

NO. 50130-9-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

DEPARTMENT OF LABOR & INDUSTRIES OF THE STATE OF
WASHINGTON

Appellant,

v.

RONALD V. MA'AE

Respondent.

BRIEF OF APPELLANT (CORRECTED)
DEPARTMENT OF LABOR AND INDUSTRIES

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I. INTRODUCTION

Workers who have suffered industrial injuries deserve the best care possible, which is why the Legislature created a network of qualified doctors to care for workers. RCW 51.36.010(1). Key to this system is exclusivity: with one exception, only a network provider may care for an injured worker. RCW 51.36.010(2)(b).

The exception is care by a nonnetwork provider in the visit to file an industrial insurance claim: “injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit.” RCW 51.36.010(2)(b). The medical aid rules define an initial visit as one to fill out a report of injury after an industrial injury occurs in order to file an industrial insurance claim. WAC 296-20-01002.

A visit for a reopening exam, which often occurs years after the claim filing visit, is not an initial visit so only a network provider may perform a reopening exam. Under WAC 296-14-400, “medical treatment and documentation for reopening applications must be completed by network providers.”

Contrary to the statute and rule, a nonnetwork provider examined Ronald Ma’ae and completed a reopening application for him. Because the reopening exam occurred years after Ma’ae’s initial visit to fill out a report of injury, only a network provider could provide this care. When

conducting a reopening exam, a doctor treats or cares for a worker by obtaining a history, physically examining the worker, diagnosing the worker's condition, developing a treatment plan, and making a judgment about objective medical findings.

Since a doctor provides care to a worker when completing that exam and since it is not an initial visit, the Department of Labor & Industries properly did not consider the nonnetwork provider's medical opinion. This Court should reverse the superior court and Board of Industrial Insurance Appeals decisions that allowed the nonnetwork provider to care for Ma'ae.

II. ASSIGNMENTS OF ERROR

1. The Department assigns error to Finding of Fact No. 1.2.
2. The Department assigns error to Finding of Fact No. 1.3.
3. The Department assigns error to Finding of Fact No. 1.4.
4. The Department assigns error to Conclusion of Law No. 2.2.
5. The Department assigns error to the judgment entered February 24, 2017, including paragraphs 3.1, 3.2, 3.3.

III. STATEMENT OF THE ISSUES

1. **Initial Visit:** A nonnetwork provider may see a worker in an "initial office or emergency room visit." RCW 51.36.010(2)(b). An initial visit is "[t]he first visit to a health care provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers' compensation." WAC 296-20-01002. A reopening exam occurs

after the Department has allowed and then closed a claim. Is a reopening exam an initial visit?

2. **Care of a Worker:** RCW 51.36.010(1) and (2)(b) provide that only network providers may provide care or treatment of a worker, unless an exception applies. To complete a reopening application, a doctor must perform an exam and make medical judgments. Is examining and documenting worsening providing care to a worker so only a network provider may perform these tasks?
3. **Rule Validity:** WAC 296-14-400 provides that “medical treatment and documentation for reopening applications must be completed by network providers.” Does this rule implement RCW 51.36.010’s network exclusivity requirement so it is a legislative rule that the Board and courts must follow?
4. **Medical Substantiation:** WAC 296-14-400 requires a worker to file “medical substantiation of worsening” of a condition to seek reopening of a claim. Ma’ae provided only information from Dr. Johnson, who is not a network provider as required by RCW 51.36.010 and WAC 296-14-400. Was the Department correct to reject this information as insufficient medical documentation?

IV. STATEMENT OF THE CASE

A. To Improve the Quality of Care for Injured Workers, the Legislature Created an Exclusive Network of Providers to Care for Injured Workers

In 2011, the Legislature established minimum qualifications and standards of care for doctors treating the thousands of workers injured each year. Laws of 2011, ch. 6, § 1. Before 2011, medical providers needed only a valid clinical license and completion of a short application to treat injured workers. The Legislature recognized this system led to some providers failing to follow occupational health best practices, which

caused longer periods of disability, reductions in family incomes, and increases in insurance costs. Laws of 2011, ch. 6, § 1. In 2011, the Legislature created a new system designed to provide high quality care to injured workers: the medical provider network. Laws of 2011, ch. 6, § 1; RCW 51.36.010(1).

Over 25,000 providers are in the network, and they work in private clinics, emergency rooms, and hospitals across the state.¹ Workers can locate a network provider by using the Department’s website.²

The provider network ensures that workers receive treatment only from providers who provide high quality medical care and who follow current occupational health best practices. Laws of 2011, ch. 6, § 1; RCW 51.36.010(1), (2)(b). To achieve this purpose, the Legislature mandated the Department accept only providers in the network who meet minimum standards and who follow the Department’s “evidence-based coverage decisions and treatment guidelines.” Laws of 2011, ch. 6, § 1; RCW 51.36.010(1).

¹ *Medical Provider Network (SSB 5801) Update* (Jan. 26, 2017) <http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/PNAG/ACHIEV012617/KarenMPNUpdate.pdf>. The Department does not offer this as an evidentiary fact but as publicly available background for the Court.

² Washington State Department of Labor and Industries, *Find a Doctor*, www.findadoctor.lni.wa.gov.

When creating the network, the Legislature imposed mandatory requirements and left the details to the Department's discretion. Laws of 2011, ch. 6, § 1; RCW 51.36.010(1), (2)(c), (10). The Legislature granted the Department broad authority to adopt policies for the "development, credentialing, accreditation, and continued oversight of a network of health care providers approved to treat injured workers." Laws of 2011, ch. 6, § 1; RCW 51.36.010(2)(c). The Legislature gave the Department broad authority to adopt rules implementing RCW 51.36.010. Laws of 2011, ch. 6, § 1; RCW 51.36.010(10); *see also* RCW 51.04.030 (rulemaking authority regarding treatment).

The Legislature prohibited nonnetwork providers from caring for injured workers, with only one exception. RCW 51.36.010(1), (2)(b). The exception is limited to "[o]nce 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" following an industrial injury. RCW 51.36.010(2)(b). To implement this requirement, the Department amended WAC 296-14-400 to stress that nonnetwork providers may not care for workers in examining and documenting worsening for a reopening application:

For services or provider types where the department has established a provider network, beginning January 1, 2013,

medical treatment and documentation for reopening applications must be completed by network providers.

The Department adopted WAC 296-14-400 on April 6, 2012.

Wash. St. Reg. 12-06-066.

At the same time that it amended WAC 296-14-400, the Department also amended WAC 296-20-015(2) to provide:

(a) A nonnetwork provider is not authorized to treat and will not be reimbursed by the department or self-insurer for services other than the initial office or emergency room visit. The following services are considered part of the initial office or emergency room visit:

(i) Services that are bundled with those performed during the initial visit where no additional payment is due (as defined in WAC 296-20-01002); and

(ii) In the case of an injured worker directly hospitalized from an initial emergency room visit, all services related to the industrial injury or illness provided through the hospital discharge.

Wash. St. Reg. 12-06-066.

WAC 296-20-01002 defines an initial visit as:

[t]he first visit to a healthcare provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers' compensation.

B. To Support Reopening of a Claim, a Doctor Takes a Medical History, Physically Examines the Worker, and Renders a Medical Opinion Whether the Worker's Condition Has Objectively Worsened

This section provides an overview of the claim process, starting with allowing the claim and culminating with reopening the claim.

Workers may file industrial insurance claims for industrial injuries or occupational diseases. RCW 51.28.020; RCW 51.08.100, .140. To receive benefits, a worker must prove that he or she acted in the course of employment and suffered either a traumatic injury event or an occupational disease that arose naturally and proximately out of employment. RCW 51.32.010, .180; RCW 51.08.100, .140.

To file a claim, the worker must file a report of injury or occupational disease as an application for benefits. RCW 51.28.020. A nonnetwork provider may fill out the application. RCW 51.36.010(2)(b).

RCW 51.36.010(2)(b) allows a nonnetwork provider to care for a worker in an “initial office or emergency room visit.” The Department’s rules provide that an initial visit is the visit where the doctor and worker complete the report of industrial injury or occupational disease. WAC 296-20-01002. WAC 296-20-015 includes in the initial visit services bundled with the initial visit and all services after a hospitalization that results from the initial emergency room visit.

Once the Department allows a claim, the Department pays for “proper and necessary” treatment. RCW 51.36.010(2)(a), .080; WAC 296-20-015. While the claim is open, workers may receive care only from network providers. RCW 51.36.010(2)(b); WAC 296-20-015(2)(a). The Industrial Insurance Act directs an active role of physicians to provide

medical documentation about a claim. *See Shafer v. Dep't of Labor & Indus.*, 166 Wn.2d 710, 720, 213 P.3d 591 (2009).³

Once the worker's medical provider concludes treatment, the Department evaluates if the worker has a permanent disability as found by a medical provider. RCW 51.32.055, .060, .080; WAC 296-20-200; *Franks v. Dep't of Labor & Indus.*, 35 Wn.2d 763, 766-67, 215 P.2d 416 (1950); *Cayce v. Dep't of Labor & Indus.*, 2 Wn. App. 315, 316, 467 P.2d 879 (1970). The Department then closes the claim.

If the worker's condition worsens after claim closure, he or she may apply to reopen the claim. A reopened claim is part of the original claim, with the same claim number and reference to the same injury or occupational disease that caused the allowed claim. CP 153, 170.

To reopen the existing claim, a doctor assists the claimant with the reopening application. RCW 51.32.160; WAC 296-14-400; WAC 296-20-06101.⁴ The Department's rule provides that only network providers may examine the worker and complete the reopening application. WAC 296-14-400; *see* RCW 51.36.010(2)(b). The Department does not accept

³ *E.g.*, RCW 51.32.090(4)(b) (physician certifies when a worker can perform available work); RCW 51.32.095(6) (attending physician verifies need for job modifications); RCW 51.32.099(2)(c) (provider documents physical restrictions to determine need for vocational services); WAC 296-20-01002 (provider certifies that a worker is unable to work in definition of temporary partial disability); WAC 296-20-06101 (provider must file medical reports).

⁴ The complete text of WAC 296-14-400, WAC 296-20-015; RCW 51.36.010, and RCW 51.32.160 appears in the Appendix.

reopening applications from nonnetwork providers. WAC 296-14-400; RCW 51.36.010(2)(b). WAC 296-14-400 requires a worker to file “medical substantiation of worsening” to support reopening.

The Department reimburses any network provider for the reopening application examination, documentation, and diagnostic tests regardless of whether the Department reopens the claim. WAC 296-20-097. But under the Department’s rules, the Department reimburses only network providers—not nonnetwork providers—for reopening examinations, documentation, or diagnostic tests. RCW 51.36.010; WAC 296-14-400; WAC 296-20-015.⁵ If a worker goes to a nonnetwork provider for an examination to complete a reopening application, not only does the Department not accept the application, but the Department also does not pay for the visit. *See* RCW 51.36.010; WAC 296-14-400; WAC 296-20-015.

To reopen a claim, a worker must provide medical evidence that (1) his or her condition objectively worsened after the original injury, (2) the original injury caused the worsening, (3) his or her condition objectively worsened between the time the claim closed and time sought to reopen the claim, and (4) the worsening warranted more treatment or a

⁵ The Department’s position is that a nonnetwork provider who treats an injured worker can neither bill the injured worker for that treatment nor receive payment from the Department. *See* WAC 296-20-020, -022.

disability award beyond what the Department provided. *Phillips v. Dep't of Labor & Indus.*, 49 Wn.2d 195, 197, 298 P.2d 1117 (1956); *Cooper v. Dep't of Labor & Indus.*, 188 Wn. App. 641, 648, 352 P.3d 189 (2015); *see also Tollycraft Yachts Corp. v. McCoy*, 122 Wn.2d 426, 432, 858 P.2d 503 (1993) (in a reopening application “the burden is on the injured worker to produce some objective medical evidence, verified by a physician, that his or her injury has worsened *since* the initial closure of the claim.”).⁶

When advising whether the worker’s condition has worsened and then completing a reopening application, a doctor obtains a detailed history from the patient to understand the previous injury, determines if the worker sustained any new injuries or illnesses, and examines the worker to assess whether medical findings support objective worsening of the worker’s condition since claim closure. CP 158.

If the Department receives a reopening application that provides “medical substantiation of worsening,” the Department will reopen the claim and pay benefits if the application shows “aggravation . . . of disability [has taken] place” and shows by “sufficient medical verification [that there is] disability related to the accepted condition(s).” RCW

⁶ The objective findings requirement is not in place in cases involving psychiatric conditions. *Tollycraft*, 122 Wn.2d 432, n.3.

51.32.160(1)(a); WAC 296-14-400 (internal quotation marks omitted).

The Department will pay for treatment received 60 days before the doctor filed the reopening application, provided a network provider treats the worker. RCW 51.36.010, .080; WAC 296-20-015, -020, -097.

C. The Department Applied RCW 51.36.010 and WAC 296-14-400 to Reject a Nonnetwork Provider's Medical Opinion but the Board and Superior Court Reversed

The Department allowed Ma'ae's claim for industrial insurance benefits after he sustained a 2007 industrial injury. CP 153. The Department closed the claim in 2009. CP 154-55. In March 2014, H. Richard Johnson, MD, examined Ma'ae to request that the Department reopen Ma'ae's claim. CP 158. Dr. Johnson is not a member of the Department's provider network. CP 161.

At the examination, Dr. Johnson took a complete history, reviewed medical records, and examined Ma'ae. CP 211. He diagnosed Ma'ae as having several conditions and recommended treatment modalities. CP 158, 211-12. He opined that Ma'ae's conditions had objectively worsened since the Department had last closed the claim. CP 213. He later completed a reopening application on behalf of Ma'ae. CP 158.

The Department rejected the reopening application because Dr. Johnson was not a network provider and Ma'ae had not provided the required medical documentation. CP 170-71. Ma'ae appealed to the

Board, which reversed the Department. CP 25-26, 124. Over a dissent, the majority said that WAC 296-14-400 was not a legislative rule based on the conclusion that a provider does not treat a worker when examining and documenting worsening to file a reopening application. CP 23-26. The superior court adopted the Board's findings, and affirmed the Board. CP 324-25. The Department appeals. CP 326.

V. STANDARD OF REVIEW

Original jurisdiction in workers' compensation matters lies solely with the Department, as the executive agency charged with administering the Industrial Insurance Act. *Dep't of Labor & Indus. v. Slauch*, 177 Wn. App. 439, 452, 312 P.3d 676 (2013); *Lenk v. Dep't of Labor & Indus.*, 3 Wn. App. 977, 982, 985, 478 P.2d 761 (1970); RCW 51.04.010, .020. The Board and courts have appellate jurisdiction in workers' compensation matters, giving deference to the Department's expertise. *Kingery v. Dep't of Labor & Indus.*, 132 Wn.2d 162, 171, 937 P.2d 565 (1997); *Jones v. City of Olympia*, 171 Wn. App. 614, 621, 287 P.3d 687 (2012).

Although the Department's interpretation of the Industrial Insurance Act does not bind the court, the court defers to an agency's interpretation of a law when that agency has specialized expertise in dealing with such issues. RCW 51.04.020; *PT Air Watchers v. Dep't of Ecology*, 179 Wn.2d 919, 925, 319 P.3d 23 (2014). The court defers to the

Department when the Department and the Board conflict in their interpretations “because the department is the executive agency that is charged with administering the statute.” *Slaugh*, 177 Wn. App. at 452.

This case involves statutory interpretation, which the court reviews de novo. *See Birrueta v. Dep’t of Labor & Indus.*, 186 Wn.2d 537, 542-43, 379 P.3d 120 (2016). This Court reviews the superior court’s decision, not the Board’s. *See Rogers v. Dep’t of Labor & Indus.*, 151 Wn. App. 174, 179-81, 210 P.3d 355 (2009).

VI. ARGUMENT

When it created the network, the Legislature wanted the best care possible for injured workers. The network’s foundational principle requires a qualified provider to make medical judgments about a worker:

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.*

RCW 51.36.010(1) (emphasis added). The Legislature implemented this principle with an exclusivity mandate: “an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit.” RCW 51.36.010(2)(b); *see also* RCW 51.36.010(1).

The exclusivity mandate applies when: (1) the visit is not an initial visit and (2) the visit is care under the statute. The Department shows both here. First, the medical aid rules define an initial visit as a visit to complete a report of injury to file a claim. WAC 296-20-01002. This means it does not include reopening exams, which occur after the Department opens and then closes a claim. *See* WAC 296-20-01002.

Second, an evaluation and completion of documentation to reopen a claim is care or treatment of a worker. A doctor provides care by examining an injured worker and opining about objective findings; care encompasses more than formulating treatment plans. Any other view undermines the exclusivity mandate and high quality care.

To implement the exclusivity mandate, the Department amended WAC 296-14-400. The Legislature granted the Department authority to regulate worker care, so the rule is a legislative rule that the Board and courts must follow. The trial court erred in not doing so.

Because no network provider provided medical substantiation of worsening to show reopening, the application was properly denied.

A. Allowing Only Network Providers to Perform Reopening Exams Provides the Best Care for Workers

The Legislature found that using doctors who provide high quality medical care and follow occupational health best practices produces the

best results for workers: this use prevents disability, reduces lost income for workers and their families, and lowers labor and insurance costs for employers. RCW 51.36.010(1). To produce these results, the Legislature created a network that has the exclusive mandate to care for injured workers. As part of the exclusivity, the Legislature limited workers to receive treatment from only network providers after the initial report of injury has been filed. This limitation was a legislative choice to improve medical care.

Implementing this choice in the reopening context, the Department amended WAC 296-14-400 to ensure that only network providers provide “medical treatment and documentation for reopening applications.” WAC 296-14-400. Limiting reopening exams and documentation to network providers serves workers’ interests by:

- Providing high quality medical care: Network providers are more knowledgeable about the medical evidence (such as objective findings) necessary to reopen a claim, and they must adhere to occupational health best practices. RCW 51.36.010(1).
- Avoiding ill-informed opinions. Nonnetwork providers who do not meet network standards may not understand occupational health best practices.
- Avoiding needless examinations of the worker: The Department permits and pays for examinations performed only by a network provider. WAC 296-20-015; WAC 296-14-400.
- Avoiding needless litigation costs: Workers may rely on faulty reopening applications by nonnetwork providers to appeal

Department denials and incur the costs of an unsuccessful appeal. RCW 51.52.060; RCW 51.52.120.

By providing for high quality opinions and avoiding needless expense and litigation, the Legislature's choice to use network providers best serves workers' interests.

B. A Reopening Exam Is Not an Initial Visit so Only Network Providers May Perform One

Consistent with RCW 51.36.010(1) and (2)(b), WAC 296-14-400 requires network providers to provide exams and documentation regarding reopening applications. Strictly speaking, the Department could have elected not to adopt a reopening rule because, under RCW 51.36.010, nonnetwork providers may not examine a worker and complete a reopening application.

The court must carry out the Legislature's intent in the statute's plain language. *State v. Larson*, 184 Wn.2d 843, 848, 365 P.3d 740 (2015). RCW 51.36.010(1) provides that "the department shall establish minimum standards for providers who treat workers" The default is for providers to be members of the network to provide services to workers. And RCW 51.36.010(2)(b) directs that nonnetwork providers may care for workers only in an initial visit: "an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit."

1. The plain meaning of initial visit is a visit to fill out a report of injury at the claim's beginning

Ma'ae did not receive care in an initial visit when Dr. Johnson examined him. Under WAC 296-20-01002, an initial visit occurs when the worker first files the report of injury or occupational disease to request workers' compensation benefits:

The first visit to a health care provider during which the Report of Industrial Injury or Occupational Disease is completed and the worker files a claim for workers' compensation.

WAC 296-20-01002; Wash. St. Reg. 08-02-021, at 7 (adopting definition in 2008).

Agency rules have the force and effect of law if the agency adopts them by a legislative grant of authority, as here. *See Mills v. W. Wash. Univ.*, 170 Wn.2d 903, 910, 246 P.3d 1254 (2011); *Wingert v. Yellow Freight Sys., Inc.*, 146 Wn.2d 841, 848, 50 P.3d 256 (2002); RCW 51.36.010(10); RCW 51.04.020(1), .030. The court gives great weight to an agency's definition of an undefined statutory term where the agency must administer those statutory provisions. *Thorpe v. Inslee*, 188 Wn.2d 282, 290, 393 P.3d 1231 (2017) (citing *Phillips v. City of Seattle*, 111 Wn.2d 903, 908, 766 P.2d 1099 (1989)). Here, the Court should follow the rule because the Department adopted it under a legislative grant of authority. *See Mills*, 170 Wn.2d at 910; *Wingert*, 146 Wn.2d at 848.

Three statutes provide the legislative grant of authority: RCW 51.04.020(1), RCW 51.04.030(1), and RCW 51.36.010(10).

RCW 51.04.020(1) authorizes the Department to adopt rules to administer the Industrial Insurance Act. This allows it to have rules that facilitate the filing of claims and reopening applications.

RCW 51.04.030(1) authorizes the Department to adopt the definition of initial visit as part of the medical aid rules. The medical aid rules in WAC 296-20, including the initial visit definition, are an important component to the comprehensive industrial insurance system and the Legislature does not act on a blank slate when it amends an act that has existed since 1911. Laws of 1911, ch. 74, § 1.⁷ Nor does the Department when it implements the Act as it has done for decades. *See* RCW 51.04.020(1).

The Legislature relied on the initial visit definition when it created the network. The courts presume that the Legislature knows of regulations, and here the Legislature acquiesced to WAC 296-20-01002's definition by not changing this language when amending RCW 51.36.010. *Cf. Manor v. Nestle Food Co.*, 131 Wn.2d 439, 445 n.2, 932 P.2d 628, *amended*, 945 P.2d 1119 (1997) (court acquiesces to regulatory language when it does

⁷ The Legislature provided "proper and necessary" treatment to workers in 1917. Laws of 1917, ch. 28, § 5.

not change statute after rule's adoption), *disapproved on different grounds* by *Wash. Indep. Tel. Ass'n v. Utils. & Transp. Comm'n*, 148 Wn.2d 887, 64 P.3d 606 (2003).

RCW 51.36.010(10) allowed the Department to implement the provider network. And in WAC 296-20-015(2)(a)(i), the Department used the definition of "initial visit" in WAC 296-20-01002 to define what constitutes an initial visit in the provider network context. RCW 51.36.010(10) allowed the Department to cross-reference this rule in WAC 296-20-015 when it provided rulemaking authority to implement the provider network.

While there is a slight difference in language between the statute and the initial visit rule, both describe the same thing. RCW 51.36.010(2)(b) provides for "initial office or emergency room visit" and WAC 296-20-01002 provides for "initial visit." "Initial visit" is a shorthand term for "initial office or emergency room visit" and the meaning is the same, as shown by the use of the same terms "initial" and "visit." This was made express in WAC 296-20-015(2)(a)(i) where the Department cross-referenced WAC 296-20-01002 to detail when a nonnetwork provider could treat workers:

The following services are considered part of the initial office or emergency room visit:

(i) Services that are bundled with those performed during the initial visit where no additional payment is due (as defined in WAC 296-20-01002)

WAC 296-20-015(2)(a).

Applying the definition of initial visit to RCW 51.36.010(2)(b) implements the Legislature’s intent to require that network providers treat injured workers. *See* RCW 51.36.010(1) (“the department shall establish minimum standards for providers who treat workers”).

Here, the Court need look only at WAC 296-20-01002; nonetheless, this definition echoes the ordinary meaning in the dictionary. *See State v. Watson*, 146 Wn.2d 947, 956, 51 P.3d 66 (2002) (a court may use a dictionary to ascertain a term’s ordinary meaning). “Initial” means “of or related to the beginning.” *Webster’s Third New Int’l Dictionary* 1163 (2002). Using a word meaning “beginning” shows that the Legislature limited care from a nonnetwork provider to the first time an injured worker seeks treatment for the industrial injury or occupational disease—the beginning of the claim.

Reopening a claim is not the claim’s beginning. The Department has allowed the initial claim, provided treatment and other benefits, and then closed the claim. Reopening is a continuation of the original claim; it involves the same injury or occupational disease and the same claim number. The standards to reopen a claim differ from the initial claim

allowance. For example, a worker need not show the elements of an industrial injury, such as proving the worker was acting in the course of employment or suffered a traumatic injury event. *See* RCW 51.32.010, .160; RCW 51.08.100. The worker proved these elements when the Department originally allowed the claim. A visit to reopen a claim is not a beginning or initial visit, as it occurs after the Department allowed the claim and provided benefits.

By not excepting reopening exam visits, the Legislature precluded nonnetwork providers from acting in the reopening context. *See In re Det. of Williams*, 147 Wn.2d 476, 491, 55 P.3d 597 (2002) (including one thing means exclusion of another). The Legislature knew how to create an exception for initial visits, but it chose not to create an exception for reopening applications.

2. The meaning of initial visit is not ambiguous but if it were, legislative intent is best served by interpreting the term to further the exclusivity mandate

A reopening exam is not an initial visit, contrary to Ma'ae's arguments. CP 295. In Ma'ae's view, an initial visit is the "first time an injured worker sees a doctor to file an application to access the workers' compensation system, whether it be an initial injury application, or a reopening application." CP 295. This interpretation contradicts the statute's ordinary meaning. The statute expressly excepts only initial

office or emergency room visits from network requirements, so it does not except reopening visits.

Since there is only one reasonable interpretation, the Court must give effect to the statute's plain language. *See Larson*, 184 Wn.2d at 848. A statute is ambiguous only if it is susceptible to two or more reasonable interpretations. *Columbia Physical Therapy, Inc. v. Benton Franklin Orthopedic Assocs., P.L.L.C.*, 168 Wn.2d 421, 433, 228 P.3d 1260 (2010). A statute is not ambiguous just because two or more interpretations are conceivable. *State v. Velasquez*, 176 Wn.2d 333, 336, 292 P.3d 92 (2013).

Even if there were two reasonable interpretations of the statute so that the language might be ambiguous, the court should reject Ma'ae's interpretation for three reasons. First, the Legislature authorized the Department to implement the Act by rulemaking, so the Department can resolve any ambiguities. RCW 51.36.010(10); RCW 51.04.020(1), .030(1); *see Hama Hama Co. v. Shorelines Hearings Bd.*, 85 Wn.2d 441, 448, 536 P.2d 157 (1975) (when a statute is ambiguous, agency has the authority to "fill in the gaps" through rulemaking). WAC 296-20-015(2)(a)(i) adopts the meaning of initial visit—that of the visit to fill out the initial application of benefits—in WAC 296-20-01002. And WAC 296-14-400 provides that initial visits do not include reopening examinations because only network providers may perform them. If the

Court considers RCW 51.36.010's reference to "initial office or emergency room visit" ambiguous about what such a visit means, WAC 296-20-015(2)(a)(i), WAC 296-20-01002, and WAC 296-14-400 resolve that an initial visit does not include a visit for a reopening examination.

Second, the Department rules reasonably follow the statute's language and mandate. If rules reasonably follow the statute and statutory scheme, the court upholds the rules. *Green River Cmty. Coll., Dist. No. 10 v. Higher Ed. Pers. Bd.*, 95 Wn.2d 108, 112, 622 P.2d 826 (1980). RCW 51.36.010(1) directs that the "department shall establish minimum standards for providers who treat workers," and RCW 51.36.010(2)(b) limits nonnetwork providers to provide care only for an "initial office or emergency room visit." WAC 296-20-015, WAC 296-14-400, and WAC 296-20-01002 reasonably implement these provisions by limiting nonnetwork care of workers to the beginning of the claim and precluding nonnetwork providers from caring for a worker after the Department allows the claim.

Finally, meaningful limits on who may serve as a provider advance the goal to provide high quality care. And an interpretation that promotes the network's exclusivity mandate furthers a liberal interpretation of the

statute.⁸ RCW 51.12.010 provides “This title shall be liberally construed for the purpose of reducing to a minimum the suffering and economic loss arising from injuries and/or death occurring in the course of employment.” For providers, the Legislature has stated how to reduce suffering and economic loss. “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.” RCW 51.36.010(1). To that end, the Legislature created the network. *Id.* An exclusive network furthers this end.

It does not benefit workers such as Ma’ae to allow a nonnetwork provider such as Dr. Johnson to provide a medical opinion because it does not benefit workers to allow doctors who may not meet the minimum standards governing the network to render medical judgments about injured workers.⁹ Workers benefit from having vetted qualified medical providers opine about their medical conditions.

If a nonnetwork doctor incorrectly diagnoses a condition or finds worsening even though there are no objective findings (either because of a

⁸ The Court would apply the liberal construction doctrine only if the Court found the statute ambiguous. *Raum v. City of Bellevue*, 171 Wn. App. 124, 155 n.28, 286 P.3d 695 (2012).

⁹ Nothing prevents Ma’ae from filing a new application for reopening and the Department pays for the reopening exam. WAC 296-20-097.

lack of familiarity with the rules governing reopening applications or because of other reasons) a worker may needlessly pursue the matter, incurring costs. RCW 51.52.060; RCW 51.52.120; WAC 263-12-117(3). The Department might believe an unqualified nonnetwork provider about a treatment plan and authorize unwarranted treatment that contradicts the highest standards of care, which may ultimately harm the worker.¹⁰ The Legislature's solution to these problems is to have only providers that adhere to occupational best practices care for workers. This Court must interpret RCW 51.36.010 to achieve this result for all workers.

C. RCW 51.36.010 Precludes a Nonnetwork Provider from Providing Care by Rendering Medical Judgments About Reopening

Examining a worker and documenting worsening is care or treatment under RCW 51.36.010 because it involves examining a patient, making a diagnosis, and providing other medical judgments. Contrary to the Board's view, a doctor who provides care or treatment formulates not only treatment plans, but also assists patients with medical-legal examinations and documentation to obtain benefits.

¹⁰ The Department accredits network providers as meeting minimum standards and adhering to occupational best practices. Nonnetwork doctors do not have this accreditation, and may in fact be unqualified to be network providers. Of course, they may simply have not applied to the network, and the Department does not imply that all nonnetwork providers are unqualified doctors, only a small percentage of them. Even so, the Legislature determined that seeking treatment from network providers who met minimum standards was the way to achieve better health care results.

1. A doctor cares or treats a worker by assisting the worker with medical documentation

The Legislature decided to improve medical care and to lower costs caused by unqualified medical providers. RCW 51.36.010(1). To accomplish these goals, it limited care or treatment of workers to network providers, assuming the exception does not apply. RCW 51.36.010(1) provides that “the department shall establish minimum standards for providers who treat workers” RCW 51.36.010(2)(b) limits care to network providers: that “an injured worker may receive *care* from a nonnetwork provider only for an initial office or emergency room visit.”

The Board said that examining a worker and documenting worsening is not treatment. CP 24. Even if this were true (it is not), the statute encompasses more than treatment as it deals with the “care” of workers. RCW 51.36.010(2)(b). The relevant definition of care is “provide for or attend to needs or perform necessary personal services (as for a patient or a child).” *Webster’s Third New Int’l Dictionary* 338. Dr. Johnson performed personal services for Ma’ae by interviewing him, reviewing his records, and examining him. He attended to Ma’ae’s needs by listening to him and rendering a medical opinion on his behalf that his condition had worsened.

But even if the Court looks to just “treatment,” examining and documenting worsening is treatment. “Treatment” or “care” encompasses the many tasks that a provider performs under the Industrial Insurance Act, including medical documentation. The Court in *Shafer* stressed “the important role” of attending physicians in navigating the industrial insurance system:

[T]here are numerous . . . statutory and regulatory obligations that an attending physician is required to assume once the worker’s claim is accepted by the Department.

Shafer, 166 Wn.2d at 720; *see also Clark Cty. v. McManus*, 185 Wn.2d 466, 475-76, 372 P.3d 764 (2016) (reaffirming that the Department, Board, and courts give attending physicians special consideration, noting that the “Department applies the special consideration rule in adjudicating claims.”).

Aware of physicians’ fundamental role under the Industrial Insurance Act, the Legislature wanted vetted medical providers to care for workers. RCW 51.36.010(1). In examining physicians’ role in providing services under the Industrial Insurance Act, the Legislature recognized the reality that faces all doctors: treatment or care is more than prescribing

pills; it is helping patients receive insurance and government benefits.¹¹ In RCW 51.36.010(2)(b), the Legislature recognized that the medical-legal tasks fall within the definition of care or treatment. Under the statute, care of a worker includes an initial visit to fill out a report of injury to apply for workers' compensation benefits. RCW 51.36.010(2)(b); WAC 296-20-01002. So the Legislature recognizes that a doctor may provide care through examination and documentation for application purposes. Similarly, examining a worker to document worsening in a reopening application is care or treatment.

The Department has recognized that opining about medical-legal matters such as a reopening examination is care or treatment of a worker. WAC 296-14-400. This goes to the heart of the Department's expertise and this Court should defer to it. The court gives substantial judicial deference to agency views "when an agency determination is based heavily on factual matters, especially factual matters which are complex, technical, and close to the heart of the agency's expertise." *Hillis v. Dep't of Ecology*, 131 Wn.2d 373, 396, 932 P.2d 139 (1997).

¹¹ The medical community recognizes the role of physicians in providing evaluations for benefits purposes. *E.g.*, Oyeboode A. Taiwo, et al., *Impairment and Disability Evaluation: The Role of the Family Physician*, 77 *American Family Physician* 1633, 1689 (2008), <http://www.aafp.org/afp/2008/0615/p1689.pdf>.

Providing treatment or care requires opining on workers' compensation matters. Accepting the Board's view of a doctor's role in medical-legal matters as not providing treatment or care would create an untenable dichotomy: although nonnetwork providers cannot provide treatment, they could provide medical advice on important workers' compensation matters, such as reopening. The Board's view undermines the network's purpose to provide expertise in occupational health matters.

2. A doctor who takes a medical history, physically examines a worker, and renders a medical opinion treats a worker

Contrary to the Board's reasoning, examining a worker to complete a reopening application is not in the "nature of an administrative function." CP 24. *Tollycraft* rejected that the reopening process is a "paper act." 122 Wn.2d at 433 (internal quotation marks omitted). When examining the deadlines for processing reopening applications, the Court held that reopening a claim is not a paper act because it reflects a "substantive decision by the Department that the injured employee has met the criteria of the statute to show aggravation. In other words, the Department has concluded there has been objective worsening of the injured worker's condition." *Id.* Aiding in this process likewise is not a paper act or an administrative function.

To aid in the reopening process, a provider physically examines the worker and performs a comprehensive medical assessment to determine whether the worker's condition has objectively worsened. The provider:

- obtains a detailed history from the patient to understand the previous injury (CP 157),
- determines whether the worker sustained any new injuries or illnesses (CP 157),
- performs a physical exam (CP 157),
- diagnoses the worker's condition (CP 157),
- recommends a treatment plan (CP 157), and
- assesses whether the worker's physical findings show objective worsening of the industrial injury or occupational disease since claim closure (CP 157)

As the Board's dissenting member observed, "How is that different than any other treatment situation?" CP 27.

A doctor assisting a worker in completing a reopening application performs more than a paper act because the doctor intimately examines the worker to determine if worsening occurred. In a reopening application, an "injured worker [must] produce some objective medical evidence, verified by a physician, that his or her injury has worsened since the initial closure of the claim." *Tollycraft*, 122 Wn.2d at 432 (emphasis omitted). To support an opinion about reopening, a doctor delves into the worker's

condition through an examination, an interview, and review of the records, and in so doing provides treatment or care on the worker's behalf.

D. WAC 296-14-400 Is a Legislative Rule that the Board and Courts Must Follow

The Board and superior court erred in not following WAC 296-14-400. Agency rules have the force and effect of law if the agency adopts them under a legislative grant of authority. *Mills*, 170 Wn.2d at 910; *Wingert*, 146 Wn.2d at 848. The Legislature intended for the Department to have broad authority over all aspects of providers acting under the Industrial Insurance Act. RCW 51.36.010. RCW 51.36.010(10) allows the Department to adopt rules to implement the network: “[T]he department may adopt rules related to this section.” Similarly, RCW 51.04.020(1) allows the Department to adopt rules to administer the Industrial Insurance Act and RCW 51.04.030(1) allows rules relating to treatment. The Department adopted WAC 296-14-400 as a significant legislative rule under multiple legislative grants of authority.

The Board declined to follow the rule because it believed that it was not a legislative rule it needed to follow. CP 25. The Board is mistaken: the amended WAC 296-14-400 is a legislative rule.¹²

¹² The superior court entered findings of fact that the Department's rule was interpretive and that RCW 51.36.010 does not prevent a nonnetwork provider from filing an application to reopen a claim. CP 324. These are actually conclusions of law and are incorrect.

RCW 34.05.328(5)(c)(iii) defines a legislative rule:

A “significant legislative rule” is a rule other than a procedural or interpretive rule that (A) adopts substantive provisions of law pursuant to delegated legislative authority, the violation of which subjects a violator of such rule to a penalty or sanction; (B) establishes, alters, or revokes any qualification or standard for the issuance, suspension, or revocation of a license or permit; or (C) adopts a new, or makes significant amendments to, a policy or regulatory program.

WAC 296-14-400 is a legislative rule because the Department adopted it under legislative authority, because the rule creates a significant policy, and because there is a nonpayment sanction on the provider. As noted above, it is consistent with the legislative grant of authority. So the Board and superior court should have followed it.¹³

E. The Department Correctly Rejected the Reopening Application for Failing to Provide Medical Substantiation of Worsening

The Department correctly rejected Ma’ae’s reopening application “because no medical documentation has been provided to the department as required by law.” CP 171. In the accompanying letter, the Department explained that only a network provider could submit a reopening

¹³ In passing, the Board notes that the reopening statute, RCW 51.32.160, does not have the exclusivity requirement. The Legislature did not need to amend individual statutes, such as RCW 51.32.160, to carry out the broader scheme of the provider network once the Legislature defined who might serve as a medical provider in the workers’ compensation system. Definitional terms govern throughout a statutory scheme if the context compels this, as it does here. *See AllianceOne Receivables Mgmt., Inc. v. Lewis*, 180 Wn.2d 389, 396, 325 P.3d 904 (2014).

application. CP 170. Dr. Johnson was not a member of the provider network and it was correct for the Department to deny the claim for lacking medical substantiation. CP 161, 171.

WAC 296-14-400 requires a worker to file “medical substantiation of worsening” of a condition to seek reopening of a claim. In 1949, the Supreme Court affirmed denial of reopening by rejecting a letter that simply asked for reopening based on aggravation. *Donati v. Dep’t of Labor & Indus.*, 35 Wn.2d 151, 153-54, 211 P.2d 503 (1949). The Court said, “in addition to being in writing, such an application must give the department some information as to the reason for the application.” *Id.* at 154.

In 1988, the Department adopted its rule that required medical substantiation. Wash. St. Reg. 88-14-011. The Department had authority to adopt such a rule under RCW 51.04.020(1), which allows the Department to adopt rules to administer the Industrial Insurance Act. The rule follows decades of case law that requires a worker to provide a medical opinion to seek reopening and case law that puts a strict burden on the worker to prove eligibility for benefits. *Phillips*, 49 Wn.2d at 197;¹⁴ *Robinson v. Dep’t of Labor & Indus.*, 181 Wn. App. 415, 427, 326 P.3d

¹⁴ See also *Lewis v. ITT Cont’l Baking Co.*, 93 Wn.2d 1, 3, 603 P.2d 1262 (1979); *Dinnis v. Dep’t of Labor & Indus.*, 67 Wn.2d 654, 656, 409 P.2d 477 (1965).

744 (2014). The Board has recognized that to seek reopening, a worker must file medical substantiation:

[I]f . . . the claim is closed and the document filed contains an individual's name and claim number, medical substantiation of apparent worsening of the industrially related condition, and a proposed course of treatment or other activity regarding that condition, it adequately puts the Department on notice that the claimant is seeking reopening of his claim.

Wallace Hansen, No. 90 1429, 1991 WL 246462, at *4 (Wash. Bd. Ind. Ins. App. June 10, 1991). The Board looked for medical substantiation here. CP 25.

The superior court found that Ma'ae "submitted medical evidence with his application to reopen." CP 324 (FF 1.4). Using the term "evidence" implies that the Department conducts a hearing, which it does not as it is not a judicial or quasi-judicial body. It considers information. So it is incorrect to characterize the information as evidence.

But the real question is whether this information may be considered by the Department however it is characterized. To the extent the finding implies that the Department must consider the information, it contains an error of law and is unsupported by substantial evidence. CP 324. Similarly, Conclusion of Law 2.2 contains an error in law in that it states that Dr. Johnson may submit a reopening application, and judgment

paragraph 3.2 erred in requiring the Department to consider the application. CP 324-35.

This trial court erred because, to follow statutory direction and further the purposes of the provider network, the Department may consider only the opinions of network providers after an initial report of injury has been filed. RCW 51.36.010; WAC 296-14-400; WAC 296-20-015. The Department cannot consider improperly obtained information. *Cf. State v. Ladson*, 138 Wn.2d 343, 359, 979 P.2d 833 (1999) (courts generally suppress improperly obtained evidence). To do so would undermine the Legislature's scheme. *See State v. Williams*, 94 Wn.2d 531, 541, 617 P.2d 1012 (1980). In *Williams*, the Court held that to be admissible evidence, the government must follow statutory wiretap requirements. *Id.* Similarly, the Department must follow statutory requirements about providers.

The Department cannot consider information submitted by nonnetwork providers because RCW 51.36.010 and WAC 296-20-015 limit treatment or care to network providers and WAC 296-14-400 has certain requirements (completion by a network provider) for documentation to reopen a claim. Like in *Williams*, the Department (and the Board and trial court in turn) may not consider information submitted by someone who ignored the law.

The Department (and Board and trial court) cannot endorse statutory noncompliance by using information by the noncompliant provider. *See Ladson*, 138 Wn.2d at 359; *Williams*, 94 Wn.2d at 541. The Department properly did not consider Dr. Johnson’s information, and the superior court erred in ordering the Department to consider it.

The Board gave “duality” of evidence as a reason for not following the Department’s rule, meaning the Department would not consider Dr. Johnson’s opinion but the Board would. CP 24. But the Board may not consider evidence based on information that the Department cannot consider.

The Department has original jurisdiction over workers’ compensation matters. *Lenk*, 3 Wn. App. at 982. The Board has only appellate authority. *Kingery*, 132 Wn.2d at 171. Because the Board has only appellate authority, it cannot expand review beyond what the Department considered. *Kingery*, 132 Wn.2d at 171; *Hanquet v. Dep’t of Labor & Indus.*, 75 Wn. App. 657, 661-62, 879 P.2d 326 (1994). The Board commits reversible error when it decides issues outside the scope of review as dictated by the Department order. *See Double D Hop Ranch v. Sanchez*, 133 Wn.2d 793, 800, 947 P.2d 727 (1997); *Hanquet*, 75 Wn. App. at 662. In *Hanquet*, the Department considered only whether a worker was a sole proprietor to disallow a claim, so the Board could not

consider another ground to disallow the claim. 75 Wn. App. at 662. The Board cannot consider evidence that the Department has not. *Id.*

The court has reaffirmed that if the Department cannot consider a medical issue, the Board cannot. *Joy v. Dep't of Labor & Indus.*, 170 Wn. App. 614, 623, 625, 285 P.3d 187 (2012). In *Joy*, the court held that the Board could not determine that a treatment type was proper and necessary treatment if the Legislature prohibited the Department from doing so. *Id.* So if the Department cannot consider information submitted by a nonnetwork provider, then the nonnetwork provider cannot testify about it at the Board. Any other result would obviate the Department's original jurisdiction.

Even if the Board was correct about what it could consider in testimony, this does not mean that the Board and courts should not follow the statute's and rule's plain language to preclude a nonnetwork provider from examining and documenting worsening in a reopening application filed at the Department.

The trial court awarded attorney fees. CP 325. A party may only receive attorney fees under RCW 51.52.130 if the party prevails. This Court should reverse the judgment, including the attorney fees award, because Ma'ae should not prevail.

VII. CONCLUSION

The Legislature wants only qualified providers rendering care to workers. Dr. Johnson is not qualified, and it was error for the superior court to order the Department to consider his opinion.

This Court should reverse the superior court, holding that WAC 296-14-400 is a legislative rule that the Department, Board, and courts must follow.

RESPECTFULLY SUBMITTED this 7th day of August 2017.

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APPENDIX

WAC 296-14-400 Reopenings for benefits.

The director at any time may, upon the workers' application to reopen for aggravation or worsening of condition, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. This provision will not apply to total permanent disability cases, as provision of medical treatment in those cases is limited by RCW 51.36.010.

The seven-year reopening time limitation shall run from the date the first claim closure becomes final and shall apply to all claims regardless of the date of injury. In order for claim closure to become final on claims where closure occurred on or after July 1, 1981, the closure must include documentation of medical recommendation, advice or examination. Such documentation is not required for closing orders issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall for the purposes of this section only, be deemed issued on July 1, 1985.

The director shall, in the exercise of his or her discretion, reopen a claim provided objective evidence of worsening is present and proximately caused by a previously accepted asbestos-related disease.

In order to support a final closure based on medical recommendation or advice the claim file must contain documented information from a doctor, or nurse consultant (departmental) or nurse practitioner. The doctor or nurse practitioner may be in private practice, acting as a member of a consultation group, employed by a firm, corporation, or state agency.

For the purpose of this section, a "doctor" is defined in WAC 296-20-01002.

When a claim has been closed by the department or self-insurer for sixty days or longer, the worker must file a written application to reopen the claim. An informal written request filed without accompanying medical substantiation of worsening of the condition will constitute a request to reopen, but the time for taking action on the request shall not commence until a formal application is filed with the department or self-insurer as the case may be.

A formal application occurs when the worker and doctor complete and file the application for reopening provided by the department. Upon receipt of

an informal request without accompanying medical substantiation of worsening of the worker's condition, the department or self-insurer shall promptly provide the necessary application to the worker for completion. For services or provider types where the department has established a provider network, beginning January 1, 2013, medical treatment and documentation for reopening applications must be completed by network providers.

If, within seven years from the date the first closing order became final, a formal application to reopen is filed which shows by "sufficient medical verification of such disability related to the accepted condition(s)" that benefits are payable, the department, or the self-insurer, pursuant to RCW 51.32.210 and 51.32.190, respectively shall mail the first payment within fourteen days of receiving the formal application to reopen. If the application does not contain sufficient medical verification of disability, the fourteen-day period will begin upon receipt of such verification. If the application to reopen is granted, compensation will be paid pursuant to RCW 51.28.040. If the application to reopen is denied, the worker shall repay such compensation pursuant to RCW 51.32.240.

Applications for reopenings filed on or after July 1, 1988, must be acted upon by the department within ninety days of receipt of the application by the department or the self-insurer. The ninety-day limitation shall not apply if the worker files an appeal or request for reconsideration of the department's denial of the reopening application.

The department may, for good cause, extend the period in which the department must act for an additional sixty days. "Good cause" for such an extension may include, but not be limited to, the following:

- (1) Inability to schedule a necessary medical examination within the ninety-day time period;
- (2) Failure of the worker to appear for a medical examination;
- (3) Lack of clear or convincing evidence to support reopening or denial of the claim without an independent medical examination;
- (4) Examination scheduled timely but cannot be conducted and a report received in sufficient time to render a decision prior to the end of the ninety-day time period.

The department shall make a determination regarding “good cause” in a final order as provided in RCW 51.52.050.

The ninety-day limitation will not apply in instances where the previous closing order has not become final.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. WSR 12-06-066, § 296-14-400, filed 3/6/12, effective 4/6/12. Statutory Authority: 2004 c 65 and 2004 c 163. WSR 04-22-085, § 296-14-400, filed 11/2/04, effective 12/15/04. Statutory Authority: RCW 51.32.190 and 51.32.210. WSR 90-22-054, § 296-14-400, filed 11/5/90, effective 12/6/90. Statutory Authority: Chapters 34.04 [34.05], 51.04, 51.32 and 51.36 RCW. WSR 90-04-007, § 296-14-400, filed 1/26/90, effective 2/26/90. Statutory Authority: Chapters 51.08 and 51.32 RCW. WSR 88-14-011 (Order 88-13), § 296-14-400, filed 6/24/88.]

WAC 296-20-015 Who may treat.

To treat workers under the Industrial Insurance Act, a health care provider must qualify as an approved provider under the department's rules. The department must approve the health care provider before the health care provider is eligible for payment for services.

(1) A provider must:

(a) Apply and be enrolled in the provider network per WAC 296-20-01010; or

(b) If the provider network scope in WAC 296-20-01010 is not applicable, apply and obtain a provider account number per WAC 296-20-12401.

(2) If the provider or service is within the scope of the provider network under WAC 296-20-01010:

(a) A nonnetwork provider is not authorized to treat and will not be reimbursed by the department or self-insurer for services other than the initial office or emergency room visit. The following services are considered part of the initial office or emergency room visit:

(i) Services that are bundled with those performed during the initial visit where no additional payment is due (as defined in WAC 296-20-01002); and

(ii) In the case of an injured worker directly hospitalized from an initial emergency room visit, all services related to the industrial injury or illness provided through the hospital discharge.

(b) A nonnetwork provider must refer injured workers to network providers when additional treatment is needed, and must provide timely copies of medical records to the other provider.

(3) Para-professionals, who are not independently licensed, must practice under the direct supervision of a licensed health care professional whose scope of practice and specialty training includes the service provided by the para-professional. The department may deny direct reimbursement to the para-professional for services rendered, and may instead directly reimburse the licensed and supervising health care professional for

covered services. Payment rules for para-professionals may be determined by department policy.

(4) Procedures and evaluations requiring specialized skills and knowledge will be limited to board certified or board qualified physicians, or osteopathic physicians as specified by the American Medical Association or the American Osteopathic Association.

(5) The department as a trustee of the medical aid fund has a duty to supervise provision of proper and necessary medical care that is delivered promptly, efficiently, and economically. The department can deny, revoke, suspend, limit, or impose conditions on a health care provider's authorization to treat workers under the Industrial Insurance Act. Reasons for denying issuance of a provider number or imposing any of the above restrictions include, but are not limited to the following:

(a) Incompetence or negligence, which results in injury to a worker or which creates an unreasonable risk that a worker may be harmed.

(b) The possession, use, prescription for use, or distribution of controlled substances, legend drugs, or addictive, habituating, or dependency-inducing substances in any way other than for therapeutic purposes.

(c) Any temporary or permanent probation, suspension, revocation, or type of limitation of a practitioner's license to practice by any court, board, or administrative agency.

(d) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the provider's profession. The act need not constitute a crime. If a conviction or finding of such an act is reached by a court or other tribunal pursuant to plea, hearing, or trial, a certified copy of the conviction or finding is conclusive evidence of the violation.

(e) The failure to comply with the department's orders, rules, or policies.

(f) The failure, neglect, or refusal to:

(i) Provide records requested by the department pursuant to a health care services review or an audit.

(ii) Submit complete, adequate, and detailed reports or additional reports requested or required by the department regarding the treatment and condition of a worker.

(g) The submission or collusion in the submission of false or misleading reports or bills to any government agency.

(h) Billing a worker for:

(i) Treatment of an industrial condition for which the department has accepted responsibility; or

(ii) The difference between the amount paid by the department under the maximum allowable fee set forth in these rules and any other charge.

(i) Repeated failure to notify the department immediately and prior to burial in any death, where the cause of the death is not definitely known and possibly related to an industrial injury or occupational disease.

(j) Repeated failure to recognize emotional and social factors impeding recovery of a worker who is being treated under the Industrial Insurance Act.

(k) Repeated unreasonable refusal to comply with the recommendations of board certified or qualified specialists who have examined a worker.

(l) Repeated use of:

(i) Treatment of controversial or experimental nature;

(ii) Contraindicated or hazardous treatment; or

(iii) Treatment past stabilization of the industrial condition or after maximum curative improvement has been obtained.

(m) Declaration of mental incompetency by a court or other tribunal.

(n) Failure to comply with the applicable code of professional conduct or ethics.

(o) Failure to inform the department of any disciplinary action issued by order or formal letter taken against the provider's license to practice.

(p) The finding of any peer group review body of reason to take action against the provider's practice privileges.

(q) Misrepresentation or omission of any material information in the application for authorization to treat workers, chapter 51.04 RCW.

(6) If the department finds reason to take corrective action, the department may also order one or more of the following:

(a) Recoupment of payments made to the provider, including interest, chapter 51.04 RCW;

(b) Denial or reduction of payment;

(c) Assessment of penalties for each action that falls within the scope of subsection (5)(a) through (q) of this section, chapter 51.48 RCW;

(d) Placement of the provider on a prepayment review status requiring the submission of supporting documents prior to payment;

(e) Requirement to satisfactorily complete remedial education courses and/or programs; and

(f) Imposition of other appropriate restrictions or conditions on the provider's privilege to be reimbursed for treating workers under the Industrial Insurance Act.

(7) The department shall forward a copy of any corrective action taken against a provider to the applicable disciplinary authority.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. WSR 12-06-066, § 296-20-015, filed 3/6/12, effective 4/6/12. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. WSR 93-16-072, § 296-20-015, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. WSR 90-04-057, § 296-20-015, filed 2/2/90, effective 3/5/90; WSR 86-20-074 (Order 86-36), § 296-20-015, filed 10/1/86, effective 11/1/86; WSR 86-06-032 (Order 86-19), § 296-20-015, filed 2/28/86, effective 4/1/86. Statutory Authority: RCW 51.04.020(4),

51.04.030, and 51.16.120(3). WSR 81-01-100 (Order 80-29), § 296-20-015, filed 12/23/80, effective 3/1/81; Order 76-34, § 296-20-015, filed 11/24/76; effective 1/1/77; Order 74-4, § 296-20-015, filed 1/30/74; Order 71-6, § 296-20-015, filed 6/1/71; Order 70-12, § 296-20-015, filed 12/1/70, effective 1/1/71; Order 68-7, § 296-20-015, filed 11/27/68, effective 1/1/69.]

RCW 51.36.010 Findings—Minimum standards for providers—Health care provider network—Advisory group—Best practices treatment guidelines—Extent and duration of treatment—Centers for occupational health and education—Rules—Reports.

(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 or licensed advanced registered nurse practitioner 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 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 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 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 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 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.

[2013 c 19 § 48; 2011 c 6 § 1; 2007 c 134 § 1; 2004 c 65 § 11; 1986 c 58 § 6; 1977 ex.s. c 350 § 56; 1975 1st ex.s. c 234 § 1; 1971 ex.s. c 289 § 50; 1965 ex.s. c 166 § 2; 1961 c 23 § 51.36.010. Prior: 1959 c 256 § 2; prior: 1943 c 186 § 2, part; 1923 c 136 § 9, part; 1921 c 182 § 11, part; 1919 c 129 § 2, part; 1917 c 28 § 5, part; Rem. Supp. 1943 § 7714, part.]

NOTES:

Effective date—2011 c 6: “This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2011.” [2011 c 6 § 2.]

Report to legislature—2007 c 134: “By December 1, 2009, the department of labor and industries must report to the senate labor, commerce, research and development committee and the house of representatives commerce and labor committee, or successor committees, on the implementation of this act.” [2007 c 134 § 2.]

Effective date—2007 c 134: “This act takes effect January 1, 2008.” [2007 c 134 § 3.]

Report to legislature—Effective date—Severability—2004 c 65: See notes following RCW 51.04.030.

Effective dates—Severability—1971 ex.s. c 289: See RCW 51.98.060 and 51.98.070.

RCW 51.32.160 Aggravation, diminution, or termination.

(1)(a) If aggravation, diminution, or termination of disability takes place, the director may, upon the application of the beneficiary, made within seven years from the date the first closing order becomes final, or at any time upon his or her own motion, readjust the rate of compensation in accordance with the rules in this section provided for the same, or in a proper case terminate the payment: PROVIDED, That the director may, upon application of the worker made at any time, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. The department shall promptly mail a copy of the application to the employer at the employer's last known address as shown by the records of the department.

(b) "Closing order" as used in this section means an order based on factors which include medical recommendation, advice, or examination.

(c) Applications for benefits where the claim has been closed without medical recommendation, advice, or examination are not subject to the seven year limitation of this section. The preceding sentence shall not apply to any closing order issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall, for the purposes of this section only, be deemed issued on July 1, 1985. The time limitation of this section shall be ten years in claims involving loss of vision or function of the eyes.

(d) If an order denying an application to reopen filed on or after July 1, 1988, is not issued within ninety days of receipt of such application by the self-insured employer or the department, such application shall be deemed granted. However, for good cause, the department may extend the time for making the final determination on the application for an additional sixty days.

(2) If a worker receiving a pension for total disability returns to gainful employment for wages, the director may suspend or terminate the rate of compensation established for the disability without producing medical evidence that shows that a diminution of the disability has occurred.

(3) No act done or ordered to be done by the director, or the department prior to the signing and filing in the matter of a written order for such readjustment shall be grounds for such readjustment.

[1995 c 253 § 2; 1988 c 161 § 11; 1986 c 59 § 4; 1973 1st ex.s. c 192 § 1; 1961 c 23 § 51.32.160. Prior: 1957 c 70 § 38; prior: 1951 c 115 § 5; 1949 c 219 § 1, part; 1947 c 246 § 1, part; 1929 c 132 § 2, part; 1927 c 310 § 4, part; 1923 c 136 § 2, part; 1919 c 131 § 4, part; 1917 c 28 § 1, part; 1913 c 148 § 1, part; 1911 c 74 § 5, part; Rem. Supp. 1949 § 7679, part.]

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