Washington State Department of Labor & Industries

Miscellaneous Claim Issues

Self-Insurance Claims Adjudication Guidelines

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Claim Closure – Self-Insured Employers' Authority

RCW 51.32.055, WAC 296-15-450

Self-insured employers have the authority to close claims filed on or after August 1, 1997 if:

- The worker returned to work for the same employer at comparable wages and benefits (at least 95% of wages and benefits received at the time of injury),
- No department order has been issued resolving a dispute (a reopening order, or interlocutory order are not considered a dispute), and
- If an IME was obtained for closing medical, it was sent to the attending provider for concurrence and 14 days was allowed for a response.

The self-insurer must send a closing order to the worker and attending provider. The closing orders must be substantially similar to the forms outlined in WAC 296-15-450(5):

- For medical only claims, use a form substantially similar to L&I form F207-020-000.
- For time-loss claims, use a form substantially similar to L&I form F207-070-000.
- For medical only claims with PPD, use a form substantially similar to L&I form F207-165-000.
- For time-loss, or loss of earning power, claims with PPD, use a form substantially similar to L&I form F207-164-000.
- Self-insurer's closure orders become final and binding in 60 days, just like department orders, if there is no protest to the order (as long as the self-insurer had the authority to close the claim).

When requests have been submitted for a department order (interlocutory, allowance, etc.) the self-insurer should not close the claim until the department requested order has been received. This prevents an allowance order from being issued after a self-insured closure order the department was not aware of.

A self-insured employer cannot correct an order once it has been issued. If an error is discovered on an order (e.g., time-loss paid through date; PPD award amount or description; side of body incorrect on PPD order; etc.) before it becomes final and binding, the self-insurer must request cancelation of the order by the department. Closure must then be requested from the department on a completed Claim Closure Request form (F207-216-000) with a copy of the file.

Medical Only Claims

Medical only claim closures must be reported to the department by the end of the month following closure. The self-insured must send a copy of the closing order and the SIF-2 with the date of closure.

Time-Loss Claims

When closing a time-loss claim, the self-insured employer must submit the following to the department (WAC 296-15-450(6)) at the time of closure:

- An SIF-2 if not previously submitted.
- A completed Claim Closure Request form showing all requirements for closure have been met, any time-loss or LEP benefits paid, period of payment, and the total amount of all compensation paid on the claim.
- A copy of the closing order.

Claims with PPD Awards

When closing a claim with a PPD award, the self-insured employer must submit the following to the department (WAC 296-15-450(6)) at the time of closure:

- An SIF-2 if not previously submitted.
- A completed Claim Closure Request form showing all requirements for closure have been met, any time-loss or LEP benefits paid, period of payment, and the total amount of all compensation paid on the claim.
- A copy of the PPD closing order.
- A copy of the PPD payment schedule, substantially similar to L&I form F207-162-000, if the award is being paid by scheduled payments.
    - The first payment (down payment) of the PPD award must be paid within 5 working days of the closure order. Continuing payments must be paid according to the established payment schedule.
    - A copy of the PPD payment schedule must be submitted to the worker so they are aware of the schedule they will be receiving payments.

Self-insured employers cannot issue PPD closing orders that include a segregation of a pre-existing PPD, reduction of a previously paid PPD, or an overpayment. **These orders must be requested from the department.**

Closing orders with PPD awards must use the language as worded on the award schedule or WAC and indicate side of body if applicable.

Examples:

- 2% impairment of the right leg at ankle (syme)
- 12% of the right ring finger at proximal interphalangeal joint
- Category 2 (WAC 296-20-280) permanent dorso-lumbar and/or lumbosacral impairments
- Category 3 (WAC 296-20-260) permanent dorsal area impairments

If the rating is for the full extremity and the injured body part is at a lower level, add "This award is for permanent impairment to the (body part)" language on the closing order.

Claim Closure – Requests to the Department

WAC 296-15-450(7)(8)(9)

When requesting closure from the department, the self-insurer must submit:

- A complete and accurate Claim Closure Request form (F207-216-000).
- A transaction record of all time-loss payments made.
- The complete claim file, excluding bills; all records not previously submitted.

When the appropriate information is not submitted, it will delay closure of the claim.

Questions to Address

Before requesting closure from the department, the following questions should be addressed:

- Medical issues:
  - Were all contended medical conditions addressed?
  - Were all accepted conditions addressed in the closing medical exam?
  - Is there any permanent impairment related to this injury or occupational disease?
  - If an IME was obtained for closure, was the AP asked for concurrence?
  - Has PPD previously been paid, on this claim or another?

- Time-loss/loss of earning power compensation:
    - Have all time-loss/LEP benefits been correctly computed and paid?
    - Have the first three days after the injury been paid?
    - Were health care benefits included or excluded based on the employer's contribution?
    - Were all applicable July 1 cost of living adjustments paid?
    - Have all LEP calculation worksheets been completed, if applicable?
- Vocational issues:
    - Is the worker working or able to work?
    - Have any disputes been resolved?

Department Closures with PPD Awards

When the department closes a claim with a PPD award, the self-insurer must:

- Create a PPD payment schedule, substantially similar to L&I form F207-162-000, if the amount of the award is more than three times the state's average monthly wage at the date of injury. Send a copy to the worker and department at the time of the down payment.
- Make payment of the award, or the first scheduled payment, without delay. Payments issued within 14 days of the department's order will be considered to be timely.
- Continue payments according to the established payment schedule.

Self-Insurer Communication of Department Closing Orders

RCW 51.52.050(1)

When the department has issued an order closing a claim, the self-insurer may communicate the order to any party impacted by the order. This may be indicated if the party had not otherwise received the order (for example, if the worker's copy had been sent to the incorrect address). Service of the order by the self-insurer is considered "communication" for the purposes of filing a protest or appeal under RCW 51.52.060.

Note: If the order had previously been communicated by the department, this communication from the self-insurer does not extend the 60-day timeframe for a party to file a protest or appeal.

If the self-insurer chooses to communicate a department closing, the order must be communicated using a separate, secure, and verifiable nonelectronic means of delivery. It must contain the same information, including protest and appeal rights, as the original department order. The self-insurer's notice should include the following language:

"Enclosed, please find a copy of the department order previously mailed to you that closed this claim. If you disagree with this decision, you must protest or appeal within 60 days of when you first received the order."

Consolidation of Claims

Consolidation is the process of combining two or more claims that are duplicate claims or subsequent claims filed for aggravation.

- A duplicate claim is a second claim filed for the same injury or disease, with the same date of injury, and the same diagnosis or area of the body affected.
- An aggravation claim is a new claim filed for an aggravation to the condition accepted under an established claim, and:
    - There is already an open claim which is symptomatic.
    - The accepted condition in the open claim is susceptible to re-injury.
    - There was no new incident or additional exposure.

Adjudicate as a new claim when:

- Treatment on the new claim is completed, near completion, or palliative; and
- A new specific injury occurred.

Who Can Consolidate

Only the department can consolidate claims. When a new claim is filed with a self-insured employer, the claim must be processed and an order issued to give the party due process (protest and appeal rights). The request for consolidation is handled by the department adjudicator handling the original claim.

Forms and Publications – Substantially Similar

WAC 296-15-001

Several department WACs require the self-insured employers to use forms substantially similar to a form created by the department. WAC 296-15-001 defines substantially similar.

See the department's online Get a Form or Publication to review forms, or request those that are published by the department.

Home and Vehicle Modifications

WAC 296-23-180 requires approval from the assistant director for industrial insurance for home and vehicle modifications. However exceptions have been made in Policies 11.10 and 11.20 that allow a self-insured employer to pay without department approval. Denial of these benefits must be approved by the department.

Home Modifications

RCW 51.36.020(7), WACs 296-14-6200 through 6236, Policy 11.10

A home modification is a permanent structural change to a worker's residence. These may include, but are not limited to changes such as ramps, change in height of counters, widened doorways, and modifications to a primary bathroom.

Medical equipment such as doorknobs and grab bars may be appropriate as part of a home modification. However, the worker does not need a modification to the home to receive medical equipment such as a shower transfer bench.

In order for a worker to qualify for a home modification under RCW 51.36.020(7):

- They must have sustained a catastrophic injury;
- The modification must be proper and necessary; and
- The claim must be open or in a pension status for consideration.

Modifications must be appropriate for the worker's actual functional disability, style of home and level of self-care. Recommendations must meet accessibility standards.

The law allows for payment of up to 100 percent of the state's average annual wage at the time of modification. It should be noted that only **one** residence may be modified or constructed under RCW 51.36.020(7). Later modifications can be considered for the same residence.

Vehicle Modifications

RCW 51.36.020(8), Policy 11.20

A vehicle modification is a change made to a worker's vehicle to facilitate a return to work or to help make the worker as independent and safe as possible. These include, but are not limited to changes such as adapted foot and hand controls, electric lifts, and specialized seats. The worker **must** show proof of ownership of the vehicle to be modified.

Injured workers who have experienced catastrophic injuries in which permanent paralysis or amputation has occurred may be eligible for vehicle modification under RCW 51.36.020(8). In order for a worker to qualify for a vehicle modification:

- The paralysis or amputation must interfere with the worker's ability to operate or be transported in a motor vehicle;
- The modification must be reasonable and necessary; and
- The claim must be open or in a pension status for consideration.

The insurer should obtain a vehicle modification consultation to determine need. A vehicle modification consultation should be conducted by an occupational therapist, physical therapist or licensed medical professional with experience or training in rehabilitation and vehicle modification for people with permanent paralysis or amputation.

A vehicle modification is considered reasonable and necessary when all of the following are true:

- The modification is necessary to meet the worker's needs for safe transportation; and
- The proposed modification will satisfy the necessary transportation needs; and
- The vehicle is mechanically sound (is expected to be operational for at least five more years).

Each vehicle modification cannot exceed 50 percent of the state's average annual wage at the time of modification. An additional $4,000 may be provided over the 50 percent limit.

Regardless of the number of vehicles owned by the worker, vehicle modifications are limited to one vehicle. At such time as the modified vehicle becomes mechanically unsound, further consideration can be given to modification of another vehicle.

The worker may be entitled to multiple modifications of the same vehicle. Where the insurer has already given a worker payment for a vehicle modification, the insurer will consider an additional modification reasonable and necessary only in one of the following situations:

- The worker's functional ability has changed or a new medical condition is allowed, resulting in the need for additional modifications, or

- The original modification needs repair unless it is covered by manufacturer warranty. If the claim is closed, repair or replacement of the original modification may be made without reopening the claim (WAC 296-20-124).

No-Show Fees

RCW 51.32.110, WAC 296-14-410, Policy 13.07

Determining Whether a No-Show Fee is Appropriate

If a worker does not show up for an **insurer-scheduled** examination (e.g., IME, consultation, FCE, rating exam, etc.), the insurer may request an order from the department directing the worker to pay a no-show fee. A no-show fee **may** be requested whether or not claim suspension is requested, although some of the steps may overlap.

Step 1: SEND a letter to the worker immediately after the missed appointment.

The letter should include:

- Acknowledgement that the worker missed the scheduled appointment.

- A request that the worker respond in writing within 30 calendar days from the date of your letter stating their reasons for not attending the examination.

- Notice that benefits may be suspended as a result of the non-cooperation. Reference RCW 51.32.110, and include the specific language related to the worker non-cooperation issue. (See Missed Exam Sample Letter.)

Step 2: REVIEW the response from the worker.

The worker will not be assessed a no-show fee if a refusal to attend a scheduled examination is for any one of the following reasons:

- The department or self-insurer didn't mail notice to the worker and designated representative at least 14 but no more than 60 days prior to the examination. The notice must have contained the date, time and location of the examination.

- The worker is 30 or less minutes late for the appointment and could not be seen by the examiner(s).

- The worker has not been examined or evaluated and leaves after waiting for more than one hour after the scheduled time.

- An unforeseen event occurred prior to the examination that could not be avoided. (See additional examples listed in Non-Cooperation Overview under "Refusal to submit to or obstruction of a medical examination" section.)

- Travel expenses were not paid in advance, if necessary.

Note: If no response was received from the worker, assume the worker doesn't have good cause for the non-cooperative behavior.

Requesting a No-Show Fee from the Department

Step 1: SUBMIT.

A cover letter with "**NO-SHOW FEE REQUEST**" in bold at the top of the page

Or

A No-Show Fee Request Checklist.

Step 2: ATTACH.

Attach all documentation related to the request, including:

- Documentation of the written notice of the appointment.

- A copy of the letter to the worker asking for the reason they did not attend the appointment, along with the worker's response if received.

- Verification of the charge of the no-show fee by the examiner(s). Remember, the no-show fee should be at the department's fee scheduled rate or the amount charged, whichever is less (local codes for IMEs 1111M, 1120M, 1134M, 1139M, 1140M).

The department's adjudicator will review the request and either issue a no-show fee order or send a letter explaining why they cannot support the request for a no-show order.

If the no-show fee is higher than the department's fee schedule rate the adjudicator will make the appropriate adjustments. The no-show order will reflect reimbursement at the fee schedule rate or the charged amount, whichever is less.

Step 3: FOLLOW-UP ACTION by self-insurer/TPA.

After receiving the department's order, take the appropriate action.

Note: The no-show fee cannot be deducted prior to the date of the department order directing reimbursement.

Important: The no-show fee can only be deducted from time-loss benefits and cannot be deducted from other benefits such as PPD or vocational option 2 awards. The no-show fee may be deducted from current or future time-loss benefits for the worker under other claims with the same insurer.

Missed Exam (Sample Letter)

Corresponds with Determining Whether a No-Show Fee is Appropriate, Step 1.

Opening

I've learned you didn't attend your scheduled exam on [Enter date(s) of exam].

Statutory Authority

According to RCW 51.32.110(2), when a worker obstructs or refuses to submit to a medical examination, the department may suspend the worker's benefits, unless the worker can show "good cause" for the obstruction or refusal. Benefits can be suspended until the worker cooperates in full with the examination.

If you don't have good cause, you'll be charged for the missed examination.

Expectations

You must:

- Send a letter by [enter date 30 calendar days] explaining why you missed the examination.
- Call me by [enter date 15 days] so I can arrange a rescheduled examination.
- Attend and cooperate with the rescheduled examination.

If you don't reply, I must conclude you don't have good cause for missing the examination and I will take further action.

Non-Cooperation, Suspension

RCW 51.32.110, WAC 296-14-410

Non-Cooperation Overview

The goal of claim management is worker cooperation with reasonable employer and department requests.

Non-cooperation is a behavior by the worker (or worker's representative) which obstructs and/or delays the department or self-insurer from reaching a timely resolution of the claim.

- Each situation must individually be assessed.
- The SIE/TPA is encouraged to accommodate reasonable requests by the worker or their representative.

RCW 51.32.110(2) limits the reasons for suspending benefits. WAC 296-14-410 further defines non-cooperation as:

- Not attending or cooperating with medical examinations or vocational evaluations requested by the department or self-insurer.
- Failure to keep scheduled appointments or evaluations with attending physician or vocational counselor.
- Engaging in unsanitary or harmful actions that jeopardize or slow recovery.
- Not accepting medical and/or surgical treatment that is considered reasonably essential for recovery from the industrial injury or occupational disease. (This may include a worker continuing to treat with a provider that is not part of the provider network).

Not attending or cooperating with medical examinations or vocational evaluations requested by the department or self-insurer.		
Example	**Good Cause?**	**Recommended Action**
The worker says his wife has a surgical procedure on the date of the examination.	**YES**	Reschedule the exam
Worker attorney claims examiner bias and advises worker not attend. The worker hasn't seen this examiner before and there isn't sufficient medical to resolve the claim.	**NO**	The insurer, after consideration, may either: Reschedule the examination and do both of the following: • Advise the worker in writing that although they were not required to reschedule, they had decided to accommodate them by doing so. • Require the worker to attend the newly scheduled examination. OR Send a letter letting the worker know all of the following, the: • Accusation of examiner bias would not be considered good cause. • Examination wouldn't be rescheduled. • Worker would be expected to attend.
Worker feels they should not have to attend another independent medical examination (IME). They have already gone to 3 IMEs in the last year.	**YES**	Consider canceling the exam if there is already sufficient medical on file to manage and resolve the claim.
Worker claims he doesn't have the money to travel to the IME.	**YES**	If you have advance knowledge of this issue, arrange and provide transportation. If you find out about the transportation problem too late to arrange transportation, the IME will need to be cancelled, rescheduled and travel arrangements made as this would likely be good cause for not attending.
An unforeseen event occurred prior to the examination that could not be avoided.	**YES**	Reschedule the exam.

Per WAC 296-14-410, a worker's refusal to attend a medical examination scheduled by the insurer for any one of the following reasons won't be considered uncooperative:

- The self-insurer didn't mail notice to the worker and designated representative at least 14 but no more than 60 days prior to the examination. The notice must have contained the date, time and location of the examination.

- The worker is 30 or less minutes late for the appointment and could not be seen by the examiner(s).

- The worker has not been examined or evaluated and leaves after waiting for more than one hour after the scheduled time.

Failure to keep scheduled appointments or evaluations with attending provider or vocational counselor		
Example	**Non-Coop?**	**Recommended Action**
The worker is in an approved vocational plan, but continues to miss classes. The worker's non-attendance is affecting their grades and they are not learning the necessary skills.	**YES**	• Send a written warning that continued non-cooperative behavior may result in suspension of benefits. • Follow through with the non-cooperation process if the behavior continues.
Engaging in unsanitary or harmful actions that jeopardize or slow recovery.		
The worker has a 10 pound lifting restriction. There is documentation that shows the worker is repeatedly chopping and stacking wood at home.	**YES**	Physical restrictions apply both at home and work. The worker's actions are jeopardizing recovery and continued lifting beyond capacities could be considered non-cooperative. Send a written warning that continued non-cooperative behavior may result in suspension of benefits.
Worker suffered a broken arm and removed his cast at home after getting wet during showering. The worker returned to the doctor one week later and the bone started to heal incorrectly.	**YES**	Send a written warning that continued non-cooperative behavior may result in suspension of benefits. Be specific about the non-cooperative behavior.

Not accepting medical and/or surgical treatment that is considered reasonably essential for recovery from the industrial injury or occupational disease (this may include a worker continuing to treat with a provider that is not part of the provider network).		
Example	**Non-Coop?**	**Recommended Action**
Worker has refused to go to any of the several network providers in their area and has continued to treat with a provider that is not part of the provider network despite being notified in writing both: • That they must transfer care to a network provider. **And** • How to find a network provider.	**YES**	Send a written warning informing the worker that he or she must get ongoing treatment with a provider in the network: • Include the FindADoc link and your phone number, offering to provide assistance. • Give the worker a reasonable timeframe (for example 2 weeks) to find a network provider and to let you know who their new provider is. • Inform the worker that if he or she doesn't find a network provider and inform you within 2 weeks, it may result in suspension of benefits.
Worker is being treated by a non-network provider that lives 2 miles from their home. Worker lives in small town with no network provider within several miles. Worker is unable to travel due to his injury.	**NO**	This wouldn't be considered noncooperation since circumstances beyond the worker's control prevent care from a network provider.
Worker has rare industrial-related condition that can only be treated by a particular specialist. That doctor does not deal with Labor and Industries often enough to want to join the network.	**NO**	This wouldn't be considered noncooperation since circumstances beyond the worker's control prevent care from a network provider.
Worker isn't attending their physical therapy (PT) appointments. The non-attendance to PT is delaying the worker's recovery.	**YES**	Send the worker a warning letter specifying the behavior that may lead to suspension of benefits.
The worker has missed several physical therapy and vocational appointments.	**YES**	There is a demonstrated pattern of non-cooperation. Make sure the self-insured claim manager has documented the non-cooperative behavior to the claim file and sent the appropriate warning letters listing the specific non-cooperative behaviors.

Steps to Follow Before Requesting a Suspension Order

Remember, the goal of claim management is worker cooperation with reasonable employer and department requests.

Try to resolve any dispute regarding cooperation with the worker (or the worker's representative) by making reasonable requests or accommodations. Acting early informs the worker of your concerns and expectations. Most importantly, acting early may resolve the non-cooperation behavior, which is the ultimate goal.

Step 1: ACT EARLY.

When you **first** notice an issue, call and/or write to the worker to address:

- Concerns.
- Expectations.
- The consequences of non-cooperation (suspension of benefits).

If the worker continues to treat inappropriately with a medical provider that is not part of the medical provider network (MPN), follow-up any phone call with a letter giving them information about how to find a provider that is part of the network. (See Early Action Letters Regarding Medical Provider Network). Document all conversations, phone calls and letters regarding this.

If non-cooperative behavior continues, go to Step 2.

Step 2: SEND A FORMAL LETTER to the worker (or the worker's representative).

In order for the department to consider a suspension request the formal letter must include all of the following:

- An explanation of the problem, including specific actions expected of the worker.
- Reference RCW 51.32.110, and include the specific language related to the worker non-cooperation issue.
- Request that the worker provide the reasons for the non-cooperation.
- Notice that benefits may be suspended as a result of the non-cooperation.
- Inform the worker that per WAC 296-14-410 they have 30 calendar days from the date of the letter to respond in writing to the above request for the reasons for the non-cooperation. (See Formal Non-Cooperative Letter sample.)

Important: If the non-cooperation is due to a **vocational** issue, the letter to the worker must come from the self-insurer or their TPA. The vocational counselor should send a letter as a first effort at getting worker cooperation; however, the formal letter meeting the criteria outlined above must be sent by the self-insurer before requesting an order for suspension of benefits.

Step 3: REVIEW THE RESPONSE received from the worker.

- Determine if the worker has provided good cause for the non-cooperative behavior. (See examples listed in the Non-Cooperation Overview section above.)

- If no response was received from the worker, assume the worker doesn't have good cause for the non-cooperative behavior.

Step 4: DETERMINE whether you will request a partial or complete suspension.

A partial suspension is preferable in most situations because it permits the worker to cooperate with your expectations.

Examples:

- Missed appointments: Suspend only time-loss benefits to allow the worker to cooperate with medical or vocational expectations.

- Missed IME: Suspend only time-loss benefits to allow the worker to cooperate with attending a newly scheduled IME. (For IMEs, also see Determining Whether a No-Show Fee is Appropriate.)

Requesting a Suspension Order from the Department

Step 1: SUBMIT.

A cover letter with "**SUSPENSION REQUEST**" in bold at the top of the page.

Or

A Suspension Request Coversheet.

Step 2: ATTACH.

Attach all documentation related to your suspension request, including:

- Copies of all logged phone calls and/or letters documenting the worker's non-cooperation.

- A copy of the formal non-cooperation letter along with the worker's response if received.

The department's adjudicator will review the request and either issue a suspension order or send a letter explaining why they cannot suspend the claim.

Remember, the department may suspend partial benefits or all benefits depending on the facts of the case.

Step 3: FOLLOW-UP ACTION by self-insurer/TPA.

After receiving the department's order, take the appropriate action.

Note: Benefits cannot be delayed, terminated or suspended prior to the date of the department order.

Ending Claim Suspension

Claim suspension should be lifted if and when the worker begins to cooperate. Send written notice to the department that the worker has cooperated and include the date they began cooperating.

Example:

Worker's claim was suspended for not attending a Psychiatric IME. Later the worker called the insurer and agreed to attend a Psychiatric IME on September 1, 2011. Once the insurer gets confirmation that the worker attended the IME, the insurer should send written notice to the department that the worker's suspension should be lifted effective September 1, 2011.

How to Close a Suspended Claim

There are times when a worker does not cooperate even after the suspension of benefits. Once the suspension order is **final**, move to close the claim. If the suspension is based on a failure to attend an IME, closure may need to be based on the medical in the file. However, prior to requesting closure, ask the attending provider for closing medical.

Send a Claim Closure Request form to the department. Include an explanation that the worker is still not cooperating and the claim should be closed. Send all file documentation that has not previously been sent to the department.

Note: The suspension is lifted once the closure becomes final. A reopening request should be addressed like any other reopening request.

Early Action Letter Regarding Medical Provider Network (Sample Paragraphs)

Corresponds with Steps to Follow Before Requesting a Suspension Order, Step 1: Early Action.

Opening

Thank you for speaking with me on [date of phone call]. This letter is a follow-up to our conversation.

Or,

I attempted to contact you on [date of phone call] at [telephone number] at [time]. I left a voice mail message and requested a call back.

Documentation of Non-Cooperative Behavior

I have noted that you are still treating with a medical provider that is not part of the Medical Provider Network (MPN). Bills for treatment beyond the initial visit will not be paid for non-network providers. Please ask your current provider for a referral or go to https://lni.wa.gov/claims/for-workers/find-a-doctor/ to find a network provider to treat you.

Statutory Authority & Consequences

According to RCW 51.32.110(2), when a worker fails to attend a medical examination or refuses to submit to reasonably essential medical treatment (this may include seeing a provider that is not part of the medical provider network and not authorized to treat per RCW 51.36.010), the department may suspend benefits. This may include time-loss compensation, vocational benefits and/or medical benefits.

Expectations

You will need to transfer care to a medical provider that is part of the Medical Provider Network and notify me of that transfer by [15 days from the date of the letter].

Formal Non-Cooperative Letter (Sample Paragraphs)

Corresponds with Steps to Follow Before Requesting a Suspension Order, Step 2: Send a Formal Letter.

Opening

I noticed you didn't attend your medical appointments on [list missed appointment dates].

Or,

I noticed the examination scheduled for [date of exam] wasn't completed because of your actions. The examiner reported [examiner's description of worker's behavior].

Or,

I have noted that you are continuing to treat with [insert provider's name] who is not part of the Medical Provider Network (MPN) despite being informed that you needed to transfer care to a provider that is part of the MPN.

Or

I noticed [describe the injurious practice].

Or,

I noticed you haven't cooperated with vocational services. Your vocational counselor reports [VRC's description of worker's behavior].

Statutory Authority/Consequences

According to RCW 51.32.110(2), when a worker fails to attend a medical examination or refuses to submit to reasonably essential medical treatment (this may include seeing a provider that is not part of the medical provider network and not authorized to treat injured workers in Washington State per RCW 51.36.010), the department may suspend the worker's benefits, unless the worker can show "good cause" for not attending. Benefits can be suspended until the worker cooperates by attending the examination and submitting to the treatment.

Or,

According to RCW 51.32.110(2), when a worker obstructs or refuses to submit to a medical examination, the department may suspend the worker's benefits, unless the worker can show "good cause" for the obstruction or refusal. Benefits can be suspended until the worker cooperates in full with the examination.

Or,

According to RCW 51.32.110(2), when a worker persists in unsanitary or injurious practices that may delay or inhibit recovery, the department may suspend the workers benefits, unless the worker can show "good cause" for the practices. Benefits can be suspended until the worker ceases the unsanitary or injurious practices.

Or,

According to RCW 51.32.110(2), when a worker fails to attend vocational rehabilitation appointments, or does not cooperate in reasonable efforts at vocational rehabilitation, the department may suspend the worker's benefits, unless the worker can show "good cause" for not attending or failing to cooperate. Benefits can be suspended until the worker cooperates by attending the vocational appointments and participating in vocational rehabilitation.

Expectations:

I'll request the department suspend your benefits for non-cooperation if you don't:

1. Call your provider by [15 days from date of letter] to reschedule.
2. Attend and cooperate with all medical appointments.
3. Send a letter explaining why you missed the appointments listed above.

Or

I'll request the department suspend your benefits for non-cooperation if you don't:

1. Send a letter explaining why you obstructed the examination.
2. Call me by [15 days from date of letter] so I can arrange rescheduling.
3. Attend and cooperate with the rescheduled examination.

Or

I'll request the department suspend your benefits for non-cooperation if you don't:

1. Call your provider by [15 days from the date of this letter] to schedule an appointment to discuss how to change your behavior to aid your recovery.
2. Send a letter explaining your reason for [describe the injurious practice].

I'll need to review the treatment plan you and your provider agree upon to decide if benefits should continue.

Or

I'll request the department suspend your benefits for non-cooperation if you don't:

1. Transfer your care to a medical provider that is part of the MPN within [15 days from the date of this letter].

2. Send a letter to me confirming that you have transferred your medical to a network provider and giving me their name, address and the date of your first appointment with them.

Or

I'll request the department suspend your benefits for non-cooperation if you don't:

1. Call your vocational counselor [15 days from date of letter] to discuss what you need to do.

2. Send a letter explaining why you haven't cooperated with vocational services.

Decision:

I must receive your letter by [30 days from date of letter]. Once I receive your response, I'll decide if you had good cause for your non-cooperation. If you do not respond in writing I'll assume you do not have good cause and will move forward with requesting suspension from the department.

Overpayments

RCW 51.32.240, WAC 296.14.200, Policy 2.81

Self-insurers can assess overpayments in accordance with RCW 51.32.240. Overpayments can be recovered from:

- Time-loss benefits.
- Loss of earning power benefits.
- Permanent partial disability awards.
- Vocational option 2 awards.
- Total permanent disability benefits.

Within five days of knowledge of the overpayment, the self-insured employer must notify the worker using the Assessment of Overpayment template (WAC 296-15-425). The worker must be notified in writing within one year of the date of the incorrect payment; otherwise the overpayment will be deemed waived.

> **Exception:** There is no time limitation on an overpayment assessed for provisional benefits paid on a claim that was later denied.

A self-insurer does not need an order and notice to recover an overpayment. However, in order to obtain a lien from a county clerk, the self-insurer must have an overpayment order from the department. To request an overpayment order, submit a completed Overpayment Request form to the department with proof of payment.

If an overpayment order is requested and is related to a time-loss rate error, a wage order will be needed before the overpayment can be addressed.

Consider equity and good conscience when determining how much of the overpayment will be deducted from future benefits. Ongoing benefits should generally be reduced by no more than 25% of the payment. If there are not adequate anticipated payments to cover the overpayment, a higher percentage can be assessed. The full amount of an overpayment may be deducted from a PPD award.

If a recovery of an overpayment causes a hardship to the worker, the worker may request a waiver of the overpayment. The worker's request must be in writing. The director may exercise his or her discretion to waive, in whole or in part, the amount of any overpayment where the recovery would be against equity and good conscience.

See Payment of Benefits During Protest and Appeal regarding Recovery of Overpayments in the Protests and Appeals guidelines.

Releasing Claim File Information

RCW 51.28.070

The information contained in claim files is deemed to be confidential and is not "open to public inspection," except to public employees who are in the performance of their official duties. WAC 296-15-350(1) requires self-insurers to establish procedures for securing the confidentiality of claim information.

Several exceptions to this rule of confidentiality are identified within the statute:

- Representative of a worker: A lay or legal representative of the worker may review a claim upon receipt of a written authorization signed by the worker.
- Workers: A worker may review their own claim file if the director determines, pursuant to criteria adopted by rule that the review is in the worker's best interest.
- Employers: Employers or their duly authorized representatives may review any claims of their own workers as long as there is a claim pending with the requesting employer.
- Physicians treating/examining: A worker's claim may be sent to physicians involved in the evaluation or treatment of a worker.
- Other persons rendering assistance to the department: This covers other situations at the department's discretion when such persons are rendering assistance to the department at any state or any matter pertaining to the administration of the title.

Effective July 28, 2019, the department may assess a civil penalty of $1,000.00 per occurrence if an employer or their representative reveals confidential information in a claim file to any person other than a duly authorized representative.

Confidentially of Sexually Transmitted Diseases (STDs)

RCW 70.24.105

An STD is defined as a bacterial, viral, fungal or parasitic disease or condition usually transmitted through sexual contact. Stricter confidential safeguards regarding the release of STD information are required than usually apply to claims. A general authorization to release claims information is not adequate for STD information; a separate and special release form should be used.

File Requests

RCW 51.32.195, WAC 296-15-420

A self-insured employer must provide a complete copy of a claim file, or specific information from a claim file:

- Within 10 working days of receipt of the department's request by certified mail.

- Within 15 calendar days of receiving a written request from the worker or worker's representative.

If a self-insured employer determines that release of all or part of a claim file may not be in the worker's interest, the self-insured employer must submit a request to the department's Self-Insurance Section to deny the file request by order and notice. The request must be sent to the department, along with a copy of that portion of the claim, within 20 calendar days of receipt of the worker's request (WAC 296-14-970).

A claim file contains all information obtained or prepared by the department, self-insured employer, and /or the self-insured employer's third party administrator (TPA) concerning an individual worker's claim for industrial insurance benefits.

In their claim file request, an injured worker, their representative, or the department can specifically ask for any of the following information. An unspecified request for a claim file must include, but is not limited to, **ALL** of the following:

- Information gathered to evaluate an application for benefits and to initiate, report or provide benefits on the claim including:

    - Forms used to collect or provide information.

    - Incident reports and worker or witness interviews.

- Medical records and reports, including all records related to all independent medical examinations (IMEs) or consultations, all nurse case management notes and reports, and the records of an employer's on-site medical facilities.

- Documentation of vocational and return to work activities provided on the claim, including all reports, plans, and supporting documentation provided by a vocational professional.

- Records of all activities completed on the claim; any communication, including electronic, whether phone notes, logs, or other like records.

- Incoming or outgoing correspondence regarding the claim, including both original and translated versions when applicable.

- Orders and determinations issued on the claim.

- Employer payroll records, worker earning information and other documentation required or obtained to determine the worker's wages under RCW 51.08.178.

- Records of time-loss, loss of earning power, kept-on-salary, and permanent partial disability calculations and payments made.

- Records of bills received on the claim and all action taken on the bill. These records must reflect whether the bill was paid, denied, or adjusted and on what date. Bill records are part of the claim file but need to be provided **only if specifically requested**.

Information that is inadvertently included in a file through administrative or clerical error is not part of the claim file and may be removed (e.g., medical reports, etc. from another worker's claim, which were misfiled).

Third Party Actions

RCW 51.04.010, RCW 51.24

Although workers cannot sue their employer or coworkers due to work injuries, the law allows them to sue other third parties for damages. A "third party" is any person or company responsible for the injury that is not the injured worker's employer or co-worker. Injuries or diseases caused by the failure of a product or machine or by someone not employed by the worker's employer are considered third party claims.

Workers injured by a third party remain entitled to workers' compensation benefits, but the self-insured employer may obtain a lien against the third party recovery for the benefits it pays as part of the claim. The department's Third Party Section handles the recovery aspects of these claims. For questions on third party claims, call 360-902-5100.

Right of Election

RCW 51.24.070, RCW 51.24.080

The injured worker must choose to pursue damages against the third party, or assign that right to the self-insured employer. The self-insured employer must serve the worker with a written election demand by registered or certified mail, or personal service. If an election is not made within 60 days of the demand, the action is deemed assigned to the self-insured employer to pursue the claim.

Where a worker is involved in an automobile accident, is bitten by an animal, or assaulted, the potential of third party liability is fairly obvious, and identification should be routine. Less obvious, however, are cases involving possible product liability (e.g., machine failure, asbestos exposure), medical malpractice, explosions, etc. Additional information may have to be gathered in such cases to determine if tort liability exists.

Action on Self-Insured Claim

WAC 296-15-495

All third party recoveries must be confirmed by department order. When there is third party action on a claim, the self-insurer must send the department copies of:

- Written indication of the worker's election upon notification.
- After recovery of damages:
    - Signed settlement agreement or court order,
    - Total amount of attorney fees and costs, and
    - Total amount of benefits paid, including time-loss, PPD, and medical excluding payments for IMEs.

Deficient Recovery

RCW 51.24.090

Any settlement of the third party cause of action by the injured worker or beneficiary which results in less than the entitlement (benefits paid on a closed claim and benefits paid and estimated to be paid on an open claim) is void unless it is made with the written approval of the self-insurer. This is important in light of *Tobin v. Dept. of L&I*, which held that the portion of the settlement allocated to pain and suffering is not subject to the lien. If the net recovery after pain and suffering allocation is less than the entitlement, the settlement is void unless the self-insured employer gives written approval.

The self-insured employer remains obligated to adjudicate and pay all claim benefits despite a deficient recovery.

Excess Recovery

RCW 51.24.050, RCW 51.24.060, WAC 296-20-023

In the event a recovery exceeds the current claim expenses (including PPD and/or TPD benefits), the self-insurer's obligation to pay claim benefits is transferred to the worker, who must pay all claim benefits from the excess portion of the third party recovery.

The worker should be advised to maintain a record of such expenses. In addition, all medical bills should be submitted for self-insured employer adjudication so that the worker can benefit from the medical fee schedule and receive credit towards the excess recovery balance. Disability certification for any periods of temporary total disability (TTD) should be submitted to credit the excess balance. The self-insurer's obligation to pay claim benefits resumes once the worker has expended the "excess recovery" on claim benefits.

Travel Expenses

WAC 296-20-1103 defines the requirements for reimbursement of workers' travel expenses.

Prior authorization is not required for travel expenses for:

- Insurer-requested examinations.

- Vocational services.

  Exception: During Vocational Retraining, travel reimbursement must be authorized as part of the approved vocational retraining plan.

- Prosthetic or orthotic fittings or replacements.

Prior authorization is required when the worker must travel more than 15 miles one-way from the worker's home to the nearest point of adequate treatment. Travel expense *is not* payable when adequate treatment is available within 15 miles of injured worker's home, yet the injured worker prefers to report to an attending provider outside the worker's home area.

When travel expense is authorized for necessary treatment, the first 15 miles one-way are not payable. The first and last 15 miles are not payable on an authorized round trip.

Insurer-requested examinations and approved vocational services or retraining are **not** subject to the deduction for the first and last 15 miles.

Nearest Point of Adequate Treatment

RCW 51.36.010(2)(a) and (b) allows the worker to choose their attending provider (AP).

Travel is reimbursable with prior authorization (WAC 296-20-1103) when the worker must travel more than 15 miles one way from their home to the nearest point of adequate treatment. Travel is not reimbursable when there is adequate treatment available within 15 miles of the worker's home.

Adequate treatment means at least two (to allow a choice) L&I-approved providers with the same specialty, available to treat.

- If there is only one L&I approved provider available within 15 miles of the worker's home, and the worker doesn't choose to see that provider, travel is payable to the nearest point of adequate treatment (minus the first and last 15 round trip miles).

- When adequate treatment is available within 15 miles of the worker's home but the worker chooses to see a provider beyond 15 miles of their home, travel expenses are not payable.

- When the nearest point of adequate treatment available is 20 miles from the worker's home, but the worker chooses to see a provider 25 miles from their home, the insurer will only pay travel for 5 miles each way. The first and last 15 miles of a round trip aren't payable. The worker is responsible for the extra mileage beyond the nearest point of adequate treatment.

Worker Requirements

Workers must pay their travel expenses and then submit travel reimbursement requests to the insurer. Receipts are required for all medical travel expenses, and for parking expenses over $10.

The insurer must receive the worker's travel reimbursement request within one year after the date of the travel (WAC 296-20-1103). Workers can obtain travel reimbursement request forms from several sources including the department, and vocational or medical providers.

The worker must submit:

- The correct, completed travel reimbursement request form.
    - For Independent Medical Examination (IME) travel, the IME Travel & Wage Reimbursement Request found in *Your Independent Medical Exam for Employees of Self-Insured Businesses* is the correct form. Only the worker needs to sign this travel reimbursement request.
    - For all other travel, the Travel Reimbursement Request is the correct form. Both the worker and the medical or vocational provider must sign this travel reimbursement request.
- Receipts for:
    - Food.
    - Lodging.
    - Fares.
    - Parking expenses over $10.

    Exception: When the insurer provides vouchers for lodging or fares, the lodging or fare provider will bill the insurer.

The worker must complete travel reimbursement requests. The insurer may return incorrect or incomplete forms to the worker for completion if, for example, it needs a signature from the medical or vocational provider verifying each date traveled.

Companion travel – Companion travel must be preauthorized. When it is medically necessary for a companion to participate in the worker's treatment or provide travel assistance, the insurer will reimburse the travel expenses for both. The worker must submit the travel reimbursement request covering both people.

Payment Rates

Mileage – Privately Owned Vehicle mileage is paid at the appropriate state of Washington rate found at the Office of Financial Management web site.

Lodging & meals – Rates for lodging and/or meals within the contiguous 48 states are found at the U.S. General Services Administration website. From this web site, you may also access the rates for Alaska, Hawaii, U.S. Territories and Possessions, and foreign countries.

- The maximum meal rate amounts for the contiguous 48 states include taxes, tips, and incidental expenses.
- The maximum lodging rate amounts for the contiguous 48 states don't include the applicable, payable, state and local taxes.

Parking, storage, ferry, tolls – Parking, vehicle storage, ferry, and bridge tolls, are reimbursable for authorized travel. Receipts are required for parking expenses over $10.

Taxi/cabulance/bus/commuter train fare – Public transportation is payable for authorized travel to treatment over 15 miles away from the worker's home.

Airfare – Airfare is payable for preauthorized long distance travel.

Travel-Related Expenses Not Payable

In addition to travel-related expenses in excess of the state rate, the insurer doesn't pay for:

- Car purchase, lease, licensing (car or driver), insurance, repair, or maintenance.
- Child care services or travel to child care services unless authorized as part of an approved vocational retraining plan.
- Travel on closed claims, except:
    - When the insurer asks the worker to attend a medical or vocational evaluation.
    - For travel dates on or after June 12, 2008, for repair, replacement, or alteration of insurer provided prosthetics, orthotics, or other similar permanent mechanical appliances (except hearing aids) (RCW 51.36.020(5)(b)).

Worker Address Changes

Workers should be encouraged to notify the self-insured employer and the department of any address changes as soon as possible to prevent any delay in benefits. It is important for both to have current address information for the proper communication of order and notices.

The law does not prohibit a representative of the worker from reviewing the file, or discussing the case with staff. A written request from the worker is mandatory.

Change of Address to an Attorney

RCW 51.04.080

A written request from the worker is required to change their mailing address to a representative's office. This may be a letter or even an appeal notice signed by the worker.

The worker must make an address change request in writing if they want their address changed to another legal firm, or back to their regular mailing address.

When a worker applies to reopen a claim following a final closure and the address on the reopening application is not the address of the worker's representative, the representative's address is removed and the mailing address from the reopening application is used on the claim.

Penalty Matrix

Per WAC 296-15-266: In deciding whether to assess a penalty, the department will consider only the underlying record and supporting documents at the time of the request which will include documents listed in (2)(a) and (b), if timely available, to determine if the alleged untimely benefit was appropriately requested and if the employer timely responded.

Under RCW 51.48.017, the department's time-frame for determining a penalty is "within" 30 days of the worker's request.

Benefit Type	Section of WAC 296-15-266	Related Statute/WAC	Time Frames
Time-Loss (TL) 1st payment (Includes provisional)	(1)(a)(i), (1)(a)(ii), (1)(e)	RCW 51.32.190(3)	Within 14 days
TL ongoing (Includes provisional)	(1)(a)(i), (1)(a)(ii), (1)(e)	RCW 51.32.190(3)	Bi-weekly or Semi-monthly
Time-loss for newly contended condition	(1)(a)(iii), (1)(e)	WAC 296-15-266	If there is no ongoing payment of TL, within 30 days of receipt of written notice of the newly contended condition, the SIE must request that the department settle the dispute regarding TL.

Benefit Type	Section of WAC 296-15-266	Related Statute/WAC	Time Frames
Time-loss for newly contended condition – Good cause extension	(1)(a)(iii)	WAC 296-15-266	For good cause, in the department's sole discretion, a sixty-day extension may be granted. The factors the department will consider in determining whether good cause exists for an extension are: • An exam is needed in a specialized field, provider availability • Prior medical records have not been received • Specialized testing or diagnostics, availability
Loss of Earning Power (LEP)	(1)(b), (1)(e)	RCW 51.32.090(3)(a)	Bi-weekly or Semi-monthly
Permanent Partial Disability (PPD) Award Department closed	(1)(b), (1)(e)	WAC 296-15-450(9)	14 days
PPD closure by self-insurer	(1)(b), (1)(e)	WAC 296-15-450(6)(B)	5 working days
Medical bills prior to claim allowance	(1)(c), (1)(e)	WAC 296-20-124(1)	Initial exam and diagnostic services; pay within 60 days of receipt of a proper bill.* Initial exam and authorized diagnostics are paid regardless if claim allowed or denied.
Medical authorizations prior to claim allowance	(1)(c), (1)(e)	WAC 296-20-124(1)	Initial exam and diagnostic services carried out at the specific request of the department or SIE; within 60 days of receipt of a proper bill* as authorized diagnostics are paid regardless if claim allowed or denied.
Medical bills after claim allowance	(1)(c), (1)(c)(i), (1)(c)(ii), (1)(e)	RCW 51.36.080 WAC 296-20-125 through 296-20-17004	Pay within 60 days of receipt of a proper bill. Within 30 days of receiving written notice of a dispute, SIE must forward to the department.
Payment of medical treatment benefits; newly contended conditions after claim allowance	(1)(c), (1)(c)(i), (1)(c)(ii), (1)(e)	WAC 296-20-125 through WAC 296-20-17004	Pay or deny within 60 days of receipt of a proper bill. Within 30 days of receiving a dispute to the denial of a bill for new condition, SIE must forward dispute to the department.

Benefit Type	Section of WAC 296-15-266	Related Statute/WAC	Time Frames
Emergent medical	(1)(d), (1)(d)(i), (1)(d)(ii), (1)(e)	WAC 296-20-01002 RCW 51.36.020(1)	Respond within 14 days after receiving written notice of treatment.
Paying benefits during appeal	(1)(f), (1)(e)	RCW 51.52.050(2)(b)	Pay benefits until the BIIA grants a stay or the department reassumes the order which places the order in abeyance.

Note: Department orders directing benefits and protests to a department order are addressed in the Pay During Appeal Matrix and covered by RCW 51.52.050(2)(b). If a department order has not been issued, the department will issue an order determining an unreasonable delay of benefits has occurred based on the merits.

*Proper bill is defined by WAC 296-20-125.

Stipulations

Stipulations are conditions or agreements put in writing, signed and made in conjunction with requests for claim closure. They may include requests for segregation or acceptance of conditions, permanent partial disability awards, etc.. Self-Insurance will only take action on stipulation requests that meet the following conditions:

- The worker must be represented.
- The stipulation request must be accompanied by a completed Stipulation Coversheet.
- The signed stipulation should include only the actions being requested.
- Medical documentation or declaration supporting all medical aspects of the agreement is included.
- A completed SIF-2 must be attached, if not previously submitted to the claim file.