Washington State Department of Labor & Industries

Reopening

Self-Insurance Claims Adjudication Guidelines

Reopening Authority

RCW 51.32.160, WAC 296-14-400

When the worker makes application, the department has the authority to reopen injury or occupational disease claims within 7 years from the date the first closing order was final. The 7-year limitation does not apply to those claims closed without medical recommendation, advice or examination. The time limitation is 10 years for claims involving the eyes. (See Reopening Applications on Claims Closed Over 7 Years for additional information on over 7 reopening applications.)

The department has sole authority to determine whether claims will be reopened. The department will issue an order and notice with the decision.

Timeframes for Department Action

Determination in 90 Days—Deemed Granted

RCW 51.32.160, WAC 296-14-400

Applications for reopening are deemed granted if the department does not issue a decision within **90 days of receipt** by the self-insurer or department. The department may extend the time for making a determination for an additional 60 days if good cause is established. Good cause may include, but is not limited to the following:

- The department has not received requested information from the medical provider.
- Inability to schedule a necessary examination within the 90 day period.
- Additional time is needed to receive the examination report.
- Legitimate failure of the worker to appear for a medical examination.

If a valid reason is not established to extend the 90 day limit, a decision will be made based on the information available.

An order granting reopening does not stop the 90-day timeframe if a protest is received. If a timely protest is received to a department order reopening the claim, the department must still issue a final order within 90 days or the extended period. If a final order is not issued within the statutory time limit, the reopening will be deemed granted (*In re Raymond W. Belden*, BIIA Dec., 12 14005 (2013)).

Timeframes for Self-Insured Employers

Employer Timeframes for Sending Applications to Reopen a Claim to the Department

WAC 296-15-470

A self-insured employer must forward an application to reopen a claim to the department within five working days of receipt.

What is a Reopening Application?

Formal vs. Informal Applications

The worker must file a written application to reopen a claim. The statute does not require it to be on the department's formal application form. A written application from the worker, **in any format**, will constitute a request for reopening. A reopening application may be either:

- The department's formal application for reopening, sufficiently completed and accompanied by medical findings.
    - The application must be completed by both the worker and the medical provider. **The provider does not need to be in the department's Medical Provider Network.** However, a non-network provider cannot provide treatment.
- An informal written request (such as a letter from the worker) accompanied by medical substantiation of an aggravation of the condition.

If the self-insured employer receives a request for reopening from the worker or medical on a closed claim, they must forward it to the department within five working days of receipt.

Reopening Request Without Medical

If the department receives a letter from the worker requesting reopening without a medical report, the department adjudicator will send the worker:

- A reopening application.
- A letter explaining that they must provide the required medical information within 60 days or the department will deny the reopening.

The 90 day clock for determination begins to run from the date the department or self-insured employer received the worker's letter requesting reopening.

If the worker does not provide the required information, the department adjudicator will issue an order and notice denying the reopening for the reason: no medical documentation has been provided to the department as required by law.

Medical Information Without a Reopening Request

If the department receives medical information on a final and binding closed claim without a reopening request from the worker, the department adjudicator will send the worker:

- A reopening application, and
- A letter explaining, if reopening is being requested, the required information must be returned within 60 days or the department will deny the request.

If the worker does not return the required information, the department adjudicator will issue an order and notice denying reopening for the reason: no application for reopening has been made to the department by the worker as required by law.

If the department or self-insured employer receives medical information within 60 days of a closing order, showing treatment after the closure date, it should be treated as a protest to the closing order.

Reopening Application Received on the Wrong Claim Number

If the department receives a reopening application filed under the wrong claim number the application will be denied. A letter will be sent explaining that the reopening will be considered under the proper claim number.

The 90 day clock begins to run from the date the reopening denial order and notice was issued under the incorrect claim number.

If the department reopens the claim, the reopening effective date can be no earlier than 60 days before the application was received under the incorrect claim number.

Exception: When a reopening application is filed under a claim for the wrong injured worker, the department will not issue a denial order and notice. Rather, the department will send a letter explaining that the reopening will be considered under the correct claim number.

Aggravation

Definition

Aggravation is objective worsening of the worker's industrially related condition since the claim was last closed or ordered to remain closed (either by an affirming order or a reopening denial order). Demonstrated aggravation of an industrial related condition is required to reopen a claim.

Determination of Aggravation

Criteria needed to prove aggravation:

- A causal relationship between the accepted condition at the time of closure and the current condition.
- Medical opinion that the condition has worsened.
- Objective medical findings to substantiate the medical opinion.

Steps for determining aggravation:

When determining if a claim should be reopened, the department adjudicator will compare the worker's current medical condition to the condition at closure. They will consider the provider's opinion, particularly, if it is the same provider who treated the worker at the time of closure. If necessary, the department may:

- Provide a closing report to the provider asking for an opinion regarding objective worsening, or
- Authorize recommended diagnostic testing, or
- Obtain an independent medical examination or utilize a telemedicine IME, if appropriate.

Note: For more information on telemedicine, see Independent Medical Examinations under Medical Treatment

Newly Contended Conditions

A worker may file a reopening application solely for a condition not previously accepted on the claim or for a worsening of an accepted condition and contend a new condition.

When a worker contends a medical condition, unrelated to the injury, the department adjudicator will address segregation of the unrelated condition when issuing an order, denying reopening. There must be medical opinion to support the segregation.

Aggravation Resolved

Sometimes, an aggravated condition returns to baseline prior to issuance of a reopening order. The aggravated condition may have reached the point where no evidence of aggravation exists and the worker's condition has returned to the previous level of disability.

If the department adjudicator determines this situation exists, they will reopen the claim to cover any appropriate treatment and/or period of time-loss certification.

Reopening Effective Date

RCW 51.28.040, WAC 296-20-097

The department has the authority to reopen a claim **up to 60 days** prior to the receipt of an application. However under the RCW it can be reopened **up to 120 days** if certain criteria are met. Those criteria are:

- The application was not received by the department or self-insurer within 60 days of medical services, due to a failure of the treating provider to timely complete or submit the provider information section of the application; AND
- The worker demonstrates that their information section was completed and submitted via certified mail or electronic verification of receipt to the department, self-insurer, or the treating provider within 30 days of medical services.

The effective date of reopening cannot be before the date of first treatment. No medical or disability benefits will be paid before the reopening effective date.

Aggravation or New Injury/Exposure

Aggravation or New Injury on Closed Claims with No PPD

Sometimes a worker may apply for reopening of a claim after suffering an aggravation resulting from an activity or a new injury. The department adjudicator must make a determination as to whether or not the original injury is responsible for the aggravation.

The department adjudicator considers the opinion of the attending or examining provider, regarding the causal relationship, together with the reasonableness of the sequence of events described. As a general rule, where a specific traumatic injury is established after claim closure without permanent partial disability, the application should be denied. However, if the new injury occurred in the course of employment, the department will notify the worker that they should file a new claim.

Non Work-Related Aggravation on PPD Claims

If a worker's claim was closed with a PPD award, and they later request reopening based on a non-work aggravation, an additional test is applied' An off the job injury could constitute reopening of the claim. The following is from a decision of the Washington State Supreme Court:

> "Aggravation of the worker's condition caused by the ordinary incidents of living – by work which he could be expected to do; by sports or activities in which he could be expected to participate – is compensable because it is attributable to the conditions caused by the original injury."

The test to be applied, in cases such as the present, is whether the activity which caused the aggravation is something the claimant might reasonably be expected to be doing, or whether it is something that one with his disability would not reasonably be expected to be doing."
In a subsequent ruling in the same case, the court further held that the degree of disability present in determining whether the activity is a "reasonable" one is the department-established percentage rather than the "worker's subjective personally known condition" (*McDougle v. Dept. of L&I*).

New Exposure – Occupational Disease Claims

When a worker files a reopening application on an occupational disease claim, the department must determine if the original exposure is responsible for the aggravation or if there has been a new exposure.
The adjudicator must determine if the worker returned to the job of injury, or another job with similar job duties, and the additional exposure caused the present condition. In general, if the worker has returned to work and the repetition of job duties caused the aggravation, the worker should file a new claim. If there was no new exposure, the department will apply the same criteria used on an injury claim to determine if there was an aggravation to the original condition.

Reopening Applications on Appeals Claims

The department has no authority to make a reopening determination when the closing order or denial of a reopening application is on appeal at the Board or Court (*Reid v. Dept. of L&I*). If this occurs, the department will send a letter to the worker informing them that the department will not take action on the reopening application until the appeal is resolved.

The 90 day clock begins to run from the date of the Board or Court decision or judgment.

Payment of Benefits

Medical Services

WAC 296-20-097

The Medical Aid Rules allow payment to the medical provider who examines the worker and assists in filing a reopening application. The examination and necessary diagnostic tests are paid for, whether or not the claim is reopened. Treatment for the condition will not be covered unless the claim is reopened.

Provisional Time-Loss/LEP

RCW 51.32.210, RCW 51.32.240

Provisional time-loss or LEP benefits will be paid if medical certification is received. **This does not apply to reopening applications received on claims closed over 7 years**.

Guidelines to remember when considering provisional time-loss or LEP benefits are:

- The self-insurer must pay provisional benefits within 14 days of receipt of medical certification.
- Provisional benefits are not paid for dates prior to receipt of the reopening application. If the claim is reopened then benefits are payable from the reopening effective date.
- Provisional benefits are only paid for conditions accepted under the claim prior to closure. If new conditions are accepted when the claim is reopened, benefits are then payable for those conditions.

When reopening is denied and provisional time-loss or LEP benefits have been paid, the self-insurer can assess an overpayment. Overpayments can be offset against future benefits the injured worker may receive.

Reopening Applications on Claims Closed Over 7 Years

RCW 51.32.160

Medical Benefits

Claims closed over 7 years (10 years for eye claims) can be reopened any time for medical benefits using the same criteria that applies to claims closed under 7 years. If the claim does not meet the criteria for reopening, the department will issue an order and notice denying the reopening. If the claim can be reopened the department will issue an over 7 reopening order and notice for medical benefits.

Disability Benefits – Director's Discretion

Provisional time-loss or LEP benefits are not ordinarily payable on an over 7 reopening. However, the director has discretion to grant disability benefits (time-loss, LEP, vocational services, PPD and total permanent disability) on over 7 year reopening requests. Workers can contend disability benefits at any time during the reopening process or after the claim has been reopened.

If disability benefits are contended on an over 7 reopening, the adjudicator will prepare a briefing paper for the director's consideration. Upon approval, or denial, of benefits by the director, the department will issue an order and notice addressing disability benefits.

Determining the 7 Year Time Limit

The department must determine if reopening was received more than 7 years after the first medically documented closure or reopening denial became final. The 7 year time limit begins with a medically recommended closure or reopening denial. The date the order became final is determined by:

- Counting 7 years plus 60 days from the closing order if no protest or appeal was filed; or
- Counting 7 years plus 60 days from the affirm order if no appeal was filed; or
- Counting 7 years from the date of the last Board or court decision or judgment if the closing was appealed.

An application for reopening where a claim was closed without medical opinion is not subject to the 7 year time limit.

Examples of Calculating Over 7 Reopening

By provisions of statute, the date of first closure for claims closed between July 1, 1981 and July 1, 1985 shall be July 1, 1985.

First closing order became final prior to July 1, 1981

1.	First claim closure	June 1, 1979	Without medical (no protest or appeal)
	Claim reopened	May 1, 2007	

The 7 year reopening limitation has run on this claim because the first closure was prior to July 1, 1981. Because the closure was prior to July 1, 1981, it doesn't matter whether the claim was closed with or without medical documentation.

Closing orders with medical

2.	First claim closure	May 2, 1997	With medical (no protest or appeal)
	Claim reopened	July 2, 2005	

The closure was final July 1, 1997. The 7 year reopening limitation began to run on May 2, 1997, plus 60 days, because the closure wasn't appealed.

3.	First claim closure	January 7, 1993	With medical (protested)
	Closure affirmed	March 25, 1993	(No protest or appeal)
	Claim reopened	February 8, 2002	

The closure was final May 24, 1993. The 7 year reopening limitation began to run on March 25, 1993, plus 60 days, because the affirmation of the closure was not appealed.

4.	First claim closure	September 1, 1995	With medical (protested)
	Closure affirmed	December 3, 1995	(Appealed)
	BIIA upholds closure	April 7, 1996	(Appealed)
	Superior Court upholds closure	November 15, 1996	
	Claim reopened	April 14, 2005	

The closure was final as of the date of the Superior Court order, November 15, 1996. The 7 year reopening limitation began to run on that date.

Reopening denials with medical

5.	First claim closure	August 1, 1988	Without medical
	Reopening denial	May 1, 1992	With medical (no protest or appeal)

The reopening denial was final on June 30, 1992. The 7 year clock began to run on May 1, 1992, plus 60 days, because the first closure was not medically supported, and the reopening denial was not protested or appealed.