Claim Validity

Self-Insurance Claims Adjudication Guidelines

Page

Notice of A Claim

WAC 296-15-320 RCW 51.28.010 RCW 51.28.025

Notice is when a worker notifies their employer by written communication that a work injury occurred or they believe they have an occupationally related illness and are seeking, or intend to seek, compensation benefits. Examples include but are not limited to: medical report provided by a medical professional indicating that they saw a worker and the worker reported the cause of the condition is work related, a completed SIF-2, provider initial report, employer incident report and/or any written communication from the worker that they had an injury and want to apply for worker's compensation benefits. This is one of the reasons why date stamping documents by employers is required per WAC 296-15-350(8).

Note: Failure to receive written notice from a worker does not relieve the employer from their duties of administering a claim. If verbal notice is given, the employer must still take appropriate action, such as providing an SIF-2 to the worker for completion per WAC 296-15-320.

Claim Resolution

RCW 51.14.130, WAC 296-15-420(4)

Self-Insured Employers are required to make a determination on a claim within 60 days from the date the claim is filed by requesting:

- Allowance (except on medical only claims where an allowance order is not required),
- An interlocutory order, or
- Denial of the claim.

If one of the above is not requested from the department within 60 days, the department may intervene and adjudicate the claim. Additionally, a penalty may be assessed for not requesting a timely determination. Further medical information may be obtained, if needed to make a determination.

If time loss or loss of earning power benefits are paid on a claim that was originally medical only, the self-insured employer is required to request a department order, allowing the claim, within 60 days of the initial time loss or loss of earning power payment.

Allowance

WAC 296-15-420(1)

When a claim has been accepted, and compensation has been paid, the self-insurer is required to send the following to the department for an allowance order:

- The SIF-2,

- The Claim Allowance Request form (F207-215-000), and
- The SIF-5A Total Monthly Wage Calculations form (F207-156-000).
- An explanation and the documentation used to determine the date of manifestation for occupational disease claims.

The department will issue an allowance order based on an injury or occupational disease claim.

The department does not issue allowance orders on accepted medical only claims, unless:

- There was an interlocutory order issued on the claim, or
- There was a request for denial and the department determined the claim was allowable.

When Validity Requires Additional Investigation

WAC 296-15-420(2)

If the self-insurer is unable to make a determination within 60 days, and needs additional time to investigate claim validity, a request should be made for an interlocutory order. The following must be sent to the department when requesting an interlocutory order:

- The SIF-2,
- An Interlocutory Request Form,
- A copy of the claim file (excluding bills), and
- A reasonable explanation of why an interlocutory order is needed.

The department will review the claim file and the explanation of why additional time is needed to determine claim validity. If claim validity has been met, or there is not a reasonable explanation for why additional time is needed, the department may issue an allowance order instead of an interlocutory order.

If an interlocutory order is issued, a deadline will be set 90 days from notice of a claim. During this period, the worker is entitled to provisional time-loss/LEP benefits if their provider has certified them unable to work due to the injury or illness. The self-insured should complete their investigation and send their determination to allow or deny the claim to the department as soon as possible.

If additional time is needed to make a determination an extension to the interlocutory period may be requested by letter and must include:

- A **valid reason** (e.g., worker was unable to attend a scheduled IME due to a family emergency and the examination could not be rescheduled within the 90 day initial interlocutory period).

- Documentation of all activity on the claim since the original interlocutory request was made.

Extensions will not be made due to inactivity.

If an extension is granted, a letter will be sent with a new deadline for a determination. If there is no valid reason for an extension, the department will move forward and make a determination on the claim based on the information received. For all claims, only one 30 day interlocutory period extension will be considered, for a maximum 120 day interlocutory period from notice of a claim.

Denials

RCW 51.32.190, WAC 296-15-420(3)

The department issues all orders denying self-insured claims. If the self-insurer determines a claim is not allowable, they must complete a Claim Denial Request form. A complete copy of the claim file must also be sent to the department with the denial request.

The self-insurer must also notify the worker when a request for claim denial is sent to the department. The self-insurer may send a letter to the worker explaining the reason for denial or send the worker a copy of the Claim Denial Request form.

After review of the request for denial, the department will:

- Request additional information if necessary,
- Issue an order denying the claim, or
- Issue an allowance order if they disagree with the denial.

No Application Denials

When a worker provides notice of an injury but fails to provide application for a claim, the employer must still request a denial order for no application. This can be a situation where the worker fails to return a signed SIF-2, and there are no other signed documents in file which can be construed as an application. Written documentation of the worker declining to file a claim could also be the basis for a no application denial reason. A worker emailing or writing their employer that they do not wish to file a workers' compensation claim would meet this criteria.

The Claim Denial Request form should be sent to the department, with the 'No Application' box checked and the worker's date of birth entered in the appropriate box. Documentation supporting the denial reason must also be sent. For a denial based on failure to return the SIF-2, this would be documentation of the employer's initial instructions sent to the worker for filing a

claim, along with any documentation of follow up requests to the worker for return of the SIF-2. A copy of the SIF-2 sent to the worker must be included with your Claim Denial Request form (with all available information filled in).

A no application denial is requested under the claim number assigned by the employer when the SIF-2 was first sent to the worker. Any denial order will be issued under this same claim number. This means that this claim number should not be re-used, even if no signed SIF-2 was ever returned.

No Medical Report Denials

There are times where a worker completes an SIF-2 but never seeks medical treatment or the self-insurer is unable to obtain medical information. The self-insurer should request denial due to no medical information by completing a Claim Denial Request along with documentation that at least one attempt was made to determine if the worker received any treatment. If provider information is present, such as a provider listed on the SIF-2, or in communication with the worker, then the employer must provide documentation that medical records were requested from that provider.

Denying a claim for no medical information allows the worker the opportunity to later seek treatment, if it becomes necessary, and file a new claim within the statutory deadline.

Claim Denial Guidelines

The back of the Claim Denial Request form lists most of the codes that may be used when requesting claim denial. Specialty codes, such as those used for Radiological Hazardous Waste Facility presumption claims, are not included in this list. It may be appropriate to use more than one denial code on a claim.
The following chart provides basic guidance about when to use the codes listed on the back of the form. The chart and examples below provide basic guidelines and are not intended to address all possible claim situations in which a denial code may be used.

Claim Denial Reasons	Use this code when:
There is no proof of a specific injury at a definite time and place in the course of employment.	The worker is unable to point to a specific incident that led to the diagnosed condition.
The worker's condition is not the result of an industrial injury as defined by the Industrial Insurance Laws.	The attending provider states that the worker's condition is not causally related to the incident described by the worker.
The claimant's condition is not the result of exposure alleged.	The medical opinion states that the worker's occupational condition is not related to his or her job duties.

The worker's condition pre-existed the alleged injury and is not related thereto.	There is documented evidence that the worker's condition existed prior to the incident described and was not affected by the incident.
The loss or damage of glasses is not the result of an industrial accident when they are not being worn as an artificial substitute as contemplated by RCW 51.36.020.	The worker's glasses were lost or broken due to an industrial accident, but the glasses were not in use (being worn), and the worker sustained no other injury.

Claim Denial Reasons	**Use this code when:**
The worker was not under the Industrial Insurance Laws at the time of the injury.	The injury occurred after the worker had removed him or herself from coverage by deviating from a work errand, business trip, etc.
At the time of injury the worker was not in the course of employment.	The worker sustained an injury as the result of a specific incident, but it is determined that he or she was not in the course of employment (e.g., the worker left the job site for an unpaid lunch break).
There is no provision in the Industrial Insurance Laws to provide for replacement of broken safety glasses which are not of prescription quality.	The worker's non-prescription safety glasses were broken due to an industrial accident, and the worker sustained no other injury.
The claimant's condition is not an occupational disease as contemplated by section 51.08.140 RCW.	It is determined that the worker has a medical condition, but it is not work-related (e.g., fibromyalgia).
The worker's condition is not an occupational disease as contemplated by section RCW 51.08.140, and is excluded from coverage pursuant to section RCW 51.08.142 and section WAC 296-14-300.	The claim is filed for occupational/mental stress developing over a period of time. ***Exception:*** *PTSD may be an allowable occupational stress condition in certain occupations such as firefighters, EMTs, registered nurses, fire investigators and law enforcement officers (RCW 51.32.185).*
No personal injury was sustained by the claimant.	An incident occurred (trip, slip, etc.), but the worker did not sustain an actual injury.
The injury occurred in a parking area and is not covered under the Industrial Insurance Laws in accordance with section 51.08.013 RCW.	An incident occurred and the worker was injured, but the worker was in a parking area.

That no personal injury was sustained by the claimant nor occupational disease contracted. Inoculation or other immunological treatment to avoid the occurrence of an infectious occupational disease may be paid for at the self-insurer's discretion. This claim is rejected with the understanding that the claimant has the right to file a further claim in the event an occupational disease or infection arises as a result of the work-related exposure.	The worker is exposed to potentially infectious bodily fluids but the skin did not break, so no injury occurred.

Claim Denial Reasons	**Use this code when:**
This claim for occupational disease is denied because no licensed physician's report or medical proof has been filed as required by law. You still have the right to file another claim under RCW 51.28.055 which requires a claim for benefits be filed within two years following the date you had written notice from a physician of the existence of an occupational disease and that a claim for benefits may be filed.	The worker has filed a claim for an occupational disease but has either not seen a medical provider or the self-insurer has not been able to obtain medical documentation.
No licensed physician's report or medical proof has been filed as required by law. You still have the right to file another claim under RCW 51.28.050 which requires a claim for benefits be filed within one year from the date of injury.	The worker has filed a claim for an industrial injury but has either not seen a medical provider or the self-insurer has not been able to obtain medical documentation.
We have determined that this claim is a duplicate of a previously filed accident report.	A prior claim was filed for the same injury or occupational disease.
Claim has been rejected because it is a state fund claim that has been submitted erroneously on a Self-Insurance report of accident form.	The worker completed an SIF-2, but it is determined that the employer was not self-insured on the date of injury or date of manifestation.

The Department is unable to substantiate whether you were a covered worker at the time of your alleged injury.	The worker complete an SIF-2 but the Department is unable to substantiate coverage at the time of the alleged injury.

Example 1:

Jean was injured in the parking lot when she was leaving the building for lunch with a friend. Her lunches are not paid, and the lunch was not work-related.

This claim should be denied with the following code:

At the time of injury the worker was not in the course of employment.

Example 2:

George filed a claim when he fainted in a meeting at work. He did not sustain any injuries as a result of the incident. The emergency room doctor found that George had undiagnosed diabetes and had fainted due to unregulated blood sugar.

This claim should be denied with the following codes:

- That there is no proof of a specific injury at a definite time and place in the course of employment.

- That the claimant's condition is not the result of an industrial injury as defined by the Industrial Insurance Laws.

In this case, it is clear that the worker is not contending an occupational disease, so it is appropriate to use only the codes related to injury validity.

Example 3:

Grace filed a claim when she fainted in a meeting at work, and she hit her head on the table when she fell. The emergency room doctor found that she had a forehead contusion and had fainted due to unregulated blood sugar from her diabetes.

This claim should **not** be denied, and therefore no denial code is indicated. The diabetes would not be work-related, but the claim should be allowed for the forehead contusion because the injury occurred during the course of employment.

Example 4:

Rick has been a warehouse worker for 20 years, lifting 40+ pound boxes on a regular basis. He has started having pain in his lower back over the last few months, but he cannot point to a specific incident that caused it start hurting. He filed a claim for his low back pain, and the MRI

showed two small disc bulges at L3-4 and L4-5. His attending provider stated that the MRI findings were likely not caused or worsened by his work duties, rather are related to aging and degeneration.

This claim should be denied with the following codes:

- There is no proof of a specific injury at a definite time and place in the course of employment.
- The worker's condition is not the result of an industrial injury as defined by the Industrial Insurance Laws.
- The claimant's condition is not an occupational disease as contemplated by section 51.08.140 RCW.

The use of these three codes addresses the multiple possibilities of the origin of the worker's condition. He is unable to remember a specific point in time, and the provider said the condition is not work-related, so it is appropriate to legally document that the condition is not an injury **or** an occupational disease.

Injury vs. Occupational Disease

When a claim manager reviews a claim, he or she begins by determining if the claim is filed for an injury or an occupational disease. The type of claim that is being filed will dictate further adjudication, including the application of timely filing requirements and requirements for allowance.

RCW 51.08.100 defines an injury as "a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom."

RCW 51.08.140 defines an occupational disease as a "disease or infection that arises naturally and proximately out of employment."

Claim Validity for Injury Claims

RCW 51.28.050

Timely Filing of Injury Claims

When an injury is contended in covered employment, the initial determination made by a claim manager is whether the claim has been filed on a timely basis. RCW 51.28.050 indicates injury claims must be filed within one year after the day of the injury.

The law does not require the worker to apply for benefits on the department's official accident report form or the self-insured employer's SIF-2. A letter or statement signed by the worker

regarding the injury will satisfy the filing and timeliness requirement. However, the claim manager should request the worker submit an SIF-2 if he or she initially filed application for benefits on something other than the SIF-2 form. If there is sufficient information, the claim manager may establish the claim while awaiting the worker's response.

A claim must be denied if application is not made within one year after the date of injury. The date used to calculate timely filing is the date the accident report/SIF-2 was first received by the department or the self-insured employer.

Before a denial order is requested, it should be determined whether the application is actually being submitted for the purpose of reopening an older claim previously established with the same injury date. Also, other dates referenced on an accident report should be closely examined to determine whether the entry for the date of injury is a typographical error.

The department has no authority to waive or make an exception to the time-limit statute because of hardship to the worker or any other circumstances. A trauma claim mistakenly allowed where it was filed more than one year after the day of the injury should be rejected at the time the error is discovered. This action is appropriate even if the claim previously had orders issued which would otherwise be considered final and binding. Case law has held that if the one-year period has expired, the department does not have the jurisdiction to allow the injury claim and any order issued after the statutory time limit is considered void. (See *Leschner v. Dept. of L&I*, *Pate v. General Electric Co.*, and *Wheaton v. Dept. of L&I*.)

Prima Facie Case Requirement for Injury Claims

Prima facie is Latin for "at first view." Prima facie means an injury claim should be allowed if the evidence in the claim supports allowance, and no evidence is produced to dispute allowance. Three requirements establish a prima facie case for injury claim allowance:

- Legal definition of injury – a descriptive statement must satisfy the legal definition of an injury, and
- Course of employment – the worker must have been acting in the course of employment, and
- Causal relationship – a medical opinion must relate the condition diagnosed to the incident or exposure on a more probable than not basis.

Injury Claim Adjudication

Legal Definition of Injury

RCW 51.08.100

"Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result there from.

Most injuries involve a relatively straightforward assortment of bumps, bruises, lacerations, strains, etc. Many disputed or questionable claims involve the issue of whether a particular activity or event falls within the meaning of an "injury" as was intended by the legislature.

According to the definition, there must be more than the onset of symptoms or even the onset of disability during working hours, to qualify for benefits.

There has been guidance given by the courts in cases where the injury seemingly does occur from outside the body and the activity does not require a degree of stressful exertion. As a result of the 1981 case of *Longview Fibre Company v. Weimer*, the definition of injury was expanded to include musculoskeletal conditions caused by normal bodily movement during the course of employment; no unusual or awkward angle is required for the injury to be valid, even if the injury only aggravates a pre-existing condition.

The definition of an injury was expanded by the court to include a series of jolts and jars in a defined period of time, resulting in a physical condition (*Lehtinen v. Weyerhaeuser Co.*). In this case, the worker received frequent jolts during one day while he was operating an insecurely-anchored yarding machine.

When the accident report does not have enough information to make this determination, clarification should be requested by telephone, letter, or investigation. Clarification should include a complete description of the events leading to the incident, the nature of the worker's condition and corroboration by any witnesses.

Pre-existing Conditions

The presence of a pre-existing condition does not disqualify a worker from receiving benefits under the law. A claim is allowable for an "injury" sustained in the course of employment regardless of the worker's physical condition when the injury occurred. A major factor in determining responsibility in cases involving aggravation of pre-existing conditions is whether the condition existed prior to the injury. If it is determined that the condition was asymptomatic and non-disabling prior to the injury and, in effect, was activated or "lighted up" by the injury, responsibility must be accepted for the full effects of any resulting disability (Miller v. Dept. of L&I). If medical evidence discloses the injury has accelerated a pre-existing symptomatic or disabling condition, the extent of that acceleration must be determined and the appropriate benefits, both medical and disability if indicated, awarded.

It is possible for a pre-existing symptomatic or asymptomatic condition to suffer a temporary aggravation or exacerbation as a result of a traumatic injury. In such cases, the effects of the incident exert only a temporary effect upon the condition of the worker and the worker returns to the pre-existing level of function or impairment after the aggravation has subsided.

Particularly where the pre-existing disabling condition was symptomatic, it is necessary for the worker to establish the work activity did not merely produce symptoms which are present during other activities, but some measurable aggravation or increased disability was caused by the incident. The records of a prior treating provider or opinion of that provider if they are still

treating the worker are the most useful factors to be considered in making a determination. Independent medical opinion (with access to prior records) may prove to be necessary in disputed cases.

Course of Employment

RCW 51.08.013, RCW 51.36.040

An injury does not need to be caused by a work-related activity. The worker must be acting at his or her employer's direction or furthering the employer's business.

Key distinctions between the law in Washington State and some other jurisdictions are:

- No consideration is given to degrees of "fault" by the worker or employer in determining entitlement to benefits.

- While it is necessary that the injury occur in the course of one's work, it is not necessary that the injury "arise out of" the particular duties a worker is paid to perform.

The more difficult questions concerning "course of employment" issues will generally fall into one of the categories that follow.

Parking Lots

RCW 51.08.013

Injuries occurring in parking lots are not ordinarily allowable. However, the courts have determined that the statute allows coverage for injuries in parking lots if the job duties require the worker's presence in the parking lot. For example, a grocery store employee who is injured while carrying groceries to a customer's car would be covered.

In general, workers reporting for work at the beginning of their shifts and leaving at the end of their shifts would not be covered for injuries in parking areas. The difficulty with these types of claims is that a parking area may be considered to be such by one party, but not another. If the area is used primarily for storage, loading and unloading materials or other use, coverage would not automatically be excluded. A worker is also covered under certain circumstances while walking from an employee designated parking area to the job site. (See the next section on "Coming and Going" for further details.)

Questions regarding the reasons a worker was in a parking area at the time of injury should be clarified before making a determination. If a claim manager is unclear about coverage, several considerations may help:

What did the worker indicate as the time of injury and work shift?

Why was the worker in a parking area at the time of injury?

Where is the parking area in relation to the jobsite and injury location? (See *Olson v. Stern, Taylor v. Cady, Boeing Co. v. Rooney, UW Harborview Medical Center v. Marengo, Madera v. J.R. Simplot Co.,* and *Puget Sound Energy Inc. v. Adamo* for cases pertaining to parking lots.)

Coming and Going

RCW 51.08.013

A worker injured going to and coming from the place of work in a private vehicle is usually not considered in the course of employment. However, the worker is covered within a company-controlled area, except a parking area, while reporting to or leaving work. This may include immediately before or after a time clock has been punched. Workers who must report prior to their shift to change into uniforms or clothing required by the job are considered covered because these actions further the interests of the employer (*Gordon v. Arden Farms*).

A worker may be covered while coming from or going to an employer-designated parking area if the route exposes the worker to hazards not commonly shared by the general public (*Hamilton v. Dept. of L&I*). Coverage is also extended when a hazard arises from the employer's business even if the general public is also exposed to it (*ITT Baking Co. v. Schneider*).

Coming and Going in Company-Provided Transportation

A worker may be covered when an employer provides transportation or compensation for travel. This arrangement can be a contractual obligation, an employee benefit, or a requirement of the job.

When the employer furnishes the worker with transportation to and from work, coverage for a worker's injury is not dependent upon the method of travel. The employer may:

Provide a vehicle. Coverage begins when the worker enters the vehicle and ends after completing the business-related travel (*Venho v. Ostrander Railway & Timber Co.*).

Reimburse a worker for the cost of transportation (*Aloha Lumber corp. v. Dept. of L&I*).

This rule even applies when the worker uses private transportation and receives only a "flat mileage" reimbursement not actually representing compensation for the full distance traveled from residence to jobsite. For example, a worker resides a substantial distance from the union hiring hall and drives from the union hall to the job. Travel is paid only from the union hiring hall to the jobsite. In a case like this, the claim manager should obtain a copy of the employer's written agreement for travel.

RCW 51.08.013(2) excludes coverage when the worker participates in an employer-sponsored ride-sharing or commuter program. Coming and going does not include alternative commute modes as defined in RCW 46.74.010, even if the employer provides subsidized passes for commuting. Alternative commute mode includes ride-sharing through car or van pools, taking the bus or ferry, and walking or biking.

Coming and Going When Work Causes the Worker to Travel

In situations where the worker's job involves travel away from the employer's premises, he or she will normally be considered to be in the course of employment continuously during the entire trip. For this reason, injuries are usually found to be allowable when they occur while the worker, by necessity, is sleeping in motels or eating in restaurants away from home.

Each claim must be considered on an individual basis to determine whether or not the worker was in the course of employment at the time of the incident.

Coming and Going and on a Business Errand

While traveling to or from work, a worker conducting an errand for the employer is covered while the business-related duty is being performed. For example, when a store owner asks a clerk to take a deposit to the bank, the worker is covered if injured while on this errand.

Deviation

If a worker significantly deviates from a business related task, they may not be covered, even in employer provided or reimbursed transportation. The factors that should be weighed in determining coverage are:

- The nature and purpose of the business travel.
- The nature of the deviation from the expected route.
- The length of time the side trip involves.
- The point at which the injury took place.
- The distance from the expected travel route to the place where the injury occurred.
- Any additional hazards caused by deviation from the expected travel route.

In evaluating deviation, the first step is to diagram a picture of the entire trip, including each of the following:

- The main business trip.
- Any personal side trip (deviation).
- The point of accident.
- The route the worker would have taken from that point if the accident had not occurred.
- Whether the worker had returned to the business route when the accident occurred.

Coverage would normally exist if each of the following conditions occurs:

- The injury is sustained before the worker deviated from or after the worker returned to the expected route.
- The worker is furthering the interests of the employer.
- The worker is performing duties as directed by the employer.

If the injury is sustained prior to the deviation from the expected route and the worker is furthering the interests of the employer and in performance of his/her duties as directed by the employer, coverage will normally exist. Coverage would also exist once the worker has returned to the expected route. (For deviation case law, see *Flavorland Industries Inc. v. Schumacker, Gray v. Dept. of L&I, Hays v. Lake, Hill v. Dept. of L&I,* and *Morris v. Dept. of L&I*.)

Personal Comfort and Lunch Breaks

RCW 51.08.013, **RCW 51.32.015**, **RCW 51.36.040**

The personal comfort rule applies when a worker is injured during a personal comfort activity. A personal comfort activity is reasonably necessary to the life and comfort of the worker. Examples of personal comfort activities include leaving the job station because of excessive heat or cold, taking a break, getting coffee or a drink of water, and using the restroom. These activities are considered to be in the course of employment for coverage as long as each of the following is met:

The worker was on the employer's premises or used facilities near the job site, depending upon the nature of the job.

The injury was sustained during paid working hours or during a lunch break on the job site.

The activity was implicitly or explicitly allowed by the employer.

The activity assisted the employer by helping the worker efficiently perform the job.

A worker is covered during a lunch break on the employer's premises or on a business lunch away from the employer's premises. In addition, workers are covered for damage to teeth or dentures during activities that meet all of the personal comfort doctrine criteria. An injury does not need to be caused by a work-related activity.

After leaving the jobsite during break or lunch for personal reasons (not at the employer's direction), the worker is not covered. Coverage is reinstated when the worker returns to the jobsite (*Bergsma v. Dept. of L&I*).

Intentional Injuries

RCW 51.32.020

A claim is not allowable if the worker deliberately injures or kills themselves. However, a worker's disregard for normal practice or safety rules, even to the point of gross negligence, does not constitute intentional injury.

Felonies

RCW 51.32.020

A claim is not allowable if the worker was injured or killed while committing a felony. For example, the claim of a bank guard shot while robbing the bank at which he worked would not be covered because the guard committed a felony. However, a truck driver involved in a wreck while exceeding the speed limit would be covered even though the law is broken. Speeding is not a felony.

Horseplay

Horseplay between workers that minimally interrupts work is usually covered as long as it does not take them significantly away from the course of employment (*Tilly v. Dept. of L&I*). The following factors should be considered in deciding whether there was a substantial deviation from employment:

The extent and duration of the deviation. Does the horseplay necessitate the complete abandonment of the employment for a substantial period of work time?

The completeness of the deviation. Was the horseplay mixed with job performance, or did it involve the abandonment of duty?

The extent to which the practice had become an accepted part of employment. Was the employer aware of the practice, or did the employer condone the practice?

The extent to which the nature of the employment or activity during unavoidable idleness on the job could be expected to include such horseplay.

Sometimes, horseplay can injure a worker not involved in the horseplay. When that happens, the innocent worker is covered as long as they are in the course of employment. To determine coverage, the claim manager must examine:

Where the injury occurred in relation to where the worker was expected to be.

Who else was involved.

What other factors affected the extent of deviation, if any, from the course of employment.

Altercations and Assaults

The factors that apply to horseplay also apply to altercations (quarrels) between workers, an assault by one worker on another, or an assault on a worker by a non-worker. In addition, the claim manager must establish that the worker was in the course of employment when the altercation or assault occurred. If the dispute which led to the fight arose out of an employment situation, coverage would exist. If the dispute arose out of purely personal issues, coverage would not exist. A worker who leaves the jobsite to fight is no longer in the course of employment, regardless of whether he or she is the aggressor (*Blankenship v. Dept. of L&I*).

Recreational Activities

RCW 51.08.013

Workers are not in the course of employment when they participate in social, recreational, or athletic activities, competitions, or events, whether or not the employer pays some of the cost of these activities. There are three exceptions. Workers are covered during these activities when they:

Participate during work hours, or

Are paid by the employer to participate, or

Are directed, ordered, or reasonably believe they are directed or ordered, by the employer to participate.

Goodwill Actions

Very little guidance has been provided by the courts on cases where a worker is injured while assisting in an emergency. Going to the aid of someone in an emergency may be covered if:

The worker's employment brought him or her in contact with the emergency situation.

The situation in some way was proximate to the worker's job. The individual in need of assistance need not be a coworker.

The employer derives some benefit, even if it's only goodwill to the community, from the act.

Causal Relationship

There must be a causal relationship between the description of the injury and the condition diagnosed. The provider must provide a medical opinion of whether or not the diagnosed condition was caused by the injury or exposure described. It is not sufficient that a provider indicate that the injury possibly resulted in a physical condition. The possibility of a connection is not enough to allow a claim. The provider must find, more probably than not (greater than 50 percent), that the diagnosis results from the work injury or exposure. (See *Seattle-Tacoma Shipbuilding Co. v. Dept. of L&I*; *Kralevich v. Dept. of L&I*; and *Rambeau v. Dept. of L&I*.)

Claim Validity for Occupational Disease Claims

Timely Filing of Occupational Disease Claims

RCW 51.28.055

Claims for occupational disease must be filed within two years following the date the worker had written notice from a doctor that an occupational disease exists and a claim for disability benefits may be filed. The provider must file the written notice with the department. The department has no authority to waive the statutory filing time limit. (See *Nygaard v. Dept. of L&I*.)

While determining whether to allow an occupational disease claim, any additional medical information should be reviewed to verify timely filing and the date of manifestation. An occupational disease claim is timely filed by the:

- Worker within two years from the date of the written notice from a medical provider that the condition was occupationally related and a claim may be filed.

- Spouse or beneficiary within two years from the date of written notice from a medical provider that the death was occupationally related and a claim could be filed **if the worker did not** file a claim.

  Note: If the worker did file a claim and later died, the spouse or beneficiary must file for death benefits within one year of the date of death.

Criteria for Allowance of Occupational Disease Claims

After timely filing, three additional requirements must be met before an occupational disease can be allowed:

- Legal requirement – the disease must arise naturally and proximately out of employment, and

- Causal relationship – the doctor must state, on a more probable than not basis, the disease is related to the work activities, and

- Medical findings – the doctor must substantiate the diagnosis with objective medical findings.

Occupational Disease Claims Adjudication

Legal Definition of Occupational Disease

RCW 51.08.140

"Occupational disease" means such disease or infection as arises naturally and proximately out of employment.

An occupational disease occurs over time, rather than from a fixed event. That is the key distinction between an occupational disease and an industrial injury.

Legal Requirement: Arise Naturally

An occupational condition or disease must arise naturally and proximately out of employment. To meet the definition of arising naturally out of employment, a condition must be a natural consequence of the distinctive conditions of employment. The disease must arise from the distinctive job requirements, rather than merely the workplace or everyday life.
In 1987, the Dennis decision (*Dennis v. Dept. of L&I*) expanded the definition of occupational disease to include a work-related aggravation of a preexisting nonwork-related disease and symptomatic (with symptoms) or asymptomatic (without symptoms). The decision defined a disease-based disability as an aggravation of a pre-existing condition.

The Dennis decision also clarified that for the disease or disease-based disability to arise naturally out of employment, it must result from the distinctive conditions of employment. The disease must be a natural consequence of the work process. A condition that arises naturally from distinctive conditions of employment:

- Must result from a recognizable or characteristic risk, such as an exposure, or task, such as repetitive use of a body part, constant tool gripping or pinching, vibrating equipment, constant reach, etc., that is required or expected of the worker to perform his or her job duties.

- Need not be peculiar or unique to the worker's particular occupation.

- Must be related to the worker's employment, rather than merely the workplace.

- Must be related to the particular employment, rather than to everyday life or all employment.

- Must result from the distinctive conditions of employment. In other words, the disease must be related to the particular employment rather than those present in everyday life or all employment.

The following categories are provided as an aid to identifying **distinctive conditions** of employment. Not all occupational disease will result from one of these general categories.

- **Unique to Employment:** A disease or disease-based disability that could not be contracted elsewhere is considered unique to employment. For example, only a coal miner can contract black lung disease. Therefore, the disease is unique to the employment.

- **Increased Risk:** Increased risk means that the conditions of the particular occupation, rather than other employment or non-employment, expose the worker to an increased or greater risk of contracting the disease. For example, a nurse in an intensive care unit may have a greater risk of contracting hepatitis than someone in another type of employment (*Sacred Heart v. Carrado*).

- **Continuous and Specific Activity:** This may be repetition of similar movements (like a grocery store checker/scanner makes) or a series of jars and jolts (like a jackhammer operator experiences). The activities must be required to perform the job. For example, a worker who has done a variety of jobs requiring hard labor would not be covered unless each of the jobs required similar, continuous specific activity.

If the disease or disease-based disability did not result (arise naturally) from distinctive conditions of employment, the legal requirement is not met. A claim is not allowable as an occupational disease if it results from activities that are:

- Common to all employment or non-employment life.

- Coincidental to employment.

- Distinctive to the worker.

Common to All Employment or Non-Employment Life

Diseases that can be contracted from conditions present in all employment or non-employment settings are considered common to all employment or non-employment life. For example, an office worker who develops degenerative disc disease in the lower back from 30 years of sitting, standing, and walking at work. This would not be allowable as those activities are common to all employment and non-employment life.

Coincidental to Employment

Situations where the contraction of the disease is related merely to the workplace are considered coincidental to employment and are not allowable as occupational disease claims. For example, if a worker in a sales office contracts influenza from a co-worker, this would not be allowable as the condition is coincidental to employment.

Distinctive to the Worker

If the disease results from the worker's personal choice in performing work activities, rather than distinctive conditions of employment, it is considered distinctive to the worker. For example, an employer provides an airline reservation clerk with a headset. She chooses instead to cradle a standard telephone receiver between the shoulder and neck, resulting in cervical disc disease. This would not be allowable, as the condition is distinctive to the worker.

When adjudicating occupational disease claims that do not clearly meet the legal criteria of arising naturally out of employment, the following questions should be asked to determine whether the activity is distinctive to employment:

- Is the activity distinctive to the worker's employment, rather than general and common to everyday life and all employment?
- Did the worker perform the work duties as required?
- Are the activities distinctive to employment, rather than merely distinctive to the worker?

If yes, the claim manager must ensure all other allowance requirements (proximate cause, timely filing) have also been met. If no, the claim would not be allowable.

Legal Criteria: Proximate Cause

An occupational disease or disability must arise proximately out of employment. This is called "proximate cause."

The meaning of proximate cause was clarified in the Simpson case (*Simpson Logging Company v. Dept. of L&I*). It must be established that the (distinctive) conditions of employment are probably the proximate cause of the disease. The conditions of employment need only be one of the causes of the disease. However, if it appears that another condition may be the sole cause of the disease, it is important to clarify proximate cause. The claim manager must give the provider any information that does not clearly support proximate cause and obtain clarification. A claim must meet the legal requirements of arising naturally and proximately to be allowed as an occupational disease.

Medical Requirement: Probable Medical Opinion

It is not sufficient that a provider give an opinion that the claimant's work condition "might possibly," "could possibly," or "may be" the cause of the disease or disease-based disability. The findings must be based on a "probable" or "more probable than not" (more than 50% likelihood) connection between the work conditions and the disease or disease-based disability.

Example of Sufficient Medical Opinion: An attending provider reports that the repetitive use of tin snips did make or probably did make the osteoarthritis in the claimant's wrists symptomatic and disabling.

Example of Insufficient Medical Opinion: A cedar mill worker smokes cigarettes for fifteen years and files a claim for a pulmonary condition. The provider states that the working conditions "possibly" or "could have" or "perhaps" caused the disease or disease-based disability.

The claim is denied when the provider's opinion is based upon any terminology that is speculative in nature. There must be a "more probable than not" or definite opinion regarding the causal connection.

Medical Requirement: Objective Medical Findings

Objective medical findings are those findings that can be seen, felt, or measured by the examining provider. Subjective medical findings are those findings that cannot be seen, felt, or measured by a provider.

Example of Sufficient Medical Findings: A provider provides results of a pulmonary function test to compare lung capacity prior to employment and lung capacity during employment in a cedar mill. The pulmonary function test provides the necessary objective medical findings to support the connection between the work conditions and the disease.

Example of Insufficient Medical Findings: A worker reports painful or difficult respiration. There are not objective medical findings by a provider to substantiate the pain or existence of a respiratory problem. A worker's subjective complaints alone will not support a connection between the worker's employment and a disease or disease-based disability.

Date of Manifestation for Occupational Disease Claims

RCW 51.32.180, WAC 296-14-350

Correctly establishing the date of injury for a claim is important. It will determine the monthly time-loss rate and permanent partial disability (PPD) schedule used in calculating the worker's benefits. While establishing the date of injury for an injury claim is usually straightforward, establishing a date of manifestation for an occupational disease is more difficult since no specific incident marks the onset of the disease.

RCW 51.32.180 bases a worker's occupational disease benefits on the date the disease manifested, rather than the date of last injurious exposure. WAC 296-14-350 clarifies this date. The date of manifestation of the occupational disease is either the date the disease first required medical treatment or became totally or partially disabling, whichever occurred first. In most cases, it is the date the worker first saw a doctor for the condition.

Compensation shall be based on the monthly wage of the worker as follows:

- If the worker was employed on the date of manifestation, compensation shall be based on the monthly wage paid on that date regardless of whether the worker is employed in the industry that gave rise to the disease or in an unrelated industry.

- If the worker was not employed, for causes other than voluntary retirement, on the date of manifestation, compensation shall be based on the last monthly wage paid.

For determining date of manifestation on occupation hearing loss, see Adjudication of Hearing Loss Claims.

Adjudication of Hearing Loss Claims

RCW 51.28.055(2)

Traumatic injuries to the ear should be adjudicated like any other injury claim. An occupational disease hearing loss claim is more complicated to adjudicate. Hearing loss resulting from long-term exposure to excessive noise at work is commonly referred to as occupational hearing loss. Since this condition is the result of long-term exposure, these claims are adjudicated according to the statutes related to occupational diseases and the same criteria must be met. Typically, the only treatment involved in these claims is appliances, such as a hearing aid or tinnitus masker. Occupational hearing loss benefits may be limited. If the claim is not filed within two years of the date of last injurious exposure, the worker will be eligible for medical aid benefits only. This means a worker who files a claim more than two years after the date of last injurious exposure can receive hearing aids and lifetime repairs or replacements, but no PPD.

To determine claim validity, the claim manager needs to establish if the worker was exposed to hazardous noise levels at work and may need to find out whether the worker was exposed to excessive noise in previous employments or everyday life, such as personal use of power tools or guns. This will help clarify the proximate cause of the hearing loss.
Noise level surveys are also a valuable tool. For a noise survey to be valid, it must have been conducted during the period of time the worker was exposed.

Types of Hearing Loss

There are two types of hearing loss that the claim manager needs to consider: conductive and sensorineural. At times, a worker can experience a combination of both conductive and sensorineural hearing loss.

Conductive Hearing Loss

Conductive (conducts sound) hearing loss is a breakdown or obstruction in the transmission system. This type of hearing loss:

- Is not caused by continuous excessive noise exposure.
- May be caused by a blockage of the external ear canal with ear wax, a foreign body, a broken ear drum or head trauma.
- Is usually injury-induced, such as a sudden explosion or head trauma. **Note:** An injury-induced hearing loss, from an explosion, head trauma, or similar is an injury claim, not an occupational disease claim.

Sensorineural hearing loss

Sensorineural hearing loss results from changes in the inner ear or in the nerves carrying impulses to the brain. This type of hearing loss:

- Is permanent, and not treatable by medical or surgical means.
- Is usually preventable with appropriate ear protection.
- Usually creates the need for a hearing aid.
- Can result from long-term exposure to noise and is considered an occupational disease, if industrially-related.
- Can also be caused by disease, tumor, and the aging process (presbycusis).

Presbycusis

Presbycusis is the gradual reduction of hearing caused by aging. This type of hearing loss:

- Occurs gradually over a period of years, with the very highest frequencies (8,000-12,000 Hertz or Hz) affected first, and the lower ones gradually following.
- Generally affects both ears at about the same rate.
- Generally is not noticed until the worker is over 60 years old.
- Evolves gradually into a difficulty understanding what has been said, rather than difficulty in hearing. This is due to the hearing loss affecting the higher frequencies first.

Presbycusis is a form of sensorineural hearing loss and can occur concurrently with noise-induced hearing loss. If presbycusis is present, the proximate cause of the worker's hearing loss must be clarified: Is the proximate cause noise exposure or presbycusis? The effects of presbycusis are not segregated when occupational noise exposure is the proximate cause of the worker's hearing loss and the claim is allowed (*Boeing Co. v. Heidy*).

Tinnitus

Tinnitus is a perception of sound when there is nothing external (no acoustic stimulus) to cause sound. It is often referred to as "ringing in the ears." This sound:

- May be a buzzing, ringing, roaring, whistling or hissing, or may involve more complex sounds that vary over time.
- May occur as a symptom of nearly all ear disorders, including obstruction of the ear canal, noise-induced hearing loss, sensorineural hearing loss, acoustic trauma and head trauma.
- Usually exists with another type of hearing loss.
- Is sometimes helped by using a tinnitus masker.

Work-related Hearing Loss Conditions

Both conductive and sensorineural hearing loss can be work-related conditions. Conductive hearing loss may be injury-induced, like a welder having a hot slag land in his or her ear canal, damaging the eardrum. This would be an injury claim.

Sensorineural hearing loss can be the result of long-term exposure to loud noises, like those a machine shop worker experiences. This would be an occupational disease.

Date of Manifestation for Occupational Hearing Loss Claims

The date of manifestation for occupational disease hearing loss claims is the:

- Date the occupational disease required treatment, or
- Date of last injurious exposure,
- Whichever occurred **first** (*Harry v. Buse Timber & Sales, Inc.*).

Medical treatment is the date the worker consulted with a doctor or received a hearing aid from a licensed provider, whichever occurred first. An audiogram is not considered medical treatment.

Date of Manifestation for Subsequent Occupational Hearing Loss Claims

If, after the closing of a prior claim for hearing loss, a worker is exposed to injurious occupational noise, the worker should file a new claim. The date of manifestation for the new claim will be the date the worker received medical treatment for the additional hearing loss or the last injurious exposure, whichever occurred first after the closure of the prior claim.

Medical Opinion

Medical opinion must relate the condition to the work place. The examining provider determines if and where the worker received injurious noise exposure. Medical opinion must also be present regarding the percentage of hearing loss in conformity with the American Medical Association's (AMA) guidelines.

If the worker has not undergone medical examination by a qualified provider in the process of filing the claim, an independent medical examination should be scheduled near the worker's home.

Tests range from simple screenings, such as producing a loud noise and observing the test subject, to complex tests with detailed measurements, such as the auditory evoked responses test in which an electroencephalogram is used to detect brain wave response to sounds. There are many hearing function tests:

- **Audiogram** – An audiogram tests a worker's ability to hear pure tones in each ear. Simple tests, such as the ones done at work, may be useful for screening. But a valid audiogram is necessary to accurately diagnose most hearing problems and determine the amount of impairment.

- **Tympanogram** – The tympanogram measures how easily the eardrum vibrates back and forth and at what pressure the vibration is the easiest. The middle ear is normally filled with air at the same pressure as the surrounding atmosphere. If the middle ear is filled with fluid, the eardrum won't vibrate properly, and the tympanogram will be flat. If the middle ear is filled with air but at a higher or lower pressure than the surrounding atmosphere, the tympanogram will be shifted in its position. The tympanogram is conducted by placing a special probe against the ear canal (like an earplug), and the equipment automatically makes the measurements. This test determines the functionality of the tympanic membrane by observing its responses to waves of pressure and measuring the pressure of the middle ear.

- **Auditory Brainstem Response (ABR)** – The ABR is a special hearing test that can track nerve signals from the inner ear through the auditory nerve to the region of the brain responsible for hearing. The test can show where, along that path, the hearing loss has occurred. For example, the ABR is often used for a worker with a sensorineural loss in just one ear. This loss can sometimes be caused by a benign tumor on the auditory nerve. If the ABR is normal along that region of the path, the chances of having this tumor are small. A small speaker which produces a clicking sound is placed near the ear. Special electrodes automatically record the nerve signal. The ABR requires no conscious response from the worker being tested. The worker can even sleep during the testing. It's helpful in evaluating suspected peripheral hearing loss, cerebellopontine angle lesions, brainstem tumors, infarctions, and multiple sclerosis. It's also used to evaluate the mechanisms of coma and in monitoring the cause of disorders associated with coma. ABR requires preauthorization.

- **Electronystagmography (ENG)** – The ENG is a test of the balance mechanism of the inner ear. It's a graphic recording of eye movements. Metal electrodes are attached around the eye. Standard caloric stimulation test is performed, with cold or hot water put in the ear canal. Each ear is tested separately. The electrodes record the duration and speed of eye movements that occur when the inner ear is stimulated. This test provides exact measurements of the eye movements and can record behind closed eyelids or with the head in a variety of positions. The test is performed by an audiologist and interpreted by an otolaryngologist (ear, nose, and throat specialist, or ENT). ENG is used to determine if ear nerve damage is a cause of dizziness or vertigo. It's performed to evaluate the acoustic nerve which provides hearing and helps with balance. This study aids in the differential diagnoses of lesions in the brainstem and cerebellum, unilateral hearing loss of unknown origin, and helps identify the cause of vertigo or ringing in the ears. ENGs require preauthorization.

Audiograms

Audiograms chart the sequence of tones that have been used to measure hearing thresholds. A hearing threshold is a measure of the softest sounds that a human can hear at various pitches.

A valid audiogram is needed to determine what type of hearing loss is present and if it is due to excessive noise exposure. In routine testing, some voluntary response from the patient is necessary to indicate that he or she hears the sound used to test hearing. The sound may be a word, a sentence, a pure tone, a noise or even the blast of a loud horn. The patient's response may consist of raising his or her finger or hand, pressing a button or answering a question. The test sound is reduced in intensity until the patient hears it approximately 50 percent of the times it is presented. The intensity level at which a patient first hears the sound is called the threshold of hearing.

To be considered valid, an audiogram must be:

- Preceded by at least 14 hours without exposure to high levels of noise (occupational or non-occupational); and

- Performed by a licensed or certified audiologist, an otolaryngologist or other qualified provider, or by a certified technician responsible to one of the above; and

- Performed in a sound-attenuated room; and

- Obtained from equipment calibrated to current American National Standards Institute (ANSI) standards.

Testing may be done either by air conduction (transmitted through air) or bone conduction. The department uses unmasked air conduction audiogram findings to calculate permanent impairment. There are times when a provider states that the readings from the bone conduction audiogram more correctly reflect the permanent impairment. If the provider gives a good basis for his or her opinion, the bone conduction readings can be used.

Which Audiogram to Use

If a worker is still being exposed to injurious occupational noise at the employer of record, the most recent valid audiogram is used to determine permanent impairment.

If a worker is not currently being exposed to injurious occupational noise, or has changed employers since filing the claim, the first valid audiogram performed closest to the date of last injurious exposure is used. However, if a subsequent valid audiogram shows a lower percentage of hearing loss, that audiogram is used.

Reading the Audiogram and Calculating the Loss

In order to calculate the amount of permanent impairment, the claim manager takes the readings from the appropriate audiogram. The audiogram is read at the 500 Hz, 1000 Hz, 2000 Hz and

3000 Hz levels for each ear. The readings are then applied to a formula as recommended by the American Medical Association's *Guides to the Evaluation of Permanent Impairment*.

When reviewing the audiogram, "X" is the reading for the left ear and "O" is the reading for the right ear. The loss in each ear is calculated separately and the total loss in each ear is then combined to calculate the binaural hearing loss.

To calculate the hearing loss, the following steps are taken for each ear:

1. The readings at 500 Hz, 1000 Hz, 2000 Hz and 3000 Hz are added together and then divided by 4 to get an average reading.

2. Subtract 25 from the results of step number 1.

3. Multiply the results of step number 2 by 1.5.

4. This will give you the total hearing loss in each ear. If only one ear shows loss, you are done. We do not calculate a binaural loss when there is loss in only one ear.

   If there is loss in both ears, the following steps are taken in order to calculate the binaural loss:

5. The percentage of loss in the better ear is multiplied by 5.

6. The percentage of loss in the worse ear is added to the results of step number 4.

7. The result of step number 5 is divided by 6. This will give you the percentage of binaural hearing loss.

A Hearing Impairment Calculation Worksheet is also available on the department's web site.

Tinnitus

Tinnitus is ratable for occupational hearing loss only if there is an otherwise compensable loss. (**Note:** If tinnitus results from an industrial injury, the department will accept a rating with or without an otherwise compensable hearing loss.)

In accordance with the AMA Guidelines, a maximum of 5% hearing loss impairment may be awarded to a worker for tinnitus in his or her lifetime.

Disease-Based Hearing Loss

There are several diagnoses that may be encountered when reviewing a medical report for occupational hearing loss. These diagnoses are Acoustic Neuroma, Meniere's Disease and

Otosclerosis. While these are not all of the causes of disease-based hearing loss, they are the most common. If a provider indicates that a portion of the hearing loss is due to occupational noise exposure and a portion is due to disease, the disease-based percentage should be segregated out.

Liable Insurer

The question of whether the State Fund or a self-insured employer is liable for a claim is determined on the basis of the insurer on the date of last injurious exposure. The insurer at the time of the last inurious exposure will be liable for the claim. Medical opinion must be used to determine if an exposure was injurious.

Occupational Disease Presumption Claims for First Responders

RCW 51.32.185, RCW 51.08.142, WAC 296-14-310, WAC 296-14-315, WAC 296-14-320, WAC 296-14-325, & WAC 296-14-330

Respiratory Disease in Firefighters, Emergency Medical Technicians (EMTs) and fire investigators

RCW 51.32.185 establishes a presumption that respiratory disease is an occupational disease for public or private firefighters (if the department includes over 50 firefighters), EMTs and public fire investigators.

This presumption of coverage does not apply if the worker regularly uses tobacco products, and it may not apply if the worker has a history of tobacco use. If the presumption does not apply, the claim is not automatically denied; the burden is then on the worker to prove the condition is an occupational disease.

After firefighting employment ends, coverage is extended for three calendar months for each year of service, up to a maximum of 60 months from the last date the worker was employed.

If the cause of the respiratory disease is in question, this presumption may be rebutted by evidence as outlined below.

Heart Problems in Firefighters, EMTs, Fire Investigators and Law Enforcement Officers

Heart problems are presumed to be an occupational disease for firefighters, fire investigators, EMTs, and law enforcement officers if they are experienced:

- Within 72 hours of exposure to smoke, fumes, or toxic substances, or

- Within 24 hours of strenuous physical exertion in the line of duty (for law enforcement officers) or due to firefighting activities (for firefighters).

Firefighting activities are defined by RCW 51.32.185(8) as:

- Fire suppression.
- Fire prevention.
- Fire investigation.
- Emergency medical services.
- Rescue operations.
- Hazardous materials response.
- Aircraft rescue.
- Training.
- Other assigned duties related to emergency response.

After the applicable employment ends, coverage is extended for three calendar months for each year of service, up to a maximum of 60 months from the last date the worker was employed.

This presumption of coverage does not apply if the worker regularly uses tobacco products, and it may not apply if the worker has a history of tobacco use. If the presumption does not apply, the burden is then on the worker to prove the condition is an occupational disease.

This presumption may be rebutted by evidence as outlined below.

Cancer in Firefighters, Fire Investigators & EMTs

As outlined in RCW 51.32.185, there is a presumption that certain types of cancer are occupational diseases for active or former firefighters, EMTs, and fire investigators. The covered cancer types are:

- Prostate cancer diagnosed prior to the age of 50.
- Primary brain cancer
- Malignant melanoma
- Leukemia

- Non-Hodgkin's lymphoma
- Bladder
- Ureter
- Colorectal
- Multiple myeloma
- Testicular
- Kidney
- Mesothelioma
- Stomach
- Nonmelanoma skin cancer.
- Breast cancer in women
- Cervical cancer

This presumption only applies to firefighters, EMTs, or fire investigators whose cancer develops or manifests itself after they:

- Have served at least 10 years, **and**
- Were given a qualifying medical examination that showed no evidence of cancer at the time of hire.
    - If the worker was hired before July 28, 2019, and the employer did not provide an examination at the time of hire, one may be provided on or before July 1, 2020. If the worker is diagnosed with a covered cancer at the time of this exam, the presumption still applies.
    - If the worker is hired on or after July 28, 2019, and the employer did not provide an examination at the time of hire, the presumption applies.

After firefighting employment ends, coverage is extended for three calendar months for each year of service, up to a maximum of 60 months from the last date the worker was employed.

This presumption may be rebutted by a preponderance of evidence as outlined below.

Infectious Diseases in Firefighters, EMTs, Fire Investigators and Law Enforcement Officers

RCW 51.32.185 states that certain infectious diseases are presumed to be occupational diseases for public or private firefighters, EMTs, public fire investigators, and law enforcement officers. The covered diseases are:

- Human Immunodeficiency Virus (HIV)/Acquired immunodeficiency syndrome
- Hepatitis (all strains).
- Meningococcal meningitis.
- Mycobacterium tuberculosis.

After the applicable employment ends, coverage is extended for three calendar months for each year of service, up to a maximum of 60 months from the last date the worker was employed.

If there is evidence that the worker's condition is not work-related, this presumption may be rebutted as outlined below.

PTSD as an Occupational Disease in Firefighters, EMTs, and Law Enforcement Officers

RCW 51.08.142, RCW 51.32.185, WAC 296-14-300, WAC 296-14-310

Post-traumatic stress disorder is defined by RCW 51.08.165 as "a disorder that meets the diagnostic criteria for posttraumatic stress specified by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, or in a later edition as adopted by the department in rule."

RCW 51.08.142 established that mental conditions or mental disabilities caused by stress do not fall under the definition of an occupational disease. Effective June 6, 2018, an exception was passed by the state legislature for firefighters as defined in RCW 41.26.030(17)(a), (b), (c), and (h), law enforcement officers as defined in RCW 41.26.030(19)(b), (c), and (e), who are diagnosed with posttraumatic stress disorder (PTSD).

RCW 51.32.185(1)(b) establishes the prima facie presumption that PTSD is an occupational disease in certain firefighters (including EMTs), and law enforcement officers. For the presumption to apply, the following criteria must be met:

- The worker must have served at least 10 years prior to the development of PTSD.

- If the worker was hired after June 7, 2018, they must have had a mental health examination from a Psychiatrist or Psychologist which ruled out the presence of PTSD (RCW 51.08.142(2)(b)).
    - If the employer does not provide a mental health examination or the worker was hired before June 7, 2018, the presumption applies.

PTSD is not considered an occupational disease if it is attributed to disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action.

For workers who are covered by this presumption, after the applicable employment ends, coverage is extended for three calendar months for each year of service, up to a maximum of 60 months from the last date the worker was employed.

As with all other presumptions established by RCW 51.32.185, this presumption may be rebutted by evidence as outlined in the section below.

Challenge to Presumption of Coverage under RCW 51.32.185

RCW 51.32.185(1)(d)

For any presumption of coverage established under RCW 51.32.185 for firefighters, EMTs, fire investigators or law enforcement officers, the presumption of coverage can be challenged by a preponderance, or majority, of the evidence. The evidence may show the disease did not result from workplace exposure. Instead, the disease may have resulted from the worker's:

- Use of tobacco products.
- Physical fitness and weight.
- Lifestyle.
- Hereditary factors.
- Exposure from other employment or nonemployment activities.

Legal Fees

RCW 51.32.185(9)

When a determination involving a presumption established by RCW 51.32.185 is appealed to the Board of Industrial Insurance Appeals or higher court and the claim is determined to be allowable, the opposing party must pay appeal costs, including attorney and witness fees, to the worker or the beneficiary.

PTSD in Public Safety Telecommunicators

RCW 51.08.142 & WAC 296-14-300

For public safety telecommunicators, PTSD may be considered an occupational disease as provided by RCW 51.08.142 but there is not normally a presumption of coverage. There are some Public Safety Telecommunicators that are presumptively covered under RCW 51.32.185.

PTSD in Registered Nurses

RCW 51.32.395 & WAC 296-14-300

Effective January 1, 2024, for direct care registered nurses who are employed on a fully compensated basis there exists a prima facie presumption that PTSD is an occupational disease under RCW 51.08.140. Direct care nurse is defined as an individual licensed as a nurse under chapter 18.79 RCW who provides direct care to patients. This applies only to direct care registered nurses whose disorder develops or manifests itself after they have been employed on a fully compensated basis as a direct care registered nurse in Washington State for at least 90 consecutive days.

Note: Advanced registered nurse practitioners (ARNP) are registered nurses under RCW 18.79.050. LPNs are not included in the presumption as they are not registered.

The presumption may be rebutted by a preponderance of the evidence.

The presumption extends following termination of employment for a period of three calendar months for each year they were a direct care registered nurse employed on a fully compensated basis, but may not extend more than 60 months following the last date of employment.

When a determination involving this presumption is appealed to the Board of Industrial Insurance Appeals or higher court and the final decision allows the claim for benefits, the opposing party must pay all reasonable costs of the appeal including attorney and witness fees, to the worker or the beneficiary.

Radiological Hazardous Waste Facility Presumption

RCW 51.32.187

In 2018, the legislature recognized that workers employed at the Hanford nuclear site are at an increased risk for multiple diseases and cancers as a result of exposure to nuclear waste. The Hanford site workers presumption established that certain diseases and conditions are occupational diseases for workers at the Hanford nuclear site, including contractors and subcontractors.

Effective March 11, 2022 the Governor signed SSB 5890 and it became effective immediately. The bill changed, and expanded the definition of those covered under the law from only Hanford site workers to a definition that includes workers at other radiological hazardous waste facilities, excluding military installations.

The presumption covers exposed workers, defined as a worker working at a radiological hazardous waste facility for at least one 8-hour shift while covered under the state's industrial insurance laws and also includes workers conducting an inspection of the facility.

The presumption applies to current and past exposed workers, as well as survivors of workers who have died from the conditions covered under the presumption. The presumption lasts for the worker's lifetime. For exposed workers there is a prima facie presumption that the diseases and conditions listed in the law are occupational diseases under RCW 51.08.140.

The following conditions are covered under the presumption:

- Respiratory disease, except communicable diseases.
- Any heart problems experienced within 72 hours of exposure to fumes, toxic substances, or chemicals at the site.
- Beryllium sensitization, and acute and chronic beryllium disease.
- Neurological disease, except communicable diseases.

Certain cancers are also covered under the presumption, so long as the worker showed no evidence of cancer when given a qualifying medical examination upon becoming such a worker or if a qualifying medical examination was not required at the time of hire.

The cancers covered are:

- Leukemia.
- Primary or secondary lung cancer, including bronchi and trachea, sarcoma of the lung, other than in situ lung cancer that is discovered during or after a post mortem examination, but not including mesothelioma or pleura cancer.
- Primary or secondary bone cancer, including the bone form of solitary plasmacytoma, myelodysplastic syndrome, myelofibrosis with myeloid metaplasia, essential thrombocytosis or essential thrombocythemia, primary polycythemia vera (also called polycythemia rubra vera, P. vera, primary polycythemia, proliferative polycythemia, spent-phase polycythemia, or primary erythremia).
- Primary or secondary renal (kidney) cancer.
- Lymphomas, other than Hodgkin's disease.
- Waldenstrom's macroglobulinemia and mycosis fungoides.

- Primary cancer of the thyroid, male or female breast, esophagus, stomach, pharynx, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary bladder, brain, colon, ovary, or liver.

When a determination involving the presumption is appealed to the Board of Industrial Insurance Appeals (BIIA) or any court and the final decision allows the claim of benefits, the BIIA or court shall order that all reasonable costs of the appeal be paid to the worker or his or her beneficiary by the opposing party.

Public Health Emergency Presumptions

RCW 51.32.181, RCW 51.32.390

RCW 51.32.181 and RCW 51.32.390 provide that during covered public health emergencies ordered by the president of the United States or governor of Washington, involving infectious or contagious diseases, there exists a prima facie presumption for claims from frontline and health care workers. These claims are considered occupational diseases under RCW 51.08.140 during a public health emergency. Presumptive coverages ends when the public health emergency is lifted and will not apply until such time as a new public health emergency warrants their use.

Frontline Workers - RCW 51.32.181

Presumption under RCW 51.32.181 applies to frontline workers, as defined by law, who contract the disease. RCW 51.32.181 states that a frontline worker must provide verification to the department or the self-insured employer that the worker has contracted the infectious or contagious disease that is the subject of the current public health emergency.

Verification that an infectious or contagious disease has been contracted is defined under WAC 296-14-340 as written documentation of:

- A diagnosis from a medical provider made by examiniation; or
- A positive test administered or verified by a medical facility, testing facility, pharmacy, or the employer's facility.

The following cannot be used as verification that a worker has contracted an infectious or contagious disease:

- Symptoms only self-reported by the worker; or
- A report from a medical provider that solely relies on a worker's self-reported positive test results.

RCW 51.32.181(3) states that the presumption may be rebutted by the department or self-insured employer by a preponderance of evidence that:

- The exposure occurred from other employment activities or,

- The worker was working from home, on leave from employment, or a combination thereof, for the period of quarantine consistant with recommended guidance from state and federal health officials immediately prior to the positive test result.

Health Care Workers - RCW 51.32.390

Presumption under RCW 51.32.390, applies to health care professionals, as defined by law. In addition to covering workers who contract the disease, this law also covers health care workers who are quarantined due to exposure to the disease. RCW 51.32.390 states that a healthcare worker must provide verification to the department or the self-insured employer that the worker is in quarantine or has contracted the infectious or contagious disease that is the subject of the current public health emergency.

Verification that an infectious or contagious disease has been contracted is defined under WAC 296-14-341 as written documentation of:

- A diagnosis from a medical provider made by examiniation; or
- A positive test administered or verified by a medical facility, testing facility, pharmacy, or the employer's facility.

The following cannot be used as verification that a worker has contracted an infectious or contagious disease:

- Symptoms only self-reported by the worker; or
- A report from a medical provider that solely relies on a worker's self-reported positive test results.

Verification that a worker has been quarantined due to exposure requires written documentation of:

- A medical provider or public health official indicating the worker should remain away from work for a period of time after exposure; or
- Confirmation from the employer that it asked the worker to remain away from work for a period of time after exposure.

Quarantine does not include:

- Self-quarantine by a worker without direction from a medical provider, public health official, or their employer;
- Quarantine without exposure; or
- Quarantine after exposure for a length of time exceeding accepted public safety and health guidelines at the time of quarantine, from the relevant agencies.

RCW 51.32.390 (3) states that the presupmption may be rebutted by clear and convincing evidence that exposure to the infectious or contagious disease:

- Was the result of other employment or non-employment activities; or

- The worker was working from their home or other location not under the employers's control, on leave or some combination for the period of quarantine outlined for the disease immediately prior to the employee's date of disease contraction or period of incapacity.

Time-Loss Benefit Entitlement

For claims covered by the Public Health Emergency Presumption, time-loss benefits are payable the day after the date of manifestation. In other words, these workers are entitled to the first three days of time-loss benefits, even if they did not miss 14 or more days.

Note: Refer to the date of manifestation section for information on accurately establishing that date.

During the public health emergency, time-loss benefits are not payable for the same period of time that benefits are paid by a federal or state program.

Special Situations

Repair or Replacement of Personal Items

RCW 51.32.260

A worker may be reimbursed for replacing or repairing personal clothing, and protective equipment, such as safety glasses or footwear. However, these must be lost or damaged due to an allowable injury or during emergency treatment for the allowable injury.

A claim is not allowable if it is filed for only repair or replacement of clothing, equipment, or footwear where no personal injury was sustained.

Note: Personal items, such as jewelry or watches lost or damaged as a result of an injury or during emergency treatment for injuries, are not covered.

Glasses, Hearing Aids, Contact Lenses and Artificial Appliances

RCW 51.36.020

Glasses, contact lenses, hearing aids and artificial appliances are covered if they are damaged during an industrial accident. An industrial accident is an unexpected happening arising in the course of employment that results in damage to an artificial member, such as a prosthesis.

These items are considered part of the body when they are being used. For example, glasses and contact lenses are considered extensions of a worker's eyes and are referred to as bodily substitutes. Unused eyeglasses or contact lenses that are lost or damaged are considered personal property and are not covered, such as when a worker wears glasses on top of his or her head.

Groin Strains

Problems have developed with accepting the diagnosis of groin strains on new claims. It is difficult for the attending provider to define a specific injury to this area because of the many muscles, ligaments, and glands involved. Therefore, the diagnosis of groin strain will be accepted when there is no evidence of a definite hernia but the injured worker has sustained an allowable injury at a specific time and place in the course of employment.

Mental Conditions/Stress Claims

RCW 51.08.142, WAC 296-14-300

Most claims for mental stress can only be allowed if the stress resulted from a single, traumatic event. For example, a mental stress claim could be allowed for a window washer who saw their partner fall to the ground. If a mental condition results from witnessing this incident, it would be considered an allowable injury claim. The law specifically excludes mental health conditions or disabilities caused by stress from coverage as occupational diseases. This means the only allowable mental stress claim would be an injury claim.

Exception: The legislature has established that posttraumatic stress disorder (PTSD) is an occupational disease for certain firefighters, law enforcement officers, public safety telecommunicators and registered nurses (effective 1/1/2024). See PTSD as an Occupational Disease in Firefighters, EMTs, and Law Enforcement Officers, PTSD in Public Safety Telecommunicators and PTSD in Registered Nurses sections above for additional information.

Exposure to Heat and Cold

A claim for exposure to heat and cold may be allowable when the exposure is greater than that of the general public. Some examples are sunstroke, sunburn, heat prostration, frostbite, hypothermia and other effects of exposure to heat and cold. These claims are adjudicated as injury, rather than occupational disease, claims. The exposure is generally a one-time, specific incident or occurs over the course of one day. An example would be a roofer spreading hot tar on a 90-degree day and is diagnosed with sunstroke.

Carpal Tunnel Syndrome

This condition involves a compression of or pressure on the median nerve as it passes through an opening at the wrist called the carpal tunnel. The tunnel is a rigid structure formed by the carpal bones and roofed by the thick, transverse carpal ligament. Pressure on the nerve produces weakness and atrophy affecting the thumb, index, middle, and a portion of the ring finger in later stages of the condition. Common symptoms include numbness in the fingers and pain in the palm area that comes on during sleep and awakens the individual. Treatment may include injections, splinting, or surgical division of the transverse carpal ligament to relieve the pressure. The origin of the narrowed tunnel may be congenital, due to thickening of the connective tissue, inflammation secondary to overuse, infection, direct blunt trauma, or it may be idiopathic (without known cause).

Where existence of the condition is contended due to a traumatic event, the claim should be handled as any other injury claim.

In cases where there is no description of an overt injury, the claim manager should request from the attending provider a reasonable anatomical and pathological basis for causal relationship between the worker's condition and his or her occupational activities.

Where a given claim meets the criteria for allowance, as discussed above, the claim should either be allowed specifically as an injury or as an occupational disease.

If the claim for a condition of this nature is to be denied, the failure of the condition to meet the definitions of an injury and an occupational disease should be included in the request for denial.

Thoracic Outlet Syndrome

Thoracic outlet syndrome is a condition that involves a compression or impingement of arteries, veins (vascular), or nerves (neurogenic) between the base of the neck and the armpit. Thoracic outlet syndrome symptoms in the shoulder and arm may include swelling, pain, numbness, or impaired circulation to the extremities (causing discoloration).

Thoracic Outlet Syndrome as an Injury

The most easily identifiable cause of a thoracic outlet syndrome claim is a traumatic incident at work. Examples include:

- A torn scalene muscle from a shoulder seatbelt during a motor vehicle accident. Scar tissue could form in the muscle and compress the nerves and blood vessels

- A direct or crushing blow to the chest or clavicle. A clavicle fracture could decrease the area needed for the vessels to function properly and cause vascular compression.

Thoracic Outlet Syndrome as an Occupational Disease

Thoracic outlet syndrome may be contended as an occupational disease. The compression could result from repetitive or overuse activities. The compression could also result from poor posture. The claim manager should ask the provider if the thoracic outlet syndrome is related to the worker's job duties on a more probable than not basis.

Hemorrhoids

Hemorrhoids are common. Most people will experience them sometime in their lives. Hemorrhoids are enlarged veins in swollen tissue inside the anus. Periodic flare-up of symptoms may be due to irritation or other causes and is generally treated conservatively. A severe case involving a blood clot may require surgery.

Hemorrhoids may be caused by injury. In the absence of direct trauma, a claim contending hemorrhoids caused by lifting or straining is not considered valid unless there is documentation of a preexisting asymptomatic hemorrhoid condition. Preexisting hemorrhoids may be aggravated or lit up by lifting or straining. Without documentation of preexisting hemorrhoids, medical opinion contending a causal relationship to lifting or straining should be questioned.

Epididymitis

The epididymis is a tube-shaped structure contained in the scrotal sack that carries sperm from the testicle to the spermatic duct. Infections of one or both tubes (epididymitis) are common. A claim is allowable when there is evidence of direct trauma to the area or if the infection results from an accepted surgery in a proximate site.

In the absence of direct trauma, a claim contending epididymitis caused by heavy lifting or straining is not considered valid unless there is documentation of a preexisting lower urinary tract infection or prostatitis. When one of these preexisting conditions exists, heavy lifting or straining may force contaminated urine or bacteria-containing secretions into the epididymis and cause epididymitis. Without documentation of these preexisting conditions, medical opinion showing a causal relationship to heavy lifting or straining should be questioned.

Filing an Infectious Disease Claim

RCW 51.36.010, WAC 296-20-03005

A worker who files a claim and seeks treatment for an injury such as a needle stick or laceration has an allowable claim since the incident meets the legal definition of an industrial injury. Since the incident may also have exposed the worker to an infectious disease, the claim should be allowed and any necessary medical treatment should be authorized for both the injury itself and for and post-exposure, preventive treatment.

Infectious disease exposure claims are not allowed if a worker did not suffer an injury or contract an occupational disease as defined by law. When a claim is filed for a probable exposure (e.g., a first responder exposed to meningitis, a nurse splashed with blood or other body fluids, etc.), the claim would be denied but post-exposure testing and treatment should be authorized. If the worker later tests positive for disease, they can complete a new Self-Insurer Accident Report (SIF-2) and file a new claim. Treatment authorization for infectious diseases is covered in the Medical Treatment chapter under Communicable Diseases.

Plantar Fasciitis

The plantar fascia is a broad, fibrous tissue or ligament that extends from the heel bone (calcaneous) to the toes (metatarsals). The purpose of the plantar fascia is to support the arch and stabilize it during normal weight bearing.
Plantar fasciitis is an inflammation of the plantar fascial attachment to the anterior processes of the heel bone. The term “heel-spurs” has been used in the past; however, such spurs may or may

not be present in plantar fasciitis. Plantar fasciitis often presents as a dull, deep, ache-like pain in the plantar surface of the heel.

Plantar fasciitis may be a work-related condition when caused by a specific trauma to the heel (e.g., jumping from a high object). Plantar fasciitis is unlikely to be allowable as an occupational disease when caused by specific walking surfaces (cement floors), long periods of standing or walking, shoe wear, or repetitive foot motion.

Fibromyalgia

Fibromyalgia is not accepted as an industrial injury or occupational disease (*Grant v. Boccia*). Aggravation to a pre-existing fibromyalgia condition will not be accepted as there is no sufficient medical data to establish a causal relationship between an injury or occupational disease and worsening of a pre-existing fibromyalgia condition.
As with other conditions not causally related to the industrial injury, treatment for fibromyalgia may be authorized as an aid to recovery (WAC 296-20-055). Temporary treatment can be authorized when all of the following conditions are met:

- The accepted industrial injury is not stable.
- Fibromyalgia is directly retarding recovery of the accepted condition.
- The required documentation is submitted (see authorization and documentation requirements below).

Treatment as an aid to recovery should not be authorized for longer than 90 calendar days. If the worker has reached maximum recovery from the accepted industrial injury or occupation disease prior to the 90-day period, the fibromyalgia treatment will be terminated at that time.

Treatment Authorization Requirements for Fibromyalgia

The provider must obtain prior authorization for treatment. To request prior authorization, the provider must submit the following in writing to the self-insurer:

- Adequate documentation that the worker's diagnosis of fibromyalgia meets the American College of Rheumatology's (ACR) 1990 Criteria for the Classification of Fibromyalgia.
- An explanation of how fibromyalgia, as an unrelated condition, is affecting the accepted industrial condition, and
- A treatment plan.

When treating an unrelated condition, the attending provider must submit a report every 30 days outlining the effect of the treatment on both the unrelated and the accepted industrial conditions.

Cardiovascular Injuries

The Washington State Supreme Court has determined that a different test should be applied to claims for "heart" injuries than the one applied to the musculoskeletal system described earlier in this chapter.

In *Windust v. Dept. of L&I*, the leading decision in this area, the court held that in order for a "heart attack" or myocardial infarction (MI) to be compensable, it must have resulted from "unusual exertion" on the part of the worker, regardless of the prior condition of that worker's cardiovascular system.

For example, if a worker is normally employed lifting 50-pound bags of feed on a regular basis during the normal work week and that worker suffers myocardial infarction while lifting one of the bags, the condition would not be compensable, even if medically certified as being causally related to that event. If the same worker were to receive a special assignment for one day lifting 100-pound bags of feed and a MI occurred while lifting one, and medical certification of a causal relationship is present, the claim would normally be accepted. If the worker normally lifted the 100-pound bags one day each week, the claim probably would not be accepted.

The court later stated in *Kruse v. Dept. of L&I* that:

> In order to support a claim under the statute, there must be evidence of a sudden and tangible happening of a traumatic nature. The exertion required in the normal routine duties of a job is not, in itself, an injury within the purview of the statute. There must be some unusual strain placed upon the workman by the work he is called upon to perform which is the cause of his injury or death before compensation can be awarded.

To properly adjudicate the claim, the duties of the job for which the worker was hired and the amount of exertion expended on a day-to-day basis to accomplish his/her work must be known. It must be determined whether, on the day the worker collapsed, he/she had engaged in any physical activity on the job which required the expenditure of more exertion than that normally required to accomplish the job. The investigation should include the work duties of the worker's job, how long he/she had been so employed and, specifically, what the worker had been doing on the date of the alleged cardiac injury. If the worker suffered the alleged cardiac injury on the first day or during the first week on a new job, the investigation should include:

- Where the worker was last employed.
- The exact duties of the prior job and the amount of exertion required to perform that job.
- How that exertion compares with the exertion required on the present job.

An extended period of unemployment should be reported.

Do not contact the worker's family unless a claim is filed. Try to get information in as much detail as possible from co-workers, foreman, superintendent, employer, etc. All persons interviewed should be fully identified.

An employee who has no history of a definite traumatic incident will be considered to have possibly died of a cardiac arrest if:

- He/she collapses on the job and dies immediately.
- He/she is dead on arrival at the hospital
- He/she dies after admission to a hospital.

An investigation will establish exactly what happened and specifically what the worker was doing at or shortly prior to the time of collapse. An investigation should be performed as soon as possible while the events prior to the collapse are fresh in the minds of co-workers and available witnesses. (See *Boeing Co. v. Fine, Louderback v. Dept. of L&I*, and *Southerland v. Dept. of L&I* for additional case law.)

Guidelines for Investigation of Cardiovascular Injuries

(1) Describe the worker's physical activities on the job from the time he/she reported for work until the time of the heart attack.

- Was the worker engaged in physical activities beyond those usually required for the job? This should encompass four days prior to the date of the occurrence. Describe this physical activity.
- Did the worker previously engage in the type of activity frequently without symptoms?

(2) Try to get a description of the onset of the worker's pain:

- The bodily distribution.
- The duration.
- Whether any medication was taken to relieve it.
- Whether he/she had this pain before.
- Worker's description of any other type of pain.
- Had the worker had similar discomfort prior to the attack?

(3) Try to get a description of the worker's appearance prior to, during, and after the attack. This can probably be best obtained from co-workers.

- Did he/she appear tired on arrival at work?
- Did he/she describe any feelings of undue fatigue?
- At the onset, did he/she appear pale, sweaty, flushed, clutch at his/her chest, or appear "frozen" in one position?

(4) Get a description of the worker's usual job-related activities including any known daily, weekly, or monthly fluctuation in workload. The employer may have a written job specification.

(5) In describing any unusual activity of the worker prior to the attack, find out what time period and to what degree the physical strain extended.

- How much was lifted – how often and how far?
- How far did he/she climb – ladder, stairs, etc.?
- How far did he/she walk? Was he/she carrying anything? If so, describe the object.
- Describe the work area, including temperature and ventilation, if appropriate. Find out the actual conditions at the time of the heart attack.

(6) Could the worker be described as appearing in the "best of health" prior to the heart attack?

- Determine if the worker was taking any medication. If so, try to learn what type.
- Was the worker overweight?
- Did the worker smoke regularly? How much?
- Did the employer require a physical examination at the time of hire? If so, who performed the exam and on what date?
- Try to learn the worker's eating habits.

(7) What off-the-job activities were involved?

- What sports did he/she participate in and to what degree?
- Was the worker under-active? Chronically inactive off the job?

(8) Had the worker been receiving treatment or medication for any medical condition?

- Heart disease or condition.
- High blood pressure.
- Low blood pressure.
- Diabetes.
- Was he/she under treatment for control other than diet?
- High blood cholesterol levels.

If the worker had been receiving treatment for any of these conditions, obtain the dates, name of provider and/or hospital, etc.

(9) Had the worker been advised to reduce his/her physical activity level?

(10) Did the worker ever complain to co-workers, supervisor, etc., of undue fatigue, chest pain, shortness of breath, or chest constriction after meals or on sudden exposure to cold, either in on-the-job or off-the-job activities?

(11) When the worker was hired, had he/she been under treatment for any type of heart condition?

(12) During the worker's employment, did the employer have any reason to suspect a heart condition? If so, learn why, when, worker's symptoms and appearance, etc.