby, Moeller, and Kenney

Read first time 01/13/12. Referred to Committee on Labor & Workforce Development.

AN ACT Relating to claim files and compensation under the industrial insurance laws; amending RCW 51.08.173, 51.14.110, 51.32.055, 51.32.195, 51.32.240, and 51.52.120; adding new sections to chapter 51.08 RCW; adding new sections to chapter 51.32 RCW; adding a new section to chapter 51.14 RCW; creating a new section; and prescribing penalties.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 51.08 RCW to read as follows:

A "claim file" means all documents and information regarding the claim or claimant that is under the control of the department, self-insurer, third-party administrator, claims management entity, or self-insurer's representative. "Claim file" includes information maintained in an electronic format. "Claim file" includes, but is not limited to, the following: Electronic and other correspondence sent or received, medical treatment records, medical examination reports, records reviews, medical billing records, vocational reports, vocational records, job analyses, all self-insurer forms, investigation requests, investigation reports, claim notes, phone logs, claim costs, requests

for benefits, and benefit payment documents and information. This section shall be liberally interpreted to include all records and information available in administering the claim.

NEW SECTION. **Sec. 2.** A new section is added to chapter 51.32 RCW to read as follows:

When the department, employer, or employer's representative conducts, or a third-party administrator or claims management entity initiates, surveillance or other investigation regarding a claimant or beneficiary, all investigation materials and reports become part of the claim file, and must be immediately provided to the claimant or beneficiary, upon any of the following:

(1) No investigatory activity has taken place for thirty days;

(2) An investigation is closed;

(3) Information obtained during the investigation is considered or used for any claims management decision; or

(4) Ten days prior to review by any medical or vocational professional of any information obtained during the investigation.

NEW SECTION. **Sec. 3.** A new section is added to chapter 51.08 RCW to read as follows:

"Third-party administrator" means any entity that contracts to administer workers' compensation claims for self-insured employers qualified under RCW 51.14.020 and certified pursuant to RCW 51.14.030 and is considered to be an employer representative.

NEW SECTION. **Sec. 4.** A new section is added to chapter 51.08 RCW to read as follows:

"Claims management entity" means any individual designated by a self-insured employer qualified under RCW 51.14.020 and certified pursuant to RCW 51.14.030 to administer workers' compensation claims including self-administered organizations and third-party administrators and is considered to be an employer representative.

Sec. 5. RCW 51.08.173 and 1983 c 174 s 1 are each amended to read as follows:

"Self-insurer" or "self-insured employer" means an employer or

group of employers which has been authorized under this title to carry its own liability to its employees covered by this title.

NEW SECTION. **Sec. 6.** A new section is added to chapter 51.14 RCW to read as follows:

(1) When issuing a payment to an injured worker or beneficiary, the self-insurer shall simultaneously provide written notice identifying the specific type of benefit being paid or other specific purpose of the payment.

(2) When issuing payments of temporary total disability benefits as provided in RCW 51.32.090, the self-insurer shall provide written notice to the injured worker of the time period the payment covers, the daily rate of the payment, and the department claim number under which the benefits are being paid. Any change in the rate of temporary total disability benefits shall be accompanied by written notice of the change and the reason for the change.

(3) When issuing payments of temporary partial disability benefits as provided in RCW 51.32.090, the self-insurer shall provide written notice to the injured worker of the time period the payment covers, the full manner in which the payment was calculated, and the department claim number under which the benefits are being paid. Any change in the value of the worker's earning power at the time of injury utilized to calculate temporary partial disability benefits shall be accompanied by written notice regarding the change and the reason for the change.

(4) Failure of a self-insurer to comply with this section subjects the self-insurer to a penalty under RCW 51.48.080. The director shall issue an order determining whether a violation has occurred within thirty days of a request by an injured worker.

Sec. 7. RCW 51.14.110 and 2005 c 145 s 2 are each amended to read as follows:

(1) Every self-insurer shall maintain a record of all payments ((~~of compensation~~)) made under this title((~~.~~)) to workers, beneficiaries, medical providers, and other persons or entities. Every self-insurer shall also maintain a record of all requests for benefits or other payments submitted pursuant to this title. This information is part of the claim file.

(2) In the event of a disputed claim, an audit by the department, or a request by the department, the self-insurer shall ((~~furnish to the director all information the self-insurer has in its possession as to any disputed claim, upon forms approved by the director.~~

~~(2)~~)) provide the employee's claim file to the department within fifteen days of receipt of the dispute, notice of audit, or department request.

(3)(a) The department shall establish an electronic reporting system for the submission to the department of specified self-insurance claims data to more effectively monitor the performance of self-insurers and to obtain claims information in an efficient manner.

(b) Self-insurers shall submit claims data electronically in the format and frequency prescribed by the department.

(c) Electronic submittal to the department of specified claims data is required to maintain self-insurance certification. The department shall establish an escalating schedule of penalties for noncompliance with this requirement, up to and including withdrawal of self-insurance certification.

(d) Claims data reported to the department electronically by individual self-insurers are confidential in accordance with RCW 51.16.070 and 51.28.070. The department may publish, for statistical purposes, aggregated claims data that contain no personal identifiers.

((~~(3)~~)) (4) The department shall adopt rules to administer this section.

NEW SECTION. **Sec. 8.** A new section is added to chapter 51.32 RCW to read as follows:

(1) When an employer or its representative's third-party administrator, or claims management entity sends a written communication to a current or former treating medical provider, a copy of the correspondence must simultaneously be sent to the claimant or legal representative.

(2) When an employer or its representative's third-party administrator, or claims management entity requests a report or other information in writing from a current or former treating medical provider, a copy of the report or other writing must be sent to the claimant within five days of the receipt of the report or other writing.

(3) When an employer or its representative's third-party administrator, or claims management entity schedules a meeting or conversation by any means with a current or former treating medical provider, the employer shall provide written notice of the conversation to the claimant at least fourteen days prior to the scheduled conversation. Following the conversation, a memorandum describing the information given to the provider, the questions asked of the provider, and the responses given by the provider must be sent to the claimant within five days of the conversation. This information must be provided regardless of the source of the information, any claim of privilege, or attorney work product.

Sec. 9. RCW 51.32.055 and 2004 c 65 s 8 are each amended to read as follows:

(1) One purpose of this title is to restore the injured worker as nearly as possible to the condition of self-support as an able-bodied worker. Benefits for permanent disability shall be determined under the director's supervision, except as otherwise authorized in subsection (9) of this section, only after the injured worker's condition becomes fixed.

(2) All determinations of permanent disabilities shall be made by the department, except as otherwise authorized in subsection (9) of this section. Either the worker, employer, or self-insurer may make a request or the inquiry may be initiated by the director or, as authorized in subsection (9) of this section, by the self-insurer on the director or the self-insurer's own motion. Determinations shall be required in every instance where permanent disability is likely to be present. All medical reports and other pertinent information in the possession of or under the control of the employer or, if the self-insurer has made a request to the department, in the possession of or under the control of the self-insurer shall be forwarded to the director with the request.

(3) A request for determination of permanent disability shall be examined by the department or, if authorized in subsection (9) of this section, the self-insurer, and the department shall issue an order in accordance with RCW 51.52.050 or, in the case of a self-insured employer, the self-insurer may: (a) Enter a written order,

communicated to the worker and the department self-insurance section in accordance with subsection (9) of this section, or (b) request the department to issue an order in accordance with RCW 51.52.050.

(4) The department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a special medical examination by a physician or physicians selected by the department, and the department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a personal interview. The costs of the examination or interview, including payment of any reasonable travel expenses, shall be paid by the department or self-insurer, as the case may be.

(5) The director may establish a medical bureau within the department to perform medical examinations under this section. Physicians hired or retained for this purpose shall be grounded in industrial medicine and in the assessment of industrial physical impairment. Self-insurers shall bear a proportionate share of the cost of the medical bureau in a manner to be determined by the department.

(6) Where a dispute arises from the handling of any claim before the condition of the injured worker becomes fixed, the worker, employer, or self-insurer may request the department to resolve the dispute or the director may initiate an inquiry on his or her own motion. In any claim where the injured worker's condition has become fixed, the worker may request the department issue an order containing a permanent disability determination. In these cases, the department shall proceed as provided in this section and an order shall issue within sixty days of receipt of the request and in accordance with RCW 51.52.050.

(7)(a) If a claim (i) is accepted by a self-insurer after June 30, 1986, and before August 1, 1997, (ii) involves only medical treatment and the payment of temporary disability compensation under RCW 51.32.090 or only the payment of temporary disability compensation under RCW 51.32.090, (iii) at the time medical treatment is concluded does not involve permanent disability, (iv) is one with respect to which the department has not intervened under subsection (6) of this section, and (v) the injured worker has returned to work with the self-insured employer of record, whether at the worker's previous job or at a job that has comparable wages and benefits, the claim may be closed

by the self-insurer, subject to reporting of claims to the department in a manner prescribed by department rules adopted under chapter 34.05 RCW.

(b) All determinations of permanent disability for claims accepted under this subsection (7) by self-insurers shall be made by the self-insured section of the department under subsections (1) through (4) of this section.

(c) Upon closure of a claim under (a) of this subsection, the self-insurer shall enter a written order, communicated to the worker and the department self-insurance section, which contains the following statement clearly set forth in bold face type: "This order constitutes notification that your claim is being closed with medical benefits and temporary disability compensation only as provided, and with the condition you have returned to work with the self-insured employer. If for any reason you disagree with the conditions or duration of your return to work or the medical benefits or the temporary disability compensation that has been provided, you must protest in writing to the department of labor and industries, self-insurance section, within sixty days of the date you received this order."

(8)(a) If a claim (i) is accepted by a self-insurer after June 30, 1990, and before August 1, 1997, (ii) involves only medical treatment, (iii) does not involve payment of temporary disability compensation under RCW 51.32.090, and (iv) at the time medical treatment is concluded does not involve permanent disability, the claim may be closed by the self-insurer, subject to reporting of claims to the department in a manner prescribed by department rules adopted under chapter 34.05 RCW. Upon closure of a claim, the self-insurer shall enter a written order, communicated to the worker, which contains the following statement clearly set forth in bold-face type: "This order constitutes notification that your claim is being closed with medical benefits only, as provided. If for any reason you disagree with this closure, you must protest in writing to the Department of Labor and Industries, Olympia, within 60 days of the date you received this order. The department will then review your claim and enter a further determinative order."

(b) All determinations of permanent disability for claims accepted under this subsection (8) by self-insurers shall be made by the self-

insured section of the department under subsections (1) through (4) of this section.

(9)(a) If a claim: (i) Is accepted by a self-insurer after July 31, 1997; (ii)(A) involves only medical treatment, or medical treatment and the payment of temporary disability compensation under RCW 51.32.090, and a determination of permanent partial disability, if applicable, has been made by the self-insurer as authorized in this subsection; or (B) involves only the payment of temporary disability compensation under RCW 51.32.090 and a determination of permanent partial disability, if applicable, has been made by the self-insurer as authorized in this subsection; (iii) is one with respect to which the department has not intervened under subsection (6) of this section; and (iv) concerns an injured worker who has returned to work with the self-insured employer of record, whether at the worker's previous job or at a job that has comparable wages and benefits, the claim may be closed by the self-insurer, subject to reporting of claims to the department in a manner prescribed by department rules adopted under chapter 34.05 RCW.

(b) If a physician or licensed advanced registered nurse practitioner submits a report to the self-insurer that concludes that the worker's condition is fixed and stable and supports payment of a permanent partial disability award, and if within fourteen days from the date the self-insurer mailed the report to the attending or treating physician or licensed advanced registered nurse practitioner, the worker's attending or treating physician or licensed advanced registered nurse practitioner disagrees in writing that the worker's condition is fixed and stable, the self-insurer must get a supplemental medical opinion from a provider on the department's approved examiner's list before closing the claim. In the alternative, the self-insurer may forward the claim to the department, which must review the claim and enter a final order as provided for in RCW 51.52.050.

(c) Upon closure of a claim under this subsection (9), the self-insurer shall enter a written order, communicated to the worker and the department self-insurance section, which contains the following statement clearly set forth in bold-face type: "This order constitutes notification that your claim is being closed with such medical benefits and temporary disability compensation as provided to date and with such award for permanent partial disability, if any, as set forth below, and

with the condition that you have returned to work with the self-insured employer. If for any reason you disagree with the conditions or duration of your return to work or the medical benefits, temporary disability compensation provided, or permanent partial disability that has been awarded, you must protest in writing to the Department of Labor and Industries, Self-Insurance Section, within sixty days of the date you received this order. If you do not protest this order to the department, this order will become final."

(d) All determinations of permanent partial disability for claims accepted by self-insurers under this subsection (9) may be made by the self-insurer or the self-insurer may request a determination by the self-insured section of the department. All determinations shall be made under subsections (1) through (4) of this section.

(10) If the department receives a protest of an order issued by a self-insurer under subsections (7) through (9) of this section, the self-insurer's closure order must be held in abeyance. The department shall review the claim closure action and enter a further determinative order as provided for in RCW 51.52.050. If no protest is timely filed, the closing order issued by the self-insurer shall become final and shall have the same force and effect as a department order that has become final under RCW 51.52.050.

(11) If within two years of claim closure under subsections (7) through (9) of this section, the department determines that the self-insurer has made payment of benefits because of clerical error, mistake of identity, or innocent misrepresentation or the department discovers a violation of the conditions of claim closure, the department may require the self-insurer to correct the benefits paid or payable. This subsection (11) does not limit in any way the application of RCW 51.32.240.

(12) For the purposes of this section, "comparable wages and benefits" means wages and benefits that are at least ninety-five percent of the wages and benefits received by the worker at the time of injury.

Sec. 10. RCW 51.32.195 and 1987 c 290 s 1 are each amended to read as follows:

On any industrial injury claim where ((~~the~~)) a self-insured employer or injured worker has requested a determination by the

department, the self-insurer must submit ((~~all medical reports and any other specified information not previously submitted~~)) the claim file to the department. If the self-insured employer requests a determination by the department, it shall submit the claim file with its request. If the injured worker requests a determination by the department, the self-insured employer shall submit the claim file to the department within fifteen working days of receiving notice of the worker's request. When the department requests information from a self-insurer by certified mail, the self-insurer shall submit ((~~all information in its possession concerning a claim~~)) the claim file or other information within ten working days from the date of receipt of such certified notice.

Sec. 11. RCW 51.32.240 and 2011 c 290 s 6 are each amended to read as follows:

(1)(a) Whenever any payment of benefits under this title is made because of clerical error, mistake of identity, innocent misrepresentation by or on behalf of the recipient thereof mistakenly acted upon, or any other circumstance of a similar nature, all not induced by willful misrepresentation, the recipient thereof shall repay it and recoupment may be made from any future payments due to the recipient on any claim with the state fund or self-insurer, as the case may be. The department or self-insurer, as the case may be, must make claim for such repayment or recoupment within one year of the making of any such payment or it will be deemed any claim therefor has been waived.

(b) Except as provided in subsections (3), (4), and (5) of this section, the department may only assess an overpayment of benefits because of adjudicator error when the order upon which the overpayment is based is not yet final as provided in RCW 51.52.050 and 51.52.060. "Adjudicator error" includes the failure to consider information in the claim file, failure to secure adequate information, or an error in judgment.

(c) The director, pursuant to rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05 RCW, may exercise his or her discretion to waive, in whole or in part, the amount of any such timely claim where the recovery would be against equity and good conscience.

(2) Whenever the department or self-insurer fails to pay benefits because of clerical error, mistake of identity, or innocent misrepresentation, all not induced by recipient willful misrepresentation, the recipient may request an adjustment of benefits to be paid from the state fund or by the self-insurer, as the case may be, subject to the following:

(a) The recipient must request an adjustment in benefits within one year from the date of the incorrect payment or it will be deemed any claim therefore has been waived.

(b) The recipient may not seek an adjustment of benefits because of adjudicator error. Adjustments due to adjudicator error are addressed by the filing of a written request for reconsideration with the department of labor and industries or an appeal with the board of industrial insurance appeals within sixty days from the date the order is communicated as provided in RCW 51.52.050. "Adjudicator error" includes the failure to consider information in the claim file, failure to secure adequate information, or an error in judgment.

(3) Whenever the department issues an order rejecting a claim for benefits paid pursuant to RCW 51.32.190 or 51.32.210, after payment for temporary disability benefits has been paid by a self-insurer pursuant to RCW 51.32.190(3) or by the department pursuant to RCW 51.32.210, the recipient thereof shall repay such benefits and recoupment may be made from any future payments due to the recipient on any claim with the state fund or self-insurer, as the case may be. The director, under rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05 RCW, may exercise discretion to waive, in whole or in part, the amount of any such payments where the recovery would be against equity and good conscience.

(4) Whenever any payment of benefits under this title has been made pursuant to an adjudication by the department or by order of the board or any court and timely appeal therefrom has been made where the final decision is that any such payment was made pursuant to an erroneous adjudication, the recipient thereof shall repay it and recoupment may be made from any future payments due to the recipient on any claim whether state fund or self-insured.

(a) The director, pursuant to rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05

RCW, may exercise discretion to waive, in whole or in part, the amount of any such payments where the recovery would be against equity and good conscience. However, if the director waives in whole or in part any such payments due a self-insurer, the self-insurer shall be reimbursed the amount waived from the self-insured employer overpayment reimbursement fund.

(b) The department shall collect information regarding self-insured claim overpayments resulting from final decisions of the board and the courts, and recoup such overpayments on behalf of the self-insurer from any open, new, or reopened state fund or self-insured claims. The department shall forward the amounts collected to the self-insurer to whom the payment is owed. The department may provide information as needed to any self-insurers from whom payments may be collected on behalf of the department or another self-insurer. Notwithstanding RCW 51.32.040, any self-insurer requested by the department to forward payments to the department pursuant to this subsection shall pay the department directly. The department shall credit the amounts recovered to the appropriate fund, or forward amounts collected to the appropriate self-insurer, as the case may be.

(c) If a self-insurer is not fully reimbursed within twenty-four months of the first attempt at recovery through the collection process pursuant to this subsection and by means of processes pursuant to subsection (6) of this section, the self-insurer shall be reimbursed for the remainder of the amount due from the self-insured employer overpayment reimbursement fund.

(d) For purposes of this subsection, "recipient" does not include health service providers whose treatment or services were authorized by the department or self-insurer.

(e) The department or self-insurer shall first attempt recovery of overpayments for health services from any entity that provided health insurance to the worker to the extent that the health insurance entity would have provided health insurance benefits but for workers' compensation coverage.

(5)(a) Whenever any payment of benefits under this title has been induced by willful misrepresentation the recipient thereof shall repay any such payment together with a penalty of fifty percent of the total of any such payments and the amount of such total sum may be recouped from any future payments due to the recipient on any claim with the

state fund or self-insurer against whom the willful misrepresentation was committed, as the case may be, and the amount of such penalty shall be placed in the supplemental pension fund. Such repayment or recoupment must be demanded or ordered within three years of the discovery of the willful misrepresentation.

(b) For purposes of this subsection (5), it is willful misrepresentation for a person to obtain payments or other benefits under this title in an amount greater than that to which the person otherwise would be entitled. Willful misrepresentation includes:

(i) Willful false statement; or

(ii) Willful misrepresentation, omission, or concealment of any material fact.

(c) For purposes of this subsection (5), "willful" means a conscious or deliberate false statement, misrepresentation, omission, or concealment of a material fact with the specific intent of obtaining, continuing, or increasing benefits under this title.

(d) For purposes of this subsection (5), failure to disclose a work-type activity must be willful in order for a misrepresentation to have occurred.

(e) For purposes of this subsection (5), a material fact is one which would result in additional, increased, or continued benefits, including but not limited to facts about physical restrictions, or work-type activities which either result in wages or income or would be reasonably expected to do so. Wages or income include the receipt of any goods or services. For a work-type activity to be reasonably expected to result in wages or income, a pattern of repeated activity must exist. For those activities that would reasonably be expected to result in wages or produce income, but for which actual wage or income information cannot be reasonably determined, the department shall impute wages pursuant to RCW 51.08.178(4).

(6) The worker, beneficiary, or other person affected thereby shall have the right to contest an order assessing an overpayment pursuant to this section in the same manner and to the same extent as provided under RCW 51.52.050 and 51.52.060. In the event such an order becomes final under chapter 51.52 RCW and notwithstanding the provisions of subsections (1) through (5) of this section, the director, director's designee, or self-insurer may file with the clerk in any county within the state a warrant in the amount of the sum representing the unpaid

overpayment and/or penalty plus interest accruing from the date the order became final. The clerk of the county in which the warrant is filed shall immediately designate a superior court cause number for such warrant and the clerk shall cause to be entered in the judgment docket under the superior court cause number assigned to the warrant, the name of the worker, beneficiary, or other person mentioned in the warrant, the amount of the unpaid overpayment and/or penalty plus interest accrued, and the date the warrant was filed. The amount of the warrant as docketed shall become a lien upon the title to and interest in all real and personal property of the worker, beneficiary, or other person against whom the warrant is issued, the same as a judgment in a civil case docketed in the office of such clerk. The sheriff shall then proceed in the same manner and with like effect as prescribed by law with respect to execution or other process issued against rights or property upon judgment in the superior court. Such warrant so docketed shall be sufficient to support the issuance of writs of garnishment in favor of the department or self-insurer in the manner provided by law in the case of judgment, wholly or partially unsatisfied. The clerk of the court shall be entitled to a filing fee under RCW 36.18.012(10), which shall be added to the amount of the warrant. A copy of such warrant shall be mailed to the worker, beneficiary, or other person within three days of filing with the clerk.

The director, director's designee, or self-insurer may issue to any person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state, a notice to withhold and deliver property of any kind if there is reason to believe that there is in the possession of such person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state, property that is due, owing, or belonging to any worker, beneficiary, or other person upon whom a warrant has been served for payments due the department or self-insurer. The notice and order to withhold and deliver shall be served by a method for which receipt can be confirmed or tracked accompanied by an affidavit of service by mailing or served by the sheriff of the county, or by the sheriff's deputy, or by any authorized representative of the director, director's designee, or self-insurer. Any person, firm, corporation, municipal corporation, political subdivision of the

state, public corporation, or agency of the state upon whom service has been made shall answer the notice within twenty days exclusive of the day of service, under oath and in writing, and shall make true answers to the matters inquired or in the notice and order to withhold and deliver. In the event there is in the possession of the party named and served with such notice and order, any property that may be subject to the claim of the department or self-insurer, such property shall be delivered forthwith to the director, the director's authorized representative, or self-insurer upon demand. If the party served and named in the notice and order fails to answer the notice and order within the time prescribed in this section, the court may, after the time to answer such order has expired, render judgment by default against the party named in the notice for the full amount, plus costs, claimed by the director, director's designee, or self-insurer in the notice. In the event that a notice to withhold and deliver is served upon an employer and the property found to be subject thereto is wages, the employer may assert in the answer all exemptions provided for by chapter 6.27 RCW to which the wage earner may be entitled.

This subsection shall only apply to orders assessing an overpayment which are issued on or after July 28, 1991: PROVIDED, That this subsection shall apply retroactively to all orders assessing an overpayment resulting from fraud, civil or criminal.

(7) Orders assessing an overpayment which are issued on or after July 28, 1991, shall include a conspicuous notice of the collection methods available to the department or self-insurer.

(8) Any order, which may result in an overpayment being assessed or benefits being recouped upon becoming final, must specifically 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 based on the deficient order is deemed waived. Such an order is subject to RCW 51.52.050. This subsection does not apply to overpayments issued pursuant to RCW 51.32.220.

Sec. 12. RCW 51.52.120 and 2011 1st sp.s. c 37 s 304 are each amended to read as follows:

(1) Except for claim resolution structured settlement agreements, 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 the director or the director's designee for services performed by an attorney for such 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) 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 for the services of his or her 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. In fixing the amount of such attorney's fee, the board shall take into consideration the fee allowed, if any, by the director, for services before the department, and the board may review the fee fixed by the director. Any attorney's fee set by the department 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) For claim resolution structured settlement agreements, fees for attorney services are limited to fifteen percent of the total amount to be paid to the worker after the agreement becomes final. The board will also decide on any disputes as to attorneys' fees for services related to claim resolution structured settlement agreements consistent with the procedures in subsection (2) of this section.

(4) <u>If, on appeal to the board from a decision or order of the department denying the reopening of a claim previously resolved with a</u>

structured settlement agreement, denying treatment or payment for treatment, or segregating a medical condition or conditions as unrelated to the claim, the decision is reversed or modified and the relief sought by the claimant is fully or partially awarded, a reasonable fee for the services of the worker's attorney shall be fixed by the board, and the board shall order reimbursement for all reasonable costs of litigation, including but not limited to fees of the medical and other witnesses. In cases of self-insured employers, the attorney fees fixed by the board and the costs set by the board shall be payable directly by the self-insured employer. In all other cases, the fees and costs shall be paid by the department out of the administrative fund.

(5) In an appeal to the board involving the presumption established under RCW 51.32.185, the attorney's fee shall be payable as set forth under RCW 51.32.185.

((~~(5)~~)) (6) Any person who violates this section is guilty of a misdemeanor.

NEW SECTION. **Sec. 13.** This act applies to all claims open after January 1, 2013.

--- END ---