Workers Compensation - Rights & Responsibilities

Worker's Right to Choose a Medical Provider

Workers have the right to choose their attending physician within the Medical Provider Network. If choosing to transfer your care to another medical provider within the medical provider network, send a written note to your claims manager requesting the change of attending provider. To search for a provider, go to **www.Lni.wa.gov/FindADoc .** For your first doctor visit only, you can be seen by a non-network provider and the appointment will be covered even if the claim is rejected. Coverage is only for treatment necessary to make determination. Make sure to keep a copy of all your orders and notices for your records.

Access Claim Information

To check on State Fund claims visit Claim and Account Center (CAC) @ **www.lni.wa.gov/claiminfo**. You can also set up access to "My L&I" Dashboard. Self-Insured claims may have limited access through the Claim and Account Center (CAC). To request a copy of your claim file, send a written request to your Third Party Administrator (TPA). The TPA is required to send the file within fifteen days from receiving the request; the first copy is free of charge.

State Fund Claim Filing

State Fund report of accident (ROA) is available at the provider's office or you can file online at **www.Lni.wa.gov/FileFast**. You will still need a doctor to fill in the medical portion of the ROA. You may see a non- network provider for the initial visit to file a claim, but for additional ongoing care, you will need to transfer to a provider of your choice within the LNI Medical Providers Network. A provider directory is available at ***www.Lni.wa.gov/FindADoc*** .

The provider sends the original of the completed form to L&I. L&I will send you a "Claim Arrival Notice." The claim is neither approved nor denied at this point. L&I will handle all aspects of the claim. Keep a copy of the accident report for your records. Make sure to inform your employer about your work-related injury.

Self-Insured Claim Filing

Get the Self-Insurer accident report (SIF-2) form from your Self-Insured employer. By law, the employer must give you an SIF-2 form. Your provider will complete the Physician's Initial Report (PIR) form. You may see a non- network provider for the initial visit to file a claim, but for additional ongoing care, you will need to transfer to a provider of your choice within the LNI Medical Providers Network. A provider directory is available at ***www.Lni.wa.gov/FindADoc***

The provider mails the original to the employer or the third party administrator (TPA). The claim is neither approved nor denied at this point. The self-insured employer handles the claim and TPA will manage the claim and pays benefits. All self-insured claim numbers begin with an "S","T" or "W".

Report the injury to your employer. Make sure you retain your courtesy copy of the form. This copy is your proof of filing a self-insurance claim. The Self-Insurance section at the Department of Labor and Industries oversees Self-Insured programs and addresses statutory issues and claim disputed issues (if requested).
See dispute/protest/appeal section. Administrator (TPA) will manage the claim

Time Frames for Filing Claims

Industrial Injury Claim – The worker has one year from the date of injury to file a work-related claim. An industrial injury is a specific time and date traumatic event.

Occupational Disease Claim- The worker has two years from the date a provider has written notification that their disease is work-related to file a claim. For an occupational disease claim the disease and/or condition develops over a period of time due to the series of activities connecting to the nature of your job.

Release of medical

By signing the report of accident, you are signing a release of information for your previous medical history. The Department or Self-Insurer is entitled, by law, to medical information that was pre-existing for that exposure or condition that is pertinent to your work-related claim. Be cautious of expanded medical releases.

Things to consider- Filling out Paperwork (State Fund & Self-Insured Forms)

- Report of accident - Provide good detailed and consistent information.
- Injury Claims – When filling out the report of accident write down the specific date and time of your work-related injury…keep it consistent.
- Occupational Disease Claims – Describe in detail how the exposure happened "over-a-period-of-time", the series of job-related activities and repetitive functions that caused your symptoms. Occupational disease does not have a time of injury. The date should be your last occupational injurious exposure at work.
- *T*ime of injury- this is not applicable for an occupational disease claim. Do not leave the box blank, write in N/A or X out or over-time.
- If the claims manager requests a work history from you, call your Trust office (if applicable) or the local Employment Security office. They have a record of all of the hours worked - listed by the employer. Do your best to provide your entire work history.

Time-Loss Benefits (wage replacement)

Time-loss is an entitled benefit a worker may receive after an L&I network physician has certified the time off from work is due to a work-related condition. For time-loss consideration, the claim must be an open and allowed claim.

The claim manger will collect the following:

- Gross monthly wages and payroll records
- Family status and number of dependents at the time of injury.
- Health care benefits, board, housing and fuel
- Consistent over-time hours

Be sure to review your state fund "Wage Order" or "Calculation of Monthly Wage as a Basis for Time-Loss Compensation". For Self-Insurance, carefully read the letter "Calculation of Monthly Wage as a Basis for Time-Loss Compensation" to make sure it contains the correct information. If it is incorrect, send in an applicable dispute/protest and contact the claims manager within the proper timeframe.

Injured workers are never entitled to time-loss for the date of injury. Workers will not receive time-loss benefits for the first three days following the date of injury unless the worker remains disabled on the 14th consecutive day.

State Fund or Self-Insured employer must make the first payment of time-loss within fourteen days of notification of disability.

If the Self-Insured employer fails to pay time-loss within 14 days of notification, the injured worker can send a written dispute to Department of Labor and Industries.

Seasonal Employees

When employment is seasonal, essentially part time or intermittent, time loss calculations may be averaged over any 12 successful calendar month period that MOST FAIRLY represents the workers' employment pattern.

Health Care Benefits

When computing time-loss benefits the claims manager will add to the workers' wage rate the monthly or the hourly amount paid by employer for healthcare when they stop contributing to the benefit. Example: B***eginning the first day of the next month after the Employer stops contributing to the worker's health care benefits***.

Dispute/Protest (Reconsideration)/Appeals

Dispute: Self-Insured Injured Workers are responsible to dispute actions if they disagree with a communicated decision by TPA within 60 days. This will allow LNI Self-Insurance Section to intervene/adjudicate on your behalf (only when there is a dispute). Note: SI must first have disputed a decision by their TPA to LNI in order to receive protest rights.

Exception: All other orders (for Department Allowance, Denial or Close of certain claims), you will still have your protest (reconsideration) rights. Include all pertinent contact info on your dispute letter, state fund claim number within the 60 days' timeframe.

Protests/Reconsideration: Any party affected (worker, employer or attending physician) may protest a decision or action they disagree with by sending a written protest to L&I within sixty

days. The employer cannot deny a claim, only the Department can deny a claim.

If there is a claim dispute or if you need to protest a Notice of Decision send a written protest letter to the Department of Labor and Industries, Self-Insurance Section, PO Box 44892, Olympia, WA 98504-4892. You can also fax the dispute or protest directly to the Self-Insurance section at 360-902-6900.

Appeals: When an appeal is received, the Appeals Board (BIIA) will send L&I a copy to give them an opportunity to reconsider their decision. L&I may reconsider the decision and send an order "reassuming jurisdiction". L&I will then issue a new decision which may be appealed to the Board of Industrial Insurance Appeals (BIIA). If it is not clear whether the party is appealing or protesting an order, the Appeals Board may send the writing to L&I for further review and information. If LNI does not assume jurisdiction, the appeal stays at the Appeals Board.

Independent Medical Exams (IME)

The worker ***must appear*** for a scheduled exam. Failure to appear without good cause may result in no-show fees being deducted from future time-loss benefits. Workers should call the number on their appointment letter no later than five days prior to the exam if they cannot attend the exam with good cause.

The law allows the worker to bring a friend or a Union Representative to the physical portion of the IME. Workers cannot bring an attorney or a recording device. We recommend you obtain a copy of the IME report. To obtain a copy of the exam send a ***written request*** to the claims manager or check "My L&I" or Claim and Account Center (CAC). The claims manager is under no obligation to send you a copy of the report based on a phone call. Remember to keep copies everything you send.

Workers are paid mileage to and from the exam and any parking expenses. Workers are also paid wages if the exam is scheduled during their normal work shift.

Vocational Rehabilitation

The highest priority is to return the injured worker to their pre-injury job with the employer at the time of injury. The lowest priority is to retrain the worker. Before retraining is considered, a vocational counselor will evaluate the workers' transferable skills (which are skills needed in today's labor market). That does not mean finding the worker a job - it means finding them employable which could be a minimum wage job. If you decide to protest an employability assessment or any other vocational disagreement/dispute - you must ***protest to the Department within fifteen days***.

Retraining Options

If you qualify, you and your vocational counselor will draft a vocational plan identifying services you will need to become employable again. This plan will show the responsibilities that you, your counselor, your employer and others will have as you work toward this goal. Once your plan is approved, you will have 2 options. Choosing between them is an important decision.

Vocational Option 1: Total available for retraining, effective July 1, 2022 is $19,802.63 or up to 2 years, whichever comes first, this will include the cost of all books, tuition, fees, supplies and equipment under the program. You will continue to receive time-loss compensation and medical benefits related to your injury or disease as long as you participate and meet all the requirements of approved plan. Within the first quarter of retraining, if you decide it is not your best option, you can follow up with your TPA and request you be switched back to option 2. They will reduce your training and time-loss funds by any monies that you have received and your claim will move to closure.

Vocational Option 2: Develop your own plan, retaining funds of $19,802.63 will be set aside for up to 5 years. You can use your training money for tuition or training cost for L&I approved programs. The retraining goal or program you choose can be different from the plan submitted by the VRC approved by L&I. Time-loss payments will end and your claim will close. You will receive a vocational award equal to 9 months of time-loss compensation paid out every 2 weeks. You claim will close and medical benefits will end. Note: Less any funds used if switching from Voc. 1 to Voc. 2.

Light Duty

If the employer is requesting light or modified duty, a job description should be put in writing, with a copy to the worker. The light duty position should be approved by the workers' provider before the worker returns to work. Light duty should not interfere with recovery.

Sometimes your medical provider will attempt to get you back to work under light duty. The medical provider will give you an Activity Prescription Form stating any work restrictions, such as lifting limits, stand, sit, crawl, kneeling, etc. If you are having problems with your light duty, do not walk off the job (this means you have quit). Follow up with your provider to discuss your light duty situation.

Loss of Earning Power (LEP)

If the employer has returned an injured worker to light duty with a wage reduction of greater than 5%, and the claim is open and allowed, then LEP is payable. LEP may also be paid if the worker has returned to work and they are working less hours than their normal work pattern. LEP is paid monthly.

Job Modification Funds

May be available up to $5,000 per modification. The funding does not affect the employer's industrial insurance rates.

Reopening a Claim

If there is a new incident of trauma or an accident on the job, file a new claim. To reopen an old claim, the law says the condition must be worse than it was at the time of claim closure. The medical provider must provide objective medical findings to prove the condition has worsened.

The reopening application is available at the provider's office and is sent to the Department of Labor and Industries, whether the claim is Self-Insured or State Fund.

When you file a reopening application, the office visit and only diagnostic testing deemed necessary to make determination will be paid for by the Department or the Self-Insured Employer, whether or not the claim is reopened. The effective date of reopening cannot be more than 60 days prior to filing the reopening application.
The Department has ninety days following the receipt of the application to make a decision on the reopening application. The Department can extend that deadline to reopen the claim for an additional sixty days for good cause. Some examples of good cause are the claim manager needs additional medical information, an independent medical exam results are still pending, or further diagnostic testing is needed.

If time-loss benefits are contended as payable on the reopened claim, benefits will be paid at the rate of pay based on the original date of injury and possible cost of living adjustments may be made at the start of the calendar year. If it has been over seven years since the first claim closure and time-loss benefits are contended, the worker must appeal to the Director of the Department of Labor and Industries for benefits.
Up until seven years from the first closure, all benefits are available if the claim is reopened: medical, time-loss, permanent partial disability awards, and vocational rehabilitation. After seven years, only medical benefits are guaranteed if the claim is reopened.

Claim Closures

If a worker does not agree with their claim being closed, they can protest the closure by sending a written protest letter to Department within sixty days of receiving the notice of decision. Closure orders become final and binding 60 days after the date of your order.

Project Help - 1-800-255-9752