CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 2405

Chapter 220, Laws of 2026

69th Legislature
2026 Regular Session

WORKERS' COMPENSATION—POSTTRAUMATIC STRESS DISORDER TREATMENT AND RESEARCH—PILOT PROGRAM

EFFECTIVE DATE: July 1, 2026—Except for section 3, which takes effect June 30, 2027.

Passed by the House February 16, 2026
Yeas 90 Nays 1

LAURIE JINKINS

Speaker of the House of Representatives

Passed by the Senate March 5, 2026
Yeas 49 Nays 0

DENNY HECK

President of the Senate

Approved March 25, 2026 11:27 AM

BOB FERGUSON

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 2405** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

FILED

March 25, 2026

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 2405

Passed Legislature - 2026 Regular Session

State of Washington 69th Legislature 2026 Regular Session

By House Labor & Workplace Standards (originally sponsored by Representatives Schmidt, Bronoske, Parshley, Salahuddin, Simmons, Davis, and Nance; by request of Department of Labor & Industries)

READ FIRST TIME 02/03/26.

AN ACT Relating to establishing a pilot program for posttraumatic stress disorder treatment and research; amending RCW 49.17.243, 51.36.010, 51.36.010, and 51.36.060; adding a new section to chapter 51.36 RCW; creating a new section; providing effective dates; and providing expiration dates.

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

Sec. 1. RCW 49.17.243 and 2011 1st sp.s. c 37 s 501 are each amended to read as follows:

(1) The director is authorized to provide funding from the medical aid fund established under RCW 51.44.020, by grant or contract, for safety and health investment projects for workplaces insured for workers' compensation through the department's state fund. This shall include projects to: Prevent workplace injuries, illnesses, and fatalities; create early return-to-work programs; and reduce long-term disability through the cooperation of employers and employees or their representatives.

(2) Awards may be granted to organizations such as, but not limited to, trade associations, business associations, employers, employees, labor unions, employee organizations, joint labor and management groups, and educational institutions in collaboration with state fund employer and employee representatives.

(3) Awards may not be used for lobbying or political activities; supporting, opposing, or developing legislative or regulatory initiatives; any activity not designed to reduce workplace injuries, illnesses, or fatalities; or reimbursing employers for the normal costs of complying with safety and health rules.

(4) Funds for awards shall be distributed as follows: At least ((~~twenty-five~~)) 25 percent for projects designed to develop and implement innovative and effective return-to-work programs for injured workers; at least ((~~twenty-five~~)) 25 percent for projects that specifically address the needs of small businesses; and at least ((~~fifty~~)) 50 percent for projects that foster workplace injury and illness prevention by addressing priorities identified by the department in cooperation with the Washington industrial safety and health act advisory committee and the workers' compensation advisory committee.

(5) The department is authorized to use the funds allocated for effective return-to-work projects related to return-to-work programs under subsection (4) of this section to provide funding for grants or contracts for the development and evaluation of workplace behavioral health programs including, but not limited to, suicide prevention, mental health training, trauma-informed reintegration protocols, independent navigator programs, and developing supportive workplace cultures. The projects must be focused on occupations that have high risk of posttraumatic stress disorder through repetitive exposure to trauma. The department is authorized to determine appropriate organizations eligible for awards under this subsection.

(6) The department shall adopt rules as necessary to implement this section.

Sec. 2. RCW 51.36.010 and 2023 c 171 s 9 are each amended to read as follows:

(1) The legislature finds that high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income for workers, and lower labor and insurance costs for employers. Injured workers deserve high quality medical care in accordance with current health care best practices. To this end, the department shall establish minimum standards for providers who treat workers from both state fund and self-insured employers. The department shall establish a health care provider network to treat injured workers, and shall accept providers

into the network who meet those minimum standards. The department shall convene an advisory group made up of representatives from or designees of the workers' compensation advisory committee and the industrial insurance medical and chiropractic advisory committees to consider and advise the department related to implementation of this section, including development of best practices treatment guidelines for providers in the network. The department shall also seek the input of various health care provider groups and associations concerning the network's implementation. Network providers must be required to follow the department's evidence-based coverage decisions and treatment guidelines, policies, and must be expected to follow other national treatment guidelines appropriate for their patient. The department, in collaboration with the advisory group, shall also establish additional best practice standards for providers to qualify for a second tier within the network, based on demonstrated use of occupational health best practices. This second tier is separate from and in addition to the centers for occupational health and education established under subsection (5) of this section.

(2)(a) 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, osteopathic physician, chiropractor, naturopath, podiatric physician, optometrist, dentist, licensed advanced registered nurse practitioner, physician assistant, or psychologist in claims solely for mental health conditions, of his or her own choice, if conveniently located, except as provided in (b) of this subsection, and proper and necessary hospital care and services during the period of his or her disability from such injury.

(b) ((~~Once~~)) Except as provided under section 5 of this act, once the provider network is established in the worker's geographic area, an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit. However, the department or self-insurer may limit reimbursement to the department's standard fee for the services. The provider must comply with all applicable billing policies and must accept the department's fee schedule as payment in full.

(c) The department, in collaboration with the advisory group, shall adopt policies for the development, credentialing, accreditation, and continued oversight of a network of health care providers approved to treat injured workers. Health care providers

shall apply to the network by completing the department's provider application which shall have the force of a contract with the department to treat injured workers. The advisory group shall recommend minimum network standards for the department to approve a provider's application, to remove a provider from the network, or to require peer review such as, but not limited to:

(i) Current malpractice insurance coverage exceeding a dollar amount threshold, number, or seriousness of malpractice suits over a specific time frame;

(ii) Previous malpractice judgments or settlements that do not exceed a dollar amount threshold recommended by the advisory group, or a specific number or seriousness of malpractice suits over a specific time frame;

(iii) No licensing or disciplinary action in any jurisdiction or loss of treating or admitting privileges by any board, commission, agency, public or private health care payer, or hospital;

(iv) For some specialties such as surgeons, privileges in at least one hospital;

(v) Whether the provider has been credentialed by another health plan that follows national quality assurance guidelines; and

(vi) Alternative criteria for providers that are not credentialed by another health plan.

The department shall develop alternative criteria for providers that are not credentialed by another health plan or as needed to address access to care concerns in certain regions.

(d) Network provider contracts will automatically renew at the end of the contract period unless the department provides written notice of changes in contract provisions or the department or provider provides written notice of contract termination. The industrial insurance medical advisory committee shall develop criteria for removal of a provider from the network to be presented to the department and advisory group for consideration in the development of contract terms.

(e) In order to monitor quality of care and assure efficient management of the provider network, the department shall establish additional criteria and terms for network participation including, but not limited to, requiring compliance with administrative and billing policies.

(f) The advisory group shall recommend best practices standards to the department to use in determining second tier network

providers. The department shall develop and implement financial and nonfinancial incentives for network providers who qualify for the second tier. The department is authorized to certify and decertify second tier providers.

(3) The department shall work with self-insurers and the department utilization review provider to implement utilization review for the self-insured community to ensure consistent quality, cost-effective care for all injured workers and employers, and to reduce administrative burden for providers.

(4) 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~~)) Notwithstanding treatment provided under section 5 of this act, 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 pharmacy quality assurance commission 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.

(5)(a) The legislature finds that the department and its business and labor partners have collaborated in establishing centers for occupational health and education to promote best practices and prevent preventable disability by focusing additional provider-based resources during the first ((~~twelve~~)) 12 weeks following an injury. The centers for occupational health and education represent innovative accountable care systems in an early stage of development consistent with national health care reform efforts. Many Washington workers do not yet have access to these innovative health care delivery models.

(b) To expand evidence-based occupational health best practices, the department shall establish additional centers for occupational health and education, with the goal of extending access to at least ((~~fifty~~)) 50 percent of injured and ill workers by December 2013 and to all injured workers by December 2015. The department shall also develop additional best practices and incentives that span the entire period of recovery, not only the first ((~~twelve~~)) 12 weeks.

(c) The department shall certify and decertify centers for occupational health and education based on criteria including institutional leadership and geographic areas covered by the center for occupational health and education, occupational health leadership and education, mix of participating health care providers necessary to address the anticipated needs of injured workers, health services coordination to deliver occupational health best practices, indicators to measure the success of the center for occupational health and education, and agreement that the center's providers shall, if feasible, treat certain injured workers if referred by the department or a self-insurer.

(d) Health care delivery organizations may apply to the department for certification as a center for occupational health and education. These may include, but are not limited to, hospitals and affiliated clinics and providers, multispecialty clinics, health maintenance organizations, and organized systems of network physicians.

(e) The centers for occupational health and education shall implement benchmark quality indicators of occupational health best practices for individual providers, developed in collaboration with the department. A center for occupational health and education shall remove individual providers who do not consistently meet these quality benchmarks.

(f) The department shall develop and implement financial and nonfinancial incentives for center for occupational health and education providers that are based on progressive and measurable gains in occupational health best practices, and that are applicable throughout the duration of an injured or ill worker's episode of care.

(g) The department shall develop electronic methods of tracking evidence-based quality measures to identify and improve outcomes for injured workers at risk of developing prolonged disability. In addition, these methods must be used to provide systematic feedback to physicians regarding quality of care, to conduct appropriate objective evaluation of progress in the centers for occupational health and education, and to allow efficient coordination of services.

(6) If a provider fails to meet the minimum network standards established in subsection (2) of this section, the department is authorized to remove the provider from the network or take other appropriate action regarding a provider's participation. The department may also require remedial steps as a condition for a provider to participate in the network. The department, with input from the advisory group, shall establish waiting periods that may be imposed before a provider who has been denied or removed from the network may reapply.

(7) The department may permanently remove a provider from the network or take other appropriate action when the provider exhibits a pattern of conduct of low quality care that exposes patients to risk of physical or psychiatric harm or death. Patterns that qualify as risk of harm include, but are not limited to, poor health care

outcomes evidenced by increased, chronic, or prolonged pain or decreased function due to treatments that have not been shown to be curative, safe, or effective or for which it has been shown that the risks of harm exceed the benefits that can be reasonably expected based on peer-reviewed opinion.

(8) The department may not remove a health care provider from the network for an isolated instance of poor health and recovery outcomes due to treatment by the provider.

(9) When the department terminates a provider from the network, the department or self-insurer shall assist an injured worker currently under the provider's care in identifying a new network provider or providers from whom the worker can select an attending or treating provider. In such a case, the department or self-insurer shall notify the injured worker that he or she must choose a new attending or treating provider.

(10) The department may adopt rules related to this section.

(11) The department shall report to the workers' compensation advisory committee and to the appropriate committees of the legislature on each December 1st, beginning in 2012 and ending in 2016, on the implementation of the provider network and expansion of the centers for occupational health and education. The reports must include a summary of actions taken, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies related to new provisions, and whether any changes are needed to further improve the occupational health best practices care of injured workers.

Sec. 3. RCW 51.36.010 and 2025 c 58 s 5117 are each amended to read as follows:

(1) The legislature finds that high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income for workers, and lower labor and insurance costs for employers. Injured workers deserve high quality medical care in accordance with current health care best practices. To this end, the department shall establish minimum standards for providers who treat workers from both state fund and self-insured employers. The department shall establish a health care provider network to treat injured workers, and shall accept providers into the network who meet those minimum standards. The department shall convene an advisory group made up of representatives from or

designees of the workers' compensation advisory committee and the industrial insurance medical and chiropractic advisory committees to consider and advise the department related to implementation of this section, including development of best practices treatment guidelines for providers in the network. The department shall also seek the input of various health care provider groups and associations concerning the network's implementation. Network providers must be required to follow the department's evidence-based coverage decisions and treatment guidelines, policies, and must be expected to follow other national treatment guidelines appropriate for their patient. The department, in collaboration with the advisory group, shall also establish additional best practice standards for providers to qualify for a second tier within the network, based on demonstrated use of occupational health best practices. This second tier is separate from and in addition to the centers for occupational health and education established under subsection (5) of this section.

(2)(a) 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, osteopathic physician, chiropractor, naturopath, podiatric physician, optometrist, dentist, licensed advanced practice registered nurse, physician assistant, or psychologist in claims solely for mental health conditions, of his or her own choice, if conveniently located, except as provided in (b) of this subsection, and proper and necessary hospital care and services during the period of his or her disability from such injury.

(b) ((~~Once~~)) Except as provided under section 5 of this act, once the provider network is established in the worker's geographic area, an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit. However, the department or self-insurer may limit reimbursement to the department's standard fee for the services. The provider must comply with all applicable billing policies and must accept the department's fee schedule as payment in full.

(c) The department, in collaboration with the advisory group, shall adopt policies for the development, credentialing, accreditation, and continued oversight of a network of health care providers approved to treat injured workers. Health care providers shall apply to the network by completing the department's provider application which shall have the force of a contract with the

department to treat injured workers. The advisory group shall recommend minimum network standards for the department to approve a provider's application, to remove a provider from the network, or to require peer review such as, but not limited to:

(i) Current malpractice insurance coverage exceeding a dollar amount threshold, number, or seriousness of malpractice suits over a specific time frame;

(ii) Previous malpractice judgments or settlements that do not exceed a dollar amount threshold recommended by the advisory group, or a specific number or seriousness of malpractice suits over a specific time frame;

(iii) No licensing or disciplinary action in any jurisdiction or loss of treating or admitting privileges by any board, commission, agency, public or private health care payer, or hospital;

(iv) For some specialties such as surgeons, privileges in at least one hospital;

(v) Whether the provider has been credentialed by another health plan that follows national quality assurance guidelines; and

(vi) Alternative criteria for providers that are not credentialed by another health plan.

The department shall develop alternative criteria for providers that are not credentialed by another health plan or as needed to address access to care concerns in certain regions.

(d) Network provider contracts will automatically renew at the end of the contract period unless the department provides written notice of changes in contract provisions or the department or provider provides written notice of contract termination. The industrial insurance medical advisory committee shall develop criteria for removal of a provider from the network to be presented to the department and advisory group for consideration in the development of contract terms.

(e) In order to monitor quality of care and assure efficient management of the provider network, the department shall establish additional criteria and terms for network participation including, but not limited to, requiring compliance with administrative and billing policies.

(f) The advisory group shall recommend best practices standards to the department to use in determining second tier network providers. The department shall develop and implement financial and nonfinancial incentives for network providers who qualify for the

second tier. The department is authorized to certify and decertify second tier providers.

(3) The department shall work with self-insurers and the department utilization review provider to implement utilization review for the self-insured community to ensure consistent quality, cost-effective care for all injured workers and employers, and to reduce administrative burden for providers.

(4) 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~~)) Notwithstanding treatment provided under section 5 of this act, 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 pharmacy quality assurance commission 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.

(5)(a) The legislature finds that the department and its business and labor partners have collaborated in establishing centers for occupational health and education to promote best practices and prevent preventable disability by focusing additional provider-based resources during the first ((~~twelve~~)) 12 weeks following an injury. The centers for occupational health and education represent innovative accountable care systems in an early stage of development consistent with national health care reform efforts. Many Washington workers do not yet have access to these innovative health care delivery models.

(b) To expand evidence-based occupational health best practices, the department shall establish additional centers for occupational health and education, with the goal of extending access to at least ((~~fifty~~)) 50 percent of injured and ill workers by December 2013 and to all injured workers by December 2015. The department shall also develop additional best practices and incentives that span the entire period of recovery, not only the first ((~~twelve~~)) 12 weeks.

(c) The department shall certify and decertify centers for occupational health and education based on criteria including institutional leadership and geographic areas covered by the center for occupational health and education, occupational health leadership and education, mix of participating health care providers necessary to address the anticipated needs of injured workers, health services coordination to deliver occupational health best practices, indicators to measure the success of the center for occupational health and education, and agreement that the center's providers shall, if feasible, treat certain injured workers if referred by the department or a self-insurer.

(d) Health care delivery organizations may apply to the department for certification as a center for occupational health and

education. These may include, but are not limited to, hospitals and affiliated clinics and providers, multispecialty clinics, health maintenance organizations, and organized systems of network physicians.

(e) The centers for occupational health and education shall implement benchmark quality indicators of occupational health best practices for individual providers, developed in collaboration with the department. A center for occupational health and education shall remove individual providers who do not consistently meet these quality benchmarks.

(f) The department shall develop and implement financial and nonfinancial incentives for center for occupational health and education providers that are based on progressive and measurable gains in occupational health best practices, and that are applicable throughout the duration of an injured or ill worker's episode of care.

(g) The department shall develop electronic methods of tracking evidence-based quality measures to identify and improve outcomes for injured workers at risk of developing prolonged disability. In addition, these methods must be used to provide systematic feedback to physicians regarding quality of care, to conduct appropriate objective evaluation of progress in the centers for occupational health and education, and to allow efficient coordination of services.

(6) If a provider fails to meet the minimum network standards established in subsection (2) of this section, the department is authorized to remove the provider from the network or take other appropriate action regarding a provider's participation. The department may also require remedial steps as a condition for a provider to participate in the network. The department, with input from the advisory group, shall establish waiting periods that may be imposed before a provider who has been denied or removed from the network may reapply.

(7) The department may permanently remove a provider from the network or take other appropriate action when the provider exhibits a pattern of conduct of low quality care that exposes patients to risk of physical or psychiatric harm or death. Patterns that qualify as risk of harm include, but are not limited to, poor health care outcomes evidenced by increased, chronic, or prolonged pain or decreased function due to treatments that have not been shown to be

curative, safe, or effective or for which it has been shown that the risks of harm exceed the benefits that can be reasonably expected based on peer-reviewed opinion.

(8) The department may not remove a health care provider from the network for an isolated instance of poor health and recovery outcomes due to treatment by the provider.

(9) When the department terminates a provider from the network, the department or self-insurer shall assist an injured worker currently under the provider's care in identifying a new network provider or providers from whom the worker can select an attending or treating provider. In such a case, the department or self-insurer shall notify the injured worker that he or she must choose a new attending or treating provider.

(10) The department may adopt rules related to this section.

(11) The department shall report to the workers' compensation advisory committee and to the appropriate committees of the legislature on each December 1st, beginning in 2012 and ending in 2016, on the implementation of the provider network and expansion of the centers for occupational health and education. The reports must include a summary of actions taken, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies related to new provisions, and whether any changes are needed to further improve the occupational health best practices care of injured workers.

Sec. 4. RCW 51.36.060 and 2023 c 171 s 11 are each amended to read as follows:

Attending providers under this title shall comply with rules and regulations adopted by the director, and shall make such reports as may be requested by the department or self-insurer upon the condition or treatment of any such worker, or upon any other matters concerning such workers in their care. Except under RCW 49.17.210 and 49.17.250, and notwithstanding treatment provided under section 5(2)(a)(i) of this act, all medical information in the possession or control of any person and relevant to the particular injury in the opinion of the department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the claimant's representative, and the department upon request, and no

person shall incur any legal liability by reason of releasing such information.

NEW SECTION. **Sec. 5.** A new section is added to chapter 51.36 RCW to read as follows:

(1) **Legislative findings and intent.** The legislature finds that posttraumatic stress disorder is a serious and growing concern for workers in high risk occupations, and that emerging research supports the link between trauma exposure and the development of posttraumatic stress disorder. The legislature intends to support trauma-informed strategies to reduce the severity of work-related posttraumatic stress disorder, with the goal of improving recovery outcomes that enable sustained work. To that end, the department is authorized and directed to develop and implement a pilot program focused on these objectives.

(2) **Pilot program design and implementation.**

(a) In consultation with subject matter experts from the department and advisory committees including, but not limited to, the advisory committee established under RCW 51.04.110, the department shall design and implement a pilot program to expand access to evidence-based, high quality care for workers exposed to trauma seeking coverage of posttraumatic stress disorder as an occupational disease. Self-insurers may choose to participate in the pilot program.

(i) As part of the pilot program, when a worker files an occupational disease claim for posttraumatic stress disorder pursuant to RCW 51.08.142 (2) or (3), the department or participating self-insurer shall provide the worker the opportunity to participate in the pilot program. If the worker opts for their claim to be part of the pilot program, the department or participating self-insurer shall authorize access to treatment for posttraumatic stress disorder prior to claim adjudication, without regard to whether the worker's claim for benefits is allowed. Workers may receive the preclaim adjudication treatment from a mental health provider qualified to provide mental health treatment under this title if the provider agrees to be paid in accordance with the department's medical aid rules and fee schedules and signs a nonnetwork provider agreement. The department will survey or contact these providers to better understand barriers to entering the medical provider network. Costs for treatment prior to claim adjudication on state fund claims that

are ultimately rejected shall be spread across all risk classes for which there is a presumption of coverage of posttraumatic stress disorder as an occupational disease. Costs for treatment prior to claim adjudication on self-insured claims that are ultimately rejected shall be paid by the self-insurer. Payment for this treatment or any other benefits under this title, prior to the entry of an order by the department in accordance with RCW 51.52.050 as now or hereafter amended, shall not be considered a binding determination of the obligations of the department or self-insurer under this title. Treatment for posttraumatic stress disorder prior to claim adjudication shall be limited to a clinical diagnostic interview or mental health evaluation in which a mental health provider diagnoses posttraumatic stress disorder and 11 treatment sessions to occur within 90 days of filing the claim. If the claim has not been adjudicated for allowance within 90 days, the supervisor of industrial insurance may authorize continued treatment of up to 12 treatment sessions. Once the claim is allowed, the worker must seek treatment for posttraumatic stress disorder from a provider in the medical provider network.

(ii) As part of the pilot program, to improve access to trauma-informed care, the department may enter into agreements with health care organizations or providers experienced in the diagnosis, assessment, and treatment of posttraumatic stress disorder and probable posttraumatic stress disorder. To enter into an agreement with the department, a health care organization or provider must meet qualifications and requirements established by the department. The department may identify and implement financial and other incentives for participating providers, develop criteria for workers to receive services under these agreements, and develop criteria for evaluating the success of these agreements. These agreements may not be used to limit workers' choice of providers or organizations for mental health treatment.

(iii) As part of the pilot program, the department and participating self-insurers shall authorize up to six additional treatment sessions for posttraumatic stress disorder within one year of claim closure, when such treatment is deemed necessary to maintain the worker's level of functioning at the time of claim closure.

(iv) As part of the pilot program, the department may reduce administrative requirements as necessary to simplify and address barriers for both workers and treating providers participating in the

pilot program. "Administrative requirements" for the purpose of this act may include, but are not limited to, forms, documentation, timelines, reporting obligations, prior authorizations, or other programmatic processes imposed on workers or treating providers solely for treatment under the pilot program.

(b) Self-insurers who participate in the pilot program shall upon request produce a report of all workers' compensation claims that were subject to provisions of the pilot program in a format required by the department.

(c) To the extent any provision of the pilot program conflicts with an existing statute, the pilot program supersedes the conflicting statute for the duration of the pilot program only.

(3) **Reporting and recommendations.** By July 1, 2030, the director shall provide recommendations to the appropriate committees of the legislature on:

(a) Whether the pilot program or behavioral health programs should be extended or expanded;

(b) Any statutory or policy changes needed to support broader implementation; and

(c) Potential incentives or programmatic changes that provide measurable benefits to workers and employers.

(4) This section expires December 31, 2030.

NEW SECTION. **Sec. 6.** The department of labor and industries may adopt rules necessary to implement this act.

NEW SECTION. **Sec. 7.** Except for section 3 of this act, this act takes effect July 1, 2026.

NEW SECTION. **Sec. 8.** Section 2 of this act expires June 30, 2027.

NEW SECTION. **Sec. 9.** Section 3 of this act takes effect June 30, 2027.

Passed by the House February 16, 2026.
Passed by the Senate March 5, 2026.
Approved by the Governor March 25, 2026.
Filed in Office of Secretary of State March 25, 2026.

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