

HOUSE BILL REPORT

HB 2218

As Reported by House Committee On:
Labor & Workplace Standards

Title: An act relating to access to medical care in workers' compensation.

Brief Description: Concerning access to medical care in workers' compensation.

Sponsors: Representatives Ortiz-Self, Abbarno, Ryu, Kloba, Parshley, Leavitt, Berry, Mena, Reed, Zahn, Goodman, Reeves, Waters, Macri, Fosse, Low, Hill, Pollet and Davis.

Brief History:

Committee Activity:

Labor & Workplace Standards: 1/16/26, 2/3/26 [DPS].

Brief Summary of Substitute Bill

- Makes various changes to workers' compensation treatment coverage provisions including: (1) allowing providers to deviate from Department of Labor and Industries treatment guidelines when medically appropriate; (2) allowing treatment by a nonnetwork provider under certain circumstances; (3) authorizing continued treatment for certain permanent partial disability cases; and (4) authorizing the Department of Labor and Industries to hire more claims managers to the extent necessary to reach the recommended average claims case load of 141 claims per claims managers.

HOUSE COMMITTEE ON LABOR & WORKPLACE STANDARDS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 6 members: Representatives Berry, Chair; Fosse, Vice Chair; Ybarra, Assistant Ranking Minority Member; Bronoske, Obras and Ortiz-Self.

Minority Report: Without recommendation. Signed by 2 members: Representatives

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

Schmidt, Ranking Minority Member; McEntire.

Staff: Alison Ryan (786-7296).

Background:

The Industrial Insurance Act (Act) provides that a worker who is injured in the course of employment or injured or disabled from an occupational disease is entitled to workers' compensation benefits. Benefits may include medical, temporary time-loss, vocational rehabilitation, and permanent disabilities benefits. The Department of Labor and Industries (Department) administers the workers' compensation system.

Worker's Choice of Provider.

An injured worker must seek care from a provider within the Department's medical provider network, except for an initial or emergency visit. Within the Department's medical provider network, a worker is entitled to seek care from a provider of the worker's choice.

Coverage Decisions and Treatment Guidelines.

A network provider must follow the Department's coverage decisions, treatment guidelines, and policies, and when appropriate for the patient, other national treatment guidelines.

Utilization Review.

The Department contracts with a utilization review provider to review requests for certain medical services and compare them to the Department's coverage decisions and treatment guidelines. The utilization review provider makes a recommendation to the Department about authorizing or denying a request.

Continued Treatment.

For permanent total disability claims, covered treatment ends on the date of a lump sum settlement or when the worker is placed on a permanent pension. However, the Supervisor of Industrial Insurance may authorize continued treatment when necessary to protect the worker's life or for the administration of medical and therapeutic measures. Permanent partial disability claims may be reopened for additional treatment if a worker submits an application within seven years of claim closure.

Summary of Substitute Bill:

Worker's Choice of Provider.

An employer must inform an injured worker that the worker has a right to seek initial treatment or emergency medical treatment from a provider of the worker's choice and that the worker has a right to seek further treatment from a provider of the worker's choice within the medical provider network. An employer may not require or induce an injured worker to seek treatment from a specific provider or clinic. An employer is not prevented

from providing on-site medical care at the worker's own choice. The Department must investigate any allegation that an employer attempted to require or induce an injured worker to seek treatment from a specific provider or clinic. A violation by a self-insured employer is a violation of the statutory duty of good faith and subjects the employer to penalties. A violation by a non-self-insured employer subjects the employer to penalties for claim suppression.

If an injured worker is unable to find a provider in the medical provider network, the worker may seek care from a nonnetwork provider under certain circumstances. If a worker lives in a county with a population of 500,000 or more, and the worker cannot find a provider willing to treat the worker within 15 miles of the worker's home, then the worker may seek care outside the network. A worker who lives in a county with a population of less than 500,000 may seek care outside the network if the worker cannot find a provider within 30 miles of the worker's home. The worker may provide notice to the Department or self-insured employer, and the Department or self-insured employer must provide a declaration certifying this fact within seven days.

Coverage Decisions and Treatment Guidelines.

A provider may deviate from the Department's coverage decisions, treatment guidelines, policies, or national guidelines when medically appropriate.

Utilization Review.

Utilization review must be completed within 10 business days from the date that the utilization review provider receives all requested information necessary to make the treatment recommendation, or else the treatment must be authorized. If it is uncertain whether authorized treatment is related to a workplace injury or occupational disease, the Department shall adjudicate whether the condition is related by issuing an order within 30 days of the deadline for completion of the utilization review.

Continued Treatment.

If the Department denies an application to reopen a permanent partial disability claim, the Department may authorize continued treatment when necessary to protect the worker's life or for the administration of medical and therapeutic measures. Continued monitoring of cancer is covered at a frequency recommended by the worker's oncologist.

Written Notice When Removing a Provider from the Medical Provider Network.

When the Department removes a provider from the medical provider network, it must be done in writing. The provider may appeal to the Washington State Board of Industrial Insurance Appeals.

Substitute Bill Compared to Original Bill:

The substitute bill:

- adds an intent section;

- removes the specification that a network provider makes the determination regarding whether the Department's treatment guidelines are medically appropriate;
- provides that the prohibition on an employer inducing a worker to seek treatment from a specific provider does not prevent an employer from providing on-site medical care if the worker chooses;
- modifies the provisions that allow a worker to seek treatment from a nonnetwork provider by: (1) expanding the distance from the worker's home in which there must be no provider willing to treat the worker, if the worker lives in a county with a population of less than 500,000 to 30 miles; (2) increasing, from 7 to 10 days, the time for the Department or a self-insurer to provide a declaration certifying no provider is willing to treat the worker; and (3) providing the Department or a self-insurer with the opportunity to assist the worker in finding a network provider before the worker may seek treatment from a nonnetwork provider;
- modifies the provisions regarding utilization review by: (1) requiring the completion of utilization review within 10 business days after all necessary information for making the treatment recommendation is received by the utilization review provider; and (2) requiring the Department to adjudicate whether a condition is unrelated to the injury or occupational disease within 30 days of the completion deadline;
- provides that the Department may authorize continued treatment for certain permanent partial disability claims after claim closure;
- requires that any request for continued treatment be made within 120 days of the worker's receipt of treatment;
- removes outdated language related to establishing the Centers for Occupational Health and Education;
- removes the addition of orders awarding permanent total disability compensation from the definition of "closing order;" and
- modifies the effective dates to provide that: (1) the provision that network providers may deviate from the Department's treatment guidelines when medically appropriate takes effect 90 days after the Legislature's adjournment; and (2) all other provisions take effect on January 1, 2028.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Substitute Bill: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

(In support) This bill addresses persistent challenges related to delays in treatment and restrictive guidelines. It has become increasingly difficult for injured workers to find treatment providers. The bill ensures that a worker can choose their doctor and can find

treatment in their geographic area. When a worker's physician recommends a particular treatment, the treatment guidelines might prevent that treatment from being covered. Some physicians choose not to treat workers' compensation patients because of denials and long delays in approval. Seemingly straightforward injuries can result in extended delays. The treatment guidelines are treated as mandatory rather than advisory, and recent draft medical guidelines are not based on real world experience. The bill is fine-tuning, and not a wholesale replacement.

(Opposed) There need to be swifter mechanisms to resolve claims outside the norm, but there are more benefits to the system than there are problems. The Department operates the workers' compensation system as an insurance system and must be able to manage risk and rely on medical evidence to guide decisions. Joining the medical provider network only requires that physicians have appropriate credentials to treat patients in Washington, agree to the treatment guidelines, and agree to the Department's fee schedule. The penalties around the prohibition on directing or inducing a patient to seek care from a particular provider are too severe. The medical provider network promotes evidence-based care, controls costs by preventing unnecessary or harmful treatment, and allows the Department to remove poorly performing providers. How the bill's changes will work in the system needs to be considered.

(Other) There is agreement that delays in the system are costly for workers being able to heal and return to work. Where exceptions and delays are harming workers, this can be worked on. For most workers, the system works well. For a smaller share of workers, the system does not move quickly enough. Approving necessary care while not delaying care is a balance. The bill would fundamentally shift how medical necessity and treatment decisions are made in the workers' compensation system.

Persons Testifying: (In support) Representative Lillian Ortiz-Self, prime sponsor; Brenda Wiest, Teamsters 117; David Lauman, Washington State Association for Justice; Alan Thomas; David Penner; AJ Johnson, Washington State Council of Firefighters; and Brian Wright.

(Opposed) Patrick Connor, NFIB; Carolyn Logue, Associated Builders and Contractors Inland Pacific; Kris Tefft, Washington Self-Insurers Association; Mike Ennis, Building Industry Association of Washington; Rose Gundersen, WA Retail Association; and James Crandall, AWB.

(Other) Kirsta Glenn, Department of Labor and Industries; and Tammy Fellin, Department of Labor and Industries.

Persons Signed In To Testify But Not Testifying: None.