Legal Update

Washington

Washington Amends Workers' Compensation Laws

On March 24, 2026, the Washington Legislature enacted Senate Bill 5847 (SB5847), which changes how medical treatment is accessed, managed and regulated for employees. For employers, this reduces control over medical direction, imposes tighter administrative timelines, and heightens compliance obligations.

Importantly, the majority of the changes will go into effect by Jan. 1, 2028.

Background

Washington's workers' compensation system has relied on a structured provider network and employer involvement in early claim management. Concerns about delays in treatment, inconsistent medical outcomes and barriers to care prompted legislative changes aimed at:

- Ensuring worker choice and protection from employer influence;
- Expanding access to qualified medical providers and long-term care;
- Improving the timeliness of treatment and claim handling;
- Increasing accountability for provider quality; and
- Reducing administrative burden in utilization review.

SB5847 modifies key provisions in the Industrial Insurance Act, RCW Title 51 and introduces a phased transition to a more worker-centered system.

New Legislation Changes

The following changes occurred with SB5847, which applies retroactively to all claims regardless of the date of injury or manifestation, making these new requirements immediately relevant to both existing and future claims.

Strict Prohibition on Employer-directed Care (Effective Jan. 1, 2028)

SB5847 establishes a clear prohibition on employer influence over medical provider selection and imposes an affirmative obligation on employers at the time of injury. Upon notice of an injury, employers must inform workers that they have the right to seek initial or emergency treatment from a provider of their choice and the right to select a provider within the medical provider network for ongoing care. Employers are prohibited from directing, requiring or coercing a worker to seek treatment from a specific provider or clinic, whether through explicit instruction or more subtle forms of influence.

Prohibited conduct includes:

Important Dates

March 24, 2026
Washington enacted SB5847.

June 11, 2026
SB5847 goes into effect.

June 30, 2027
Medical treatment and provider transitional rules expire.

Jan. 1, 2028
The final, permanent framework becomes effective.

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- Requiring treatment at a specific clinic or provider;
- Steering workers through "preferred provider" programs in a way that implies obligation; or
- Applying pressure, incentives, threats or retaliation related to provider choice.

The law does not prohibit employers from offering on-site medical care, provided the worker retains the right to choose whether to use it. The Washington State Department of Labor & Industries (L&I) will investigate allegations of coercion.

Violations may result in penalties of $250 to $2,500 per occurrence for employers insured through the state, payable to the supplemental pension fund. Additionally, when L&I finds a pattern of violation conduct by an employer insured through the state fund, L&I may prohibit the employer from current or future participation in a retrospective rating program.

Modified Provider Network Rules (Effective Jan. 1, 2028)

SB5847 maintains the structure of the medical provider network but modifies its operational practices. Workers retain the right to choose any provider for initial or emergency treatment. After the initial visit, care is generally limited to providers within the approved network; however, if a worker cannot find a network provider within 25 miles of the worker's home who is willing to treat them, an exception applies.

In that situation, the worker may notify L&I or self-insured employer. Within 10 calendar days of receiving notice, L&I or the self-insured employer must provide the worker with a declaration to certify that no provider is available. After the signed declaration is returned, L&I or the self-insured employer has an additional 10 calendar days to assist the worker in locating a network provider or a provider willing to join the network to treat the worker. If no provider is identified within that time frame, the worker may seek treatment from a nonnetwork provider within 25 miles of the worker's home, provided the provider agrees to the department's fee schedule and requirements. Once these conditions are met, the worker may begin treatment immediately with a nonnetwork provider, and L&I or the self-insured employer is required to cover the treatment in accordance with applicable rules.

This framework is phased in, with the final and permanent structure taking effect on Jan. 1, 2028.

Mandatory Utilization Review (Effective Jan. 1, 2028)

SB5847 introduces strict timelines for utilization review, significantly reducing flexibility in treatment authorization and standardizing processes across state fund and self-insured claims. L&I is required to work with self-insurers and its utilization review provider to ensure consistent, cost-effective care and reduce administrative burden.

Once all necessary information has been received by the utilization review provider, a determination must be completed and recommendations submitted to L&I within 10 business days. If this deadline is not met, the requested treatment is automatically authorized. If there is a dispute as to whether the authorized treatment is related to the worker's injury or occupational disease, L&I must issue a formal determination within 30 days of the utilization review deadline.

These provisions increase administrative pressure on claims handling and significantly limit the ability to delay or contest treatment decisions. They will be implemented during the transition period and become a core part of the system by 2028.

Continued Treatment After Permanent Partial Disability Award (Effective Jan. 1, 2028)

SB5847 modifies the rules governing when medical treatment can continue after a worker reaches key claim milestones, such as a permanent partial disability (PPD) award or permanent total disability (PTD) status. In general, treatment is still expected to end at the time of a lump-sum payment, an initial PPD award payment, a settlement or a placement on the pension roll. However, the bill clarifies and, in some cases, expands the circumstances under which continued treatment may be authorized.

If L&I denies an application to reopen a claim, it may still authorize continued medical and surgical treatment for previously accepted conditions on the same order. This treatment must be necessary for the worker's condition and provide for the administration of medical and therapeutic measures, including payment for prescription medications, which requires a

formal request for approval within 120 days of receiving the treatment, along with written authorization from the supervisor of industrial insurance. Similar requirements apply in PTD cases, where continued treatment may be approved following claim closure or pension placement, subject to the same 120-day request and approval process.

The bill also removes more restrictive language for PTD cases that previously limited continued treatment to specific purposes (such as life preservation or pain management), giving L&I broader discretion to approve appropriate care.

Nothing in these provisions limits a worker's ability to reopen a claim under RCW 51.32.160, meaning additional benefits or treatment may still be pursued after claim closure if statutory requirements are met.

For employers, this means that post-award medical treatment may continue in more circumstances than before, but only if the required request and approval process is followed. This change increases the importance of monitoring post-closure treatment activity and ensuring that requests for continued care are evaluated within the new statutory framework.

Expanded Long-term Care Obligations (Effective Jan. 1, 2028)

SB5847 establishes a specific requirement for continued medical monitoring when cancer is an accepted condition under a workers' compensation claim. In these cases, L&I or the self-insured employer must continue to cover monitoring at the frequency recommended by the worker's treating oncologist.

This monitoring must include all necessary diagnostic testing and related medical consultations, ensuring that care is driven by the treating provider's clinical judgment rather than administrative limitations. Unlike other conditions where treatment may taper off after key claim milestones, cancer-related claims now carry an explicit obligation for ongoing surveillance.

For employers, this change introduces a potentially longer-term cost component for affected claims, as monitoring may continue indefinitely based on medical need. It also reinforces the importance of coordinating with treating specialists and claims administrators to ensure compliance with oncologist-directed care plans.

These provisions will be phased in and become part of the full system framework by Jan. 1, 2028.

Increased Claim Management Resources (Starting Dec. 1, 2026, and ongoing)

L&I is directed to reduce caseloads to approximately 141 claims per manager, a benchmark intended to improve oversight, responsiveness and claim resolution outcomes, by hiring additional claims managers, to the extent necessary. As staffing increases, L&I must also implement procedures to reduce caseload burdens and conduct more frequent reviews of claims.

SB5847 establishes a long-term framework for maintaining appropriate staffing levels. Beginning July 1, 2031, and every five years thereafter, L&I (or a contracted third party) must evaluate national average caseload standards and adjust staffing accordingly to remain aligned with those benchmarks. Funding for these positions is authorized through existing mechanisms without requiring separate legislative appropriations, ensuring flexibility in implementation.

SB5847 also introduces ongoing accountability measures. Starting Dec. 1, 2026, L&I must provide quarterly reports tracking key performance indicators, including claim costs, duration of disability benefits, overall claims management efficiency and other measures related to the impact of additional claims managers hired under the law.

Furthermore, a comprehensive legislative report is required by June 30, 2029, followed by an independent audit by the Joint Legislative Audit and Review Committee by Dec. 31, 2032, evaluating whether these changes improved timeliness, access to care and claim costs.

For employers, this provision signals a shift toward more active and timely claim management by the state, which may lead to faster claim progression, more frequent claim reviews and potentially improved return-to-work outcomes, while also increasing administrative pace and oversight.

Appropriations (Effective June 11, 2026)

SB5847 removed the need for new appropriations; the law allows the L&I to more quickly implement staffing increases and operational improvements outlined in the bill.

For employers, this means that system changes related to claims handling efficiency can be implemented without delay, and associated costs will be absorbed within the existing workers' compensation funding structure rather than requiring new legislative approval.

Medical Treatment and Provider Transitional Rules (Expires June 30, 2027)

SB5847 includes a transitional version of the medical treatment and provider network rules that is temporary in nature. Specifically, this version of RCW 51.36.010 is set to expire on June 30, 2027. This means that the provisions governing how medical care is delivered, managed and reviewed are part of an interim framework designed to bridge the system to its final structure.

From a practical standpoint, employers must comply fully with these rules while they are in effect, but should also prepare for additional adjustments that will take effect beginning June 30, 2027, and Jan. 1, 2028, when the final framework is implemented.

Temporary Transitional Rules (June 30, 2027-Jan. 1, 2028)

SB5847 includes a short-term transitional phase between June 30, 2027, and Jan. 1, 2028, designed to bridge the current system to the final framework. During this period, the statute governing medical treatment continues to cover the core components of the workers' compensation system, including the provider network, worker access to care, utilization review coordination, provider credentialing and oversight, and general rules for how treatment is provided and paid.

For this limited time frame, the system largely remains consistent with existing practices while aligning terminology and administrative processes with the broader changes introduced in SB5847. Key elements such as network-based care, evidence-based treatment standards, and coordination between L&I and self-insured employers are preserved.

The primary purpose of this transitional period is to ensure continuity and avoid gaps in the law before the final statutory framework takes full effect on Jan. 1, 2028.

Next Steps for Employers

Employers should review SB5847 to ensure compliance, as several key provisions, particularly those related to worker choice and anti-steering, which go into effect June 11, 2026, and apply to existing claims. Policies, procedures and supervisor training should be updated to eliminate any perceived direction of medical care and ensure proper communication of employee rights at the time of injury. Employers should also begin preparing for the 2028 framework by aligning claims processes with stricter timelines, expanded provider access and reduced flexibility in treatment authorization.