Washington State Department of
Labor & Industries

Self-Insurance Training Presents:

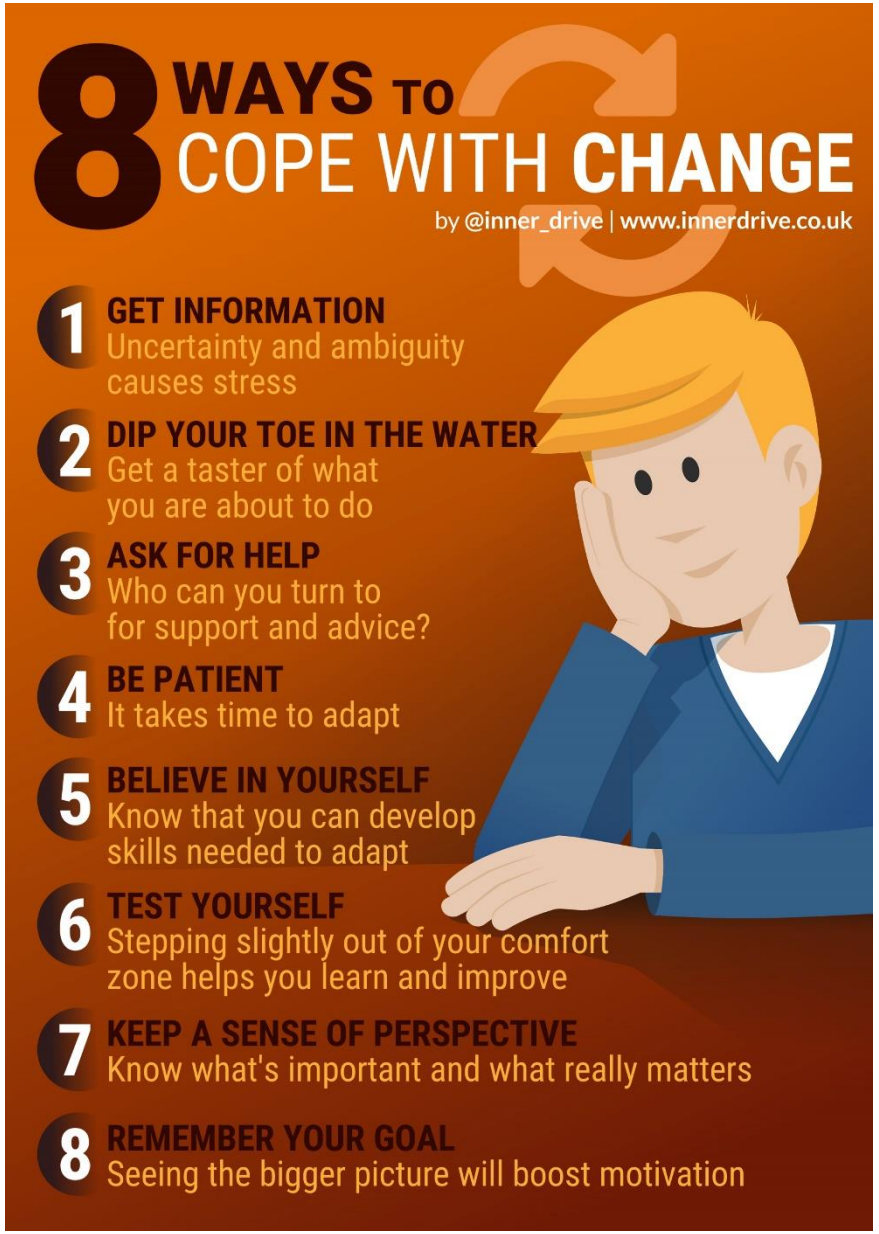
Claim Process Project Implementation Overview

2025 Training

Housekeeping

- Calling in?
  - Please put your name and phone number in the Q&A
- Certification renewing soon?
  - Double check your SICATS credits
  - Continuing Education/Certification renewal questions SIContEdu@LNI.WA.GOV
- Course ID?
  - Will be provided at the end of training.

Safety Topic



Claim Allowance Requests

- The department may request additional information if:
  - The CAR was not complete
  - The DOI/DOM cannot be confirmed
- The department will only make one request for information.

Interlocutory Requests

- If Prima Facie met, Issue Allowance
- Require Good Cause – not a right
- Maximum Interlocutory period 120 days

Prima Facie Met = Allow Claim

- Prima Facie
  - Legal definition of an injury is met.
  - The worker was in the course of employment.
  - Causal opinion (51% or more).
- Once all elements of Prima Facie are met, allow the claim
  - Even if an interlocutory request is in file.

Good Cause Requirement

- Interlocutory requests need to include good cause reasons that a validity decision could not be made within 60 days.
  - Examples of Good Cause: Prima facie not met, Missing medical/PIR, IME for occ disease causation
  - Examples of **Not** Good Cause: Need to investigate without specific reason(s) for the investigation, Need more time to review, No reason given/blank, Need prior medical records

Maximum 120 Day Interlocutory Period

- One 30 day extension may be added to the 90 day interlocutory period for good cause.
- The maximum 120 day extension applies to both injury and occupational disease claims.
- If no validity determination has been made by 120 days, the department claim manager will adjudicate the claim.

Interlocutory Request (IR) Form

Date SIF-2 and PIR was Received

Please ensure the completed SIF-2 is attached with this form. This must be date stamped (RCW 51.32.190).

Date SIF-2 was Received	Date PIR was Received

Initial Interlocutory Request Reasons

Must be received within 60 days of notice of claim with a reasonable explanation why an interlocutory order is needed. Please attach a copy of the complete claim file.

Type of Claim

☐ Specific Injury ☐ Occupational Disease ☐ Hearing Loss ☐ Unknown

Provisional Compensation Paid?

☐ Yes ☐ No

Extension of the Interlocutory Request Reasons

The department will consider an extension of an interlocutory order if a reasonable explanation is provided. An extension may be granted up to 120 days from notice of claim. Please attach an updated copy of the claim file with each request.

Claim Denial Requests

- SIE's/TPA's don't have authority to deny claims.
- The SIE/TPA must send:
  - A completed Claim Denial Request form (updated version 7/1/2025) with denial reason
  - SIF-2 with minimum 7 required fields
  - A complete copy of the claim file excluding bills
- Provisional time-loss benefits if certified must be paid until the department issues the denial order.

Claim Denial Request Form

SIF-2: Please ensure the completed SIF-2 is attached to this form, if not previously submitted to the claim file. This must be date stamped *(RCW 51.32.190)*.

OR

Option 1

☐ No application was received from the worker. If this is marked, you **must** supply the worker's date of birth _____ / _____ / _____

Denial Reason

Option 2

☐ No medical – attach copy of communication attempting to get medical documentation.

☐ Other – enter the reason for your denial request. Attach additional pages if needed. See page 2 for specific denial reasons.

Option 3

Denial Request

You must submit the complete copy of the claim file. Include your supporting documentation for denial directly behind this form. This will be reviewed with your request.

Is this a hearing loss claim?

☐ Yes ☐ No

Are you requesting an overpayment of provisional benefits at this time? If so, please include the Overpayment Request form.

☐ Yes ☐ No

No Application Denial Requests

- Appropriate when the worker clearly declines to file a claim, or fails to return the SIF-2.
- Documentation needed:
  - Worker's written declaration declining to file a claim

    OR
  - Attempts to collect back completed SIF-2 without success
- Mark "No Application" on the CDR.

“No Application Denial” Letter

We have received information that you may have been injured on the job but do not wish to file a workers' compensation claim at this time. You will receive a separate Notice of Decision that denies your claim.

If you later choose to file a claim, please ask your employer for a new accident report (SIF-2) and complete, sign and return to your employer.

^ * If you were treated for a specific injury, you have one year
^ from the date you were injured to file a claim.
^
^ * If you were treated for an occupational disease (something
^ that developed over a period of time), you have two years
^ from the date you were notified in writing by a health care
^ provider that an occupational disease exists and that a claim
^ may be filed.

If you have any questions about the denial of your claim or how to file a claim later, please contact your employer's claim representative. You may also contact the department's Self-Insurance section at (360) 902-6901.

No Medical Denial Requests

- Attach a copy of communication showing attempt(s) to get medical documentation.
- Medical documentation can include:
  - Chart notes
  - PIR
  - APF / Work Restriction Note
- The claim number is not to be reused for a different claim.

Disputes

- Department expectation is to resolve disputes within 60 days instead of 90 days.
- Letter request for SIE's position or explanation regarding received dispute is due in 15 business days.
- Request for claim file or specific documentation – send only what is asked for.
- If worker continues to disagree with denial to you (SIE), this should be forwarded to the department as a dispute to be resolved.

Letter forwarding dispute/request info

Dear Employer:

Please attach a copy of this letter to the top of your response to the department.

The attached correspondence was received by the department regarding denial of condition

If you wish to provide information for us to consider as we resolve the dispute, please do so within 15 business days of receipt of this letter. Please submit specific documentation/explanation in support of your decision-making related to this issue. Submission of the claim file with no additional information does not represent a response. If no response is received, we will make a decision using the information in our file.

How are you feeling about these changes so far?

Employer Requests

- Employer Request with No Dispute Letter
- Overpayments requesting additional information and form
- Suspensions
- No-shows

Employer Request No Dispute Letter

We have received your request for a segregation order under this claim, however it did not include the "Deny Newly Contended Condition" letter and/or a dispute from the worker. Please either resubmit your request with a copy of the letter and the worker's dispute or send the "Deny Newly Contended Condition" letter to the worker.

After the "Deny Newly Contended Condition" letter is sent, if a dispute is received or you receive continued requests for benefits, please request segregation and the department will issue an order as appropriate.

We will not be taking further action at this time. If you have any questions, please contact me at the number below.

Overpayment Requests

- Updates:
  - Overpayment Request Form
  - Department will make one attempt to gather missing information

Updated Overpayment Request Form

Washington State Department of Labor & Industries

Overpayment Request

Self-Insurance
PO Box 44892
Olympia WA 98504-4892

Fax: 360-902-6900

Injured Worker Name	Claim Number	
Injured Worker Address		
City	State	Zip Code
Date of Injury or Manifestation	Date Form Completed	
Employer Name	UBI	Account ID
Prepared By	Preparer Phone Number (include extension if needed)	

Overpayment Request

The worker must be notified of overpayments within one (1) year of the occurrence. This does not apply to provisional payments.

Type of benefits that were overpaid: ☐ Time-Loss ☐ LEP ☐ PPD	Were the benefits provisional? ☐ Yes ☐ No	Is this a Social Security Offset overpayment request? ☐ Yes ☐ No
Overpayment date(s) / / through / /		Overpayment amount already recouped $

☐ Overpayment is due to a wage calculation error (must attach the following)

- Copy of the SIF-5A used to calculate the wages
- Payment ledgers* and/or LEP calculation worksheets with matching payroll statements
- Copy of the Assessment of Overpayment notice sent to the worker
- If L&I has not already issued a wage order, attach items listed on next page

☐ Overpayment is due to the worker receiving benefits for a period of time they were not entitled (must attach the following)

- Supporting documentation of a release for work/return to work
- Payment ledgers*
- Copy of the Assessment of Overpayment notice sent to the worker

☐ Overpayment is due to a PPD award paid in error or the result of claim closure being reversed

**Payment ledgers must include the payment period(s), amount paid, and the date the payment was sent to the worker.*

Provide specifics about how the overpayment occurred.

Updated Overpayment Request Form

Translation for Communicating the Decision	
It is necessary the Employer and the Department ensure a means of communication to all parties per WAC 296-15-350.	
Does the worker have a preferred language other than English? ☐ Yes ☐ No	If "Yes", what is the preferred language?

Documentation Required for Wage Order	
☐	**Earning statements** for the requested date range. Earning statements are "unprocessed" payroll documentation, initial payroll documents such as records kept by HR to calculate the worker's recurring paychecks including deductions for each pay period. It is complete paystub information, if not actual paystubs.
☐	**Daily time records** for the requested date range. This means timecard records showing the worker's clock in and clock out time.
☐	**Definitions of all pay codes used in earning statements.**
☐	**"Bonuses" and "lump sum payments" paid in the 12 months prior to the date of injury.**
☐	**Monthly amount of the employer's contribution to the worker's health care benefits (HCB) on the date of injury.** If benefits have stopped or are going to be stopped in the future, please include that date.
☐	**Most current SIF-5A, if not yet submitted to the department.**
☐	**Earning statements for additional employment for the 12 months prior to the date of injury.** If the worker indicated more than one employer on the SIF-2, include documentation for each employer. If the records were not obtained, explain why and submit a copy of the letter sent to the worker requesting the documentation.
☐	**Any additional documentation** needed for clarification of the worker's wages.

One Attempt to Gather Missing Information

- If all required documentation is attached to the Overpayment Request, the department adjudicator will issue the appropriate orders.
- However, if required information is missing
  - The department will send a letter requesting the missing info
  - SIE has 15 working days to respond to the department letter
  - If no timely response, the request will be closed with a letter
  - If SIE would still like an Overpayment order, submit a new Overpayment Request form with the missing documentation

Suspensions

- Suspension Coversheet (updated) or letter
- If additional information is needed, the department adjudicator will send a letter requesting the missing information.
- If all required information is not received, the request will be denied with a letter.
- If SIE would still like a Suspension order, submit a new request with the missing documentation.

Overpayment/Suspension Request – Need More Information Letter

The department has received your request for an overpayment. Before further action can be taken, please submit the following within 15 business days from the date of this letter.

Include information needed to support request here

If the above is not received by the due date, your request for an overpayment will be closed. A new request will need to be submitted with the requested information and Overpayment Request Coversheet.

If you have any questions, please contact me at the phone number listed below.

The department has received your request for claim suspension. Before further action can be taken, please submit the following within 15 business days from the date of this letter.

Include information needed to support request here

If the above is not received by the due date, your request for claim suspension will be denied. A new request will need to be submitted with the requested information and Suspension Request Coversheet.

If you have any questions, please contact me at the phone number listed below.

No-Shows

- No-Show Checklist (updated)
- If additional information is needed, the department will **not** send a letter requesting missing information.
- The request will be denied with a letter explaining why the request is closed out noting any missing information.
- If SIE would still like a No-Show Fee assessed, submit a new request with the missing documentation.

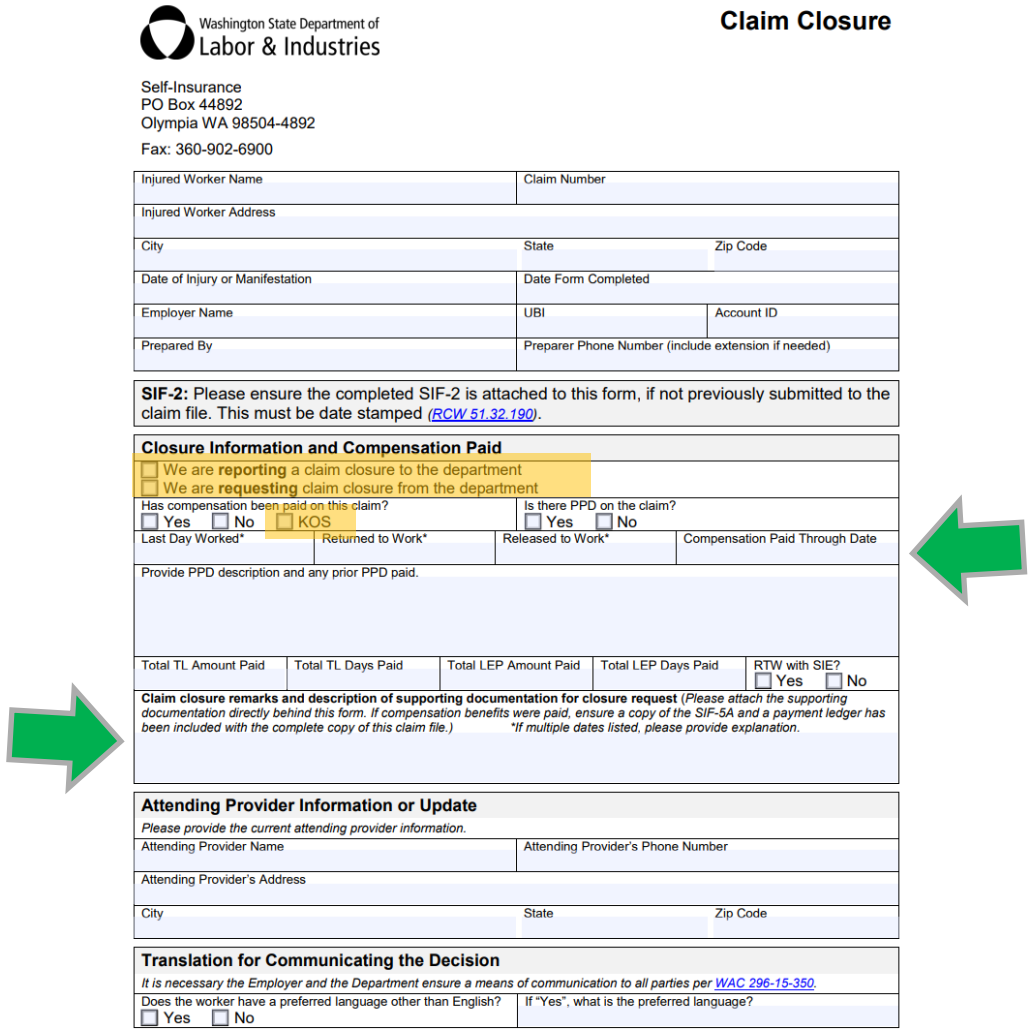
Closures

- Ensure all information is included with closure request
  - If request is received without all information the department will send a letter giving 15 business days to provide needed info.
  - If the department adjudicator does not receive a timely response, the request will be closed out with a letter
  - If SIE would still like a closing order, submit a new Claim Closure Request form with the missing documentation
- If there is a pending dispute or protest:
  - The department will send a letter directing you to resubmit the request after the issue is resolved

Employer Closing Orders

- Claim Closure Request form must be complete and accurate, or closure request will be returned
  - Complete fields indicating TL and/or LEP amount paid, dates paid through, and return/release to work details
- Form must match order actually mailed
  - Medical only on CCR form, EC order attached. Will be returned
- Future mailing date will cause delays in department processing closing order
  - Rec’d at dept 04/10/25 with mailing date 04/15/25

Claim Closure Request Form - Updates



Washington State Department of Labor & Industries

Claim Closure

Self-Insurance
PO Box 44892
Olympia WA 98504-4892

Fax: 360-902-6900

Injured Worker Name		Claim Number	
Injured Worker Address			
City	State	Zip Code	
Date of Injury or Manifestation		Date Form Completed	
Employer Name	UBI	Account ID	
Prepared By		Preparer Phone Number (include extension if needed)	

SIF-2: Please ensure the completed SIF-2 is attached to this form, if not previously submitted to the claim file. This must be date stamped *(RCW 51.32.190)*.

Closure Information and Compensation Paid

- ☐ We are **reporting** a claim closure to the department
- ☐ We are **requesting** claim closure from the department

Has compensation been paid on this claim? ☐ Yes ☐ No ☐ KOS			Is there PPD on the claim? ☐ Yes ☐ No
Last Day Worked*	Returned to Work*	Released to Work*	Compensation Paid Through Date

Provide PPD description and any prior PPD paid.

Total TL Amount Paid	Total TL Days Paid	Total LEP Amount Paid	Total LEP Days Paid	RTW with SIE? ☐ Yes ☐ No

Claim closure remarks and description of supporting documentation for closure request *(Please attach the supporting documentation directly behind this form. If compensation benefits were paid, ensure a copy of the SIF-5A and a payment ledger has been included with the complete copy of this claim file.)* **If multiple dates listed, please provide explanation.*

Attending Provider Information or Update

Please provide the current attending provider information.

Attending Provider Name	Attending Provider's Phone Number
Attending Provider's Address	

City	State	Zip Code

Translation for Communicating the Decision

It is necessary the Employer and the Department ensure a means of communication to all parties per WAC 296-15-350.

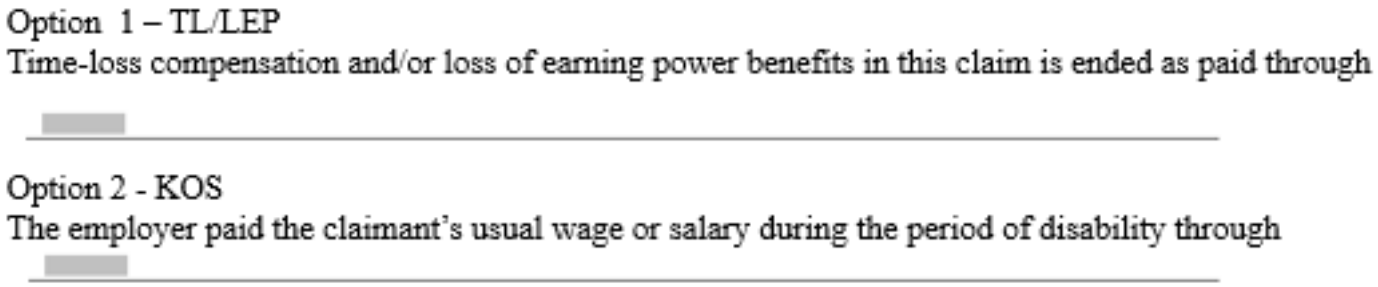
Does the worker have a preferred language other than English? ☐ Yes ☐ No	If "Yes", what is the preferred language?

Medical Only Reminders

- Medical Only (MO) closing order should be used:
  - When there is $0.00 in time-loss or loss of earning power benefits
  - Restrictions does not always equal wage compensation
  - Example: Full hours and full pay results in denied LEP and should be processed as medical only
- Employer Closure (EC) should be used when there has been any amount of money paid out to the worker or the worker was Kept on Salary (KOS).

KOS

- Kept on Salary (KOS) is considered a wage compensation closure
- The EC Order will include KOS language



Option 1 – TL/LEP
Time-loss compensation and/or loss of earning power benefits in this claim is ended as paid through

Option 2 - KOS
The employer paid the claimant's usual wage or salary during the period of disability through

- If the Claim Closure Report form and EC order don't match, the closing notification may be rejected

SIE Authority - WAC 296-15-450

- If the SIE does not have authority to issue a closing order, a penalty could be assessed
  - If issued a closing order when a department order had resolved a dispute, the SIE did not have authorization to close the claim
- If a second or corrected closing order is issued, a penalty could be assessed
  - Changing the mailing date is changing/correcting the order

Protests

- Department expectation is to now resolve protests within 60 days instead of 90 days.

Pension Review Coversheet

Washington State Department of Labor & Industries

Pension Review Coversheet

Claim Number: _____ Worker's Name: _____

Request submitted by:_____ Phone Number: _____Ext.____

Claim File Documentation

I have: (pick one option)

- ☐ Attached a copy of the complete claim file
- ☐ Attached a copy of all claim file information not previously submitted to the department.
- ☐ Already submitted a complete copy of the claim file. There is no additional claim file information to submit to the department.

Vocational Documentation

I confirm that: (pick one option)

- ☐ I have attached a copy of the complete vocational work-up (Self-Insurance Vocational Reporting Form (SIVRF)), including all existing vocational documentation for this claimant.
- ☐ I already submitted a copy of the complete vocational work-up (SIVRF), including all existing vocational documentation for this claimant to the department on the following date:_____.

I confirm I have reviewed the vocational summary and that: (pick one option)

- ☐ I have attached a copy of every document mentioned or discussed in the vocational summary narrative.
- ☐ I already submitted a copy of every document mentioned or discussed in the vocational summary narrative to the department on the following date:_____.

Time-Loss and LEP

I confirm that I have:

- ☐ Attached a Claim Closure (CCR) form.
- ☐ Included a payment ledger that shows all compensation periods paid, with an explanation for any unpaid periods.
- ☐ For all open claims without a wage order: attach a SIF5-A and required documentation.
- ☐ Listed date(s) health care benefits ended.

Medical – date contribution ended	
Dental – date contribution ended	
Vision – date contribution ended	

Medical

I have listed all **accepted and/or treated conditions** (including psych conditions) below:

(Space is limited, attach additional page if needed.)

- ☐ Yes, I have attached medical documentation to this coversheet which confirms that each of the above listed accepted condition(s) is fixed and stable or at maximum medical improvement.

Post Pension Medical Treatment (Pick one option)

- ☐ Claimant does **not** need ongoing medical monitoring/treatment for an accepted condition.
- ☐ Claimant does need ongoing medical monitoring/treatment for an accepted condition (life sustaining treatment needs and/or treatment required to alleviate chronic pain from the industrial injury). If so, complete information below in detail.

List all ongoing Medical Monitoring/Treatment (i.e. a complete list of the necessary prescriptions + frequency needed for medical monitoring. (Space is limited, attach additional page if needed.)

Second Injury Fund Relief (Pick one option)

- ☐ I am **not** requesting second injury fund relief be granted.
- ☐ I am requesting second injury fund relief be granted. Complete **all** information below in detail, failure to provide this information will lead to a review for pension without second injury fund relief.

Note: The department will not consider this information, unless it first determines the worker is entitled to a pension.

List all pre-existing conditions & any formal or informal accommodations given. (Space is limited, attach additional page if needed.)

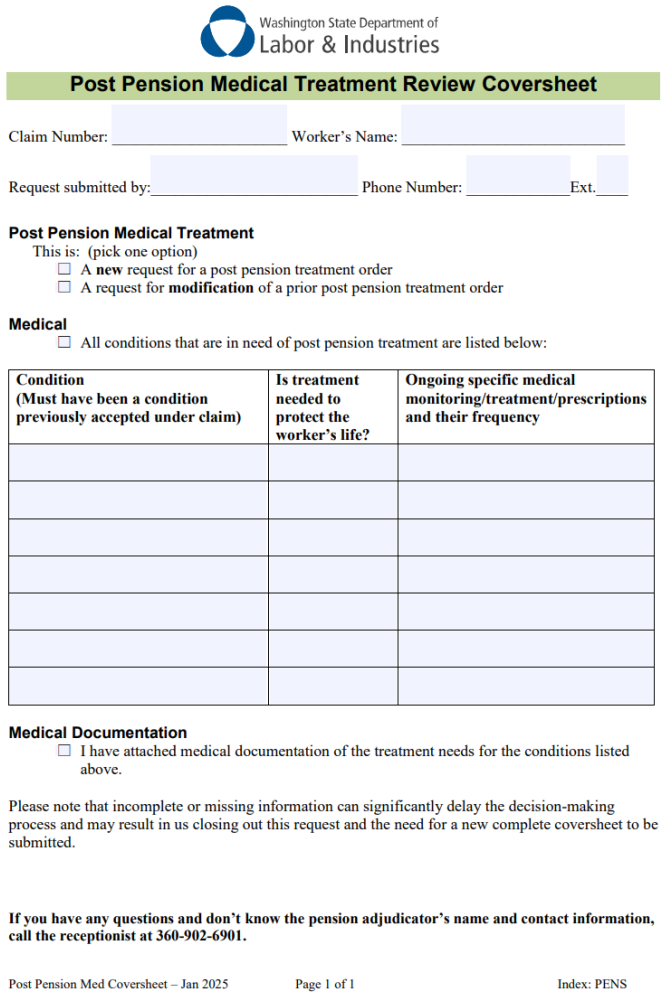
Both boxes below are required if requesting second injury fund relief.

- ☐ Yes, I certify I have attached **all medical reports or other documentation** to this coversheet which documents pre-existing disabling conditions.

- ☐ Yes, I further confirm I have attached medical reports to this coversheet which document a permanent partial disability (PPD) rating for ALL of the accepted conditions (including psych).

If you have any questions and don't know the pension adjudicator's name and contact information, call the receptionist at 360-902-6901.

Post Pension Medical Treatment Review Coversheet



Washington State Department of Labor & Industries

Post Pension Medical Treatment Review Coversheet

Claim Number: _____ Worker's Name: _____

Request submitted by:_____ Phone Number: _____Ext.____

Post Pension Medical Treatment

This is: (pick one option)

- ☐ A **new** request for a post pension treatment order
- ☐ A request for **modification** of a prior post pension treatment order

Medical

- ☐ All conditions that are in need of post pension treatment are listed below:

Condition (Must have been a condition previously accepted under claim)	**Is treatment needed to protect the worker's life?**	**Ongoing specific medical monitoring/treatment/prescriptions and their frequency**

Medical Documentation

- ☐ I have attached medical documentation of the treatment needs for the conditions listed above.

Please note that incomplete or missing information can significantly delay the decision-making process and may result in us closing out this request and the need for a new complete coversheet to be submitted.

If you have any questions and don't know the pension adjudicator's name and contact information, call the receptionist at 360-902-6901.

Post Pension Med Coversheet – Jan 2025 Page 1 of 1 Index: PENS

Death on Open Claim Coversheet

Washington State Department of Labor & Industries

Death on Open Claim Coversheet

Claim Number: _____ Worker's Name: _____

Request submitted by:_____ Phone Number: _____Ext.____

Death Related to the Conditions Accepted on the Claim
(pick one option)
☐ Yes
☐ No

Medical Fixity
☐ I have attached documentation of medical fixity or a providers indication of when this would have been reached if not for the workers death.

Permanent Partial Disability (PPD) Rating
☐ I have attached PPD ratings for all accepted conditions.

Vocational Fixity (complete if the worker was not working at the time of death)
(pick one option)
☐ I have attached documentation that the worker was expected to be able to return to work at the job of injury. If there are work restrictions, the employer would be able to accommodate those restrictions.
☐ I have attached a Self-Insurance Vocational Reporting Form (SIVRF) and appropriate report.

Claim Closure
☐ I am submitting a Claim Closure form.

Please Note:
If the deceased has a qualified beneficiary (RCW 51.08.020: "Beneficiary.") please educate and provide them the opportunity to file for further benefits with form: Beneficiary Application for Claim Benefits. This must be done within a year of the death.

NOTE: An application does not necessarily indicate a qualification for benefits. The Department will make this determination.

If you have any questions and don't know the pension adjudicator's name and contact information, call the receptionist at 360-902-6901.

Was this training helpful?

Washington State Department of
Labor & Industries

Questions?

- Claim-specific questions:
  - Contact the adjudicator assigned to the claim.

  or
  - Call 360-902-6901 and ask for the adjudicator assigned to the claim.
- General claim questions:
  - Email us at SITrainerquestions@Lni.wa.gov
- Course ID: **004-0525-0372**