AMENDATORY SECTION (Amending WSR 15-01-162, filed 12/23/14, effective 1/23/15)

WAC 296-15-266 Penalties. (1) **Under what circumstances will the department consider assessing a penalty for an unreasonable delay of benefits, when requested by a worker?** Upon a worker's request, the department will consider assessment of an unreasonable delay of benefits penalty for:

(a) Time loss compensation benefits: The department will issue an unreasonable delay order, and assess associated penalties based on the unreasonably delayed time loss as determined by the department, if a self-insurer:

(i) Has written medical certification based on objective findings from the attending medical provider authorized to treat that the claimant is unable to work because of conditions proximately caused by the industrial injury or occupational disease, or the claimant is participating in a department-approved vocational plan; and

(ii) Fails to make the first time loss payment to the claimant within fourteen calendar days of notice that there is a claim*, or fails to continue time loss payments on regular intervals as required by RCW 51.32.190(3); and

(iii) Fails to ((~~request, with supporting medical evidence and within thirty days of receiving written notice of a newly contended medical condition related to the industrial injury or occupational disease, that the department settle a dispute about the covered conditions or eligibility for time loss compensation. For good cause, in the department's sole discretion, a sixty-day extension may be granted~~)) take action per WAC 296-15-425.

* Notice of claim is provided to the self-insured employer when all the elements of a claim are met. The elements of a claim are:
- Description of incident. Examples: Self-Insurance Form 2 (SIF-2), physician's initial report (PIR), employer incident report.
- Diagnosis of the medical condition. Examples: PIR, on-site medical facility records if supervised by provider qualified to diagnose.
- Treatment provided or treatment recommendations. Examples: PIR, on-site medical facility records if supervised by provider qualified to treat.
- Application for benefits. Examples: SIF-2, PIR, or other signed written communication that evinces intent to apply.

(b) Unreasonable delays of loss of earning power compensation payments or permanent partial disability award payments will also be subject to penalty.

(c) Unreasonable delays of payment of medical treatment benefits((~~: The department will issue an unreasonable delay order, and assess associated penalties based on the department's fee schedule, order, and accrued principal and interest, if a self-insurer fails to pay all fees and medical charges within sixty days of receiving a proper billing, as defined in WAC 296-20-125 through 296-20-17004, or sixty days after the claim is allowed per RCW 51.36.080.~~

~~(i) If the self-insurer believes that it should not pay the billing, or if the self-insurer believes that the treatment is not for a condition proximately caused by the industrial injury or occupational disease, the self-insurer must, within sixty calendar days of receiving a billing, clearly state in writing to the worker and the medical provider why the payment is denied.~~

~~(ii) If a denial is disputed by the worker or medical provider and the self-insurer does not allow the bill, the self-insurer must notify the department within thirty days, and the department will review the reasons provided by the self-insurer and will make a decision by order within thirty days~~)) will also be subject to penalty.

(d) Unreasonable delays of authorization of ((~~emergent or life-saving~~)) medical treatment benefits((~~: The department will issue an unreasonable delay order, and assess associated penalties, based on~~

~~the department's fee schedule, order, and accrued principal and interest, if a self-insurer fails to respond to requests to authorize emergent or life-saving treatment within fourteen days after receiving written notice of the request for treatment.~~

~~(i) If the request is denied, the self-insured employer must clearly tell the medical provider and the claimant, in writing, why the request is being denied.~~

~~(ii) If the medical provider or claimant disagrees with the self-insurer's decision, either of them may file a dispute with the department~~)) will also be subject to penalty.

(e) Failure to pay benefits without cause: The department will issue an order determining an unreasonable refusal to pay benefits, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer fails to pay a benefit such as time loss compensation, loss-of-earning-power compensation, permanent partial disability award payments, or medical treatment when there is no medical, vocational, or legal doubt about whether the self-insurer should pay the benefit. Accrued principal and interest will apply to nonpayment of medical benefits.

(f) Paying benefits during an appeal to the board of industrial insurance appeals: The department will issue an unreasonable delay order, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer appeals a department order to the board of industrial insurance appeals, and fails to provide the benefits required by the order on appeal within fourteen calendar days of the date of the order, and thereafter at regular fourteen day or semi-monthly intervals, as applicable, until or unless the board of industrial insurance appeals grants a stay of the department order, or until and unless the department reassumes jurisdiction and places the order on appeal in abeyance, or until the claimant returns to work, or the department issues a subsequent order terminating the benefits under appeal.

(g) Benefits will not be considered unreasonably delayed if paid within three calendar days of the statutory due date. In addition, if benefits are delayed due to an underpayment from the monthly wage calculation for time-loss compensation under RCW 51.08.178, then the department shall presume the benefits are not unreasonably delayed if:

(i) The self-insurer sent a written copy of the wage calculation to the injured worker on a department-developed template; and

(ii) The self-insurer informed the worker, in writing, on a department-developed template that the worker should contact the self-insurer with any questions; and

(iii) The self-insurer notified the worker, in writing, on a department-developed template to write to the department within sixty days if the worker disputed the calculation; and

(iv) Whether the worker disputed the wage calculation in writing to the department.

This presumption may be rebutted by a showing of action without foundation or unsupported by evidence demonstrating an unreasonable delay of benefits despite the notification to the worker and the worker's failure to dispute.

Provided, (g)(i) through (iv) of this subsection will not apply to payments for statutory cost-of-living adjustments, payments that do not use the amount stated in the department-developed template, or a refusal to make payments ordered by the department.

(2) **How is a penalty request created and processed?**

(a) An injured worker may request a penalty against his or her self-insured employer by:

(i) Completing the appropriate self-insurance form or sending a written request providing the reasons for requesting the penalty;

(ii) Attaching supporting documents (optional).

(b) Within ten working days of receipt of a certified request, the self-insured employer must send its claim file to the department. Failure to timely respond may subject the self-insured employer to a rule violation penalty under RCW 51.48.080. The employer may attach supporting documents, or indicate, in writing, if the employer will be providing further supporting documents, which must be received by the department within five additional working days. If the employer fails to timely respond to the penalty request, the department will issue an order in response to the injured worker's request based on the available information.

(c) The department will issue an order within thirty days after receiving a complete written request for penalty per (a) of this subsection. The department's review during the thirty-day period for responding to the injured worker's request will include only the claim file records and supporting documents provided by the worker and the employer per (a) and (b) of this subsection.

(d) 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 (a) and (b) of this subsection, if timely available, to determine if the alleged untimely benefit was appropriately requested and if the employer timely responded.

(e) The department order issued under (c) of this subsection is subject to request for reconsideration or appeal under the provisions of RCW 51.52.050 and 51.52.060.

AMENDATORY SECTION (Amending WSR 06-06-066, filed 2/28/06, effective 4/1/06)

WAC 296-15-320 Reporting of injuries. What elements must a self-insurer have in place to ensure the reporting of injuries? Every self-insurer must:

(1) Establish procedures to assist injured workers in reporting and filing claims.

((~~(2)~~)) (a) Immediately provide a Self-Insurer Accident Report (SIF-2) form F207-002-000 to every worker who makes a request, or upon the self-insurer's first knowledge of the existence of an industrial injury or occupational disease, whichever occurs first. ((~~Only department provided SIF-2 forms may be used. Copies or reproductions are not acceptable.~~

~~(3)~~))

(b) Establish procedures for ensuring the timely delivery of completed SIF-2s to the claims management entity.

((~~(4)~~)) (2) Designate individuals as resources to address employee questions. These resources must:

(a) Have sufficient knowledge to answer routine questions; and

(b) Have responsibility for seeking answers to more complex problems; and

(c) Have detailed knowledge of the self-insurer's claim filing process; and

(d) Be reasonably accessible to employees ((~~at every work location.~~

~~(5) Maintain a claims log of all workers' compensation claims filed.~~

~~(a) For each claim, the log must consist of only the following information:~~

~~(i) The complete first and last name of the injured worker (no initials or abbreviations).~~

~~(ii) The date of injury, or for an occupational disease, the date of manifestation.~~

~~(iii) The claim number found on the department's Self-Insurer Accident Report (SIF-2, form F207-002-000).~~

~~(iv) The date the claim is closed.~~

~~(v) Whether the claim is a time loss claim or medical only.~~

~~(b) The self-insurer must designate the location of the official claims log.~~

~~(i) The self-insurer may maintain the log on its premises; or~~

~~(ii) The self-insurer may elect to have its third-party administrator maintain the claims log on its behalf. If this option is selected, there must be a written agreement between the self-insurer and the third-party administrator acknowledging that the official claims log is maintained by the third-party administrator.~~

~~The self-insurer must notify the department in writing of the location of their official claims log. If the option in (b)(ii) of this subsection is selected, a copy of the written agreement between the self-insurer and the third-party administrator must be provided to~~)).

(3) Upon request, produce a report of all workers' compensation claims filed in a format required by the department.

AMENDATORY SECTION (Amending WSR 13-09-023, filed 4/9/13, effective 5/10/13)

WAC 296-15-330 Authorization of medical care. What are the requirements for authorization of medical care? Every self-insurer must:

(1) Authorize treatment and pay bills in accordance with Title 51 RCW and the medical aid rules and fee schedules of the state of Washington.

(2) Provide a written explanation of benefits (EOB) to the provider, with a copy to the worker if requested, for each bill adjustment. A written explanation is not required if the adjustment was made solely to conform to the maximum allowable fees as set by the department.

(3) Provide a written explanation to the worker and provider(s) regarding any denied bill. Bills returned to the provider because a proper bill was not submitted under WAC 296-20-125 do not require a written explanation.

(4) Establish procedures to ensure prompt responses to inquiries regarding authorization decisions and bill adjustments.

((~~(4)~~)) (5) Comply with the requirements of the health care provider network. This includes:

(a) Utilizing only those providers approved for the provider network, except when the provider specialty or geographic location is not yet covered by the network;

(b) Providing information to workers about the requirement for providers to be enrolled in the network in order to treat injured workers and information on how a worker can find network providers. This information must be included in publications used by self-insurers to comply with WAC 296-15-400 (2)(a);

(c) Ensuring, when applicable, that only network providers are paid for care after the initial office or emergency room visit; and

(d) Promptly assisting workers who are being treated by a nonnetwork provider to transfer their care to a network provider of their choice; including, at a minimum, notification to the worker within forty-five days of receipt of the first bill from a nonnetwork provider that the provider will not be paid for treatment beyond the initial visit on the claim and information about how to find network providers.

AMENDATORY SECTION (Amending WSR 06-06-066, filed 2/28/06, effective 4/1/06)

WAC 296-15-340 Payment of compensation. What are the requirements for payment of compensation? Every self-insurer must:

(1) Pay time loss compensation in accordance with Title 51 RCW and the rules and regulations of the department.

(2) ((~~Select one method for payment of ongoing time loss compensation, either semimonthly or biweekly, and report the selected method to the department.~~

~~(3) Provide the department with a detailed written description of any practice of paying workers' regular wages in lieu of time loss compensation, or of paying workers any benefits including sick leave, health and welfare insurance benefits, or any other compensation in conjunction with time loss compensation.~~)) Provide to workers a statement of benefits with each time-loss payment, to include the type of benefit paid and the period paid with from and to dates. In addition, provide to workers a statement of benefits with payments for reimbursements to workers.

(3) When payable, time-loss must continue at regular semi-monthly or bi-weekly intervals. When making an initial payment, an employer may adjust the date for payment of time-loss to align with a worker's normal date for payment of wages; however, the payment must be made within ten days of entitlement period.

AMENDATORY SECTION (Amending WSR 14-02-121, filed 1/2/14, effective 2/2/14)

WAC 296-15-350 Handling of claims. What elements must a self-insurer have in place to ensure appropriate handling of claims? Every self-insurer must:

(1) Establish procedures for securing the confidentiality of claim information.

(2) Have sufficient numbers of certified claims administrators to ensure uninterrupted administration of claims.

(a) There must be at least one certified claims administrator involved in the daily management of the employer's claims.

(b) If claims are administered in more than one location, there must be at least one certified claims administrator in each location where claims are managed. Effective July 1, 2020, to ensure consistent application and delivery of benefits pursuant to Washington laws, every person making claim decisions outside the state of Washington must be a certified claims administrator and maintain core business office hours for Pacific Standard Time. For the purposes of this section, every person making claim decisions includes:

(i) Those persons who manage claims directly; and

(ii) Who request to allow or deny claims under WAC 296-15-420;

(iii) Take action on claims under WAC 296-15-425; or

(iv) Close claims under WAC 296-15-450.

Excluded from this requirement are those persons who manage operations indirectly in support of claims administrators, such as, human resources, accounting, or executive management.

When a new person is hired by the out-of-state employer to make claims decisions, if the new person is not already a certified claims administrator, then the new person must begin working toward achievement of certification through a goal-oriented curriculum approved by the department to achieve certification within two years. While in process of meeting educational needs, the employer must ensure mentoring is provided by a Washington certified claims administrator and maintain a minimum of one Washington certified employee at each out-of-state location where claims are managed.

Providers of the goal-oriented curriculum will conduct regular training courses to allow for a new person in the process of completing the training to successfully manage Washington claims and achieve Washington certification within two years. This will include considering online alternatives, when feasible.

When a certified claims administrator leaves the hire of an employer or third-party administrator, whether in-state or out-of-state, and this results in an employer temporarily not meeting the qualifications for a certified claims administrator, the employer may apply for a temporary waiver for up to six months pending hiring of a replacement.

(3) Designate one certified claims administrator as the department's primary contact person for claim issues.

(4) Designate one address for the mailing of all claims-related correspondence. The self-insurer is responsible for forwarding documents to the appropriate location if an employer's claims are managed by more than one organization.

(5) Establish procedures to answer questions and address concerns raised by workers, providers, or the department.

(6) Ensure claims management personnel are informed of new developments in workers' compensation due to changes in statute, case law, rule, or department policy.

(7) Include the department's claim number in all claim-related communications with workers, providers, and the department.

(8) Legibly date stamp incoming correspondence, identifying both the date received and the location or entity that received it.

(9) Ensure a means of communicating with all injured workers.

AMENDATORY SECTION (Amending WSR 14-02-121, filed 1/2/14, effective 2/2/14)

WAC 296-15-360 Qualifications of personnel—Certified claims administrators. (1) **What is a certified claims administrator?** An experienced adjudicator who has been certified by the department to meet the requirements of WAC 296-15-350(2).

(2) **How do I become a certified claims administrator for self-insured claims?**

(a) Have a minimum of ((~~three~~)) two years of experience, at least twenty hours per week, in the administration or oversight of time loss claims under Title 51 RCW. The experience must have occurred within the five years immediately prior to your filing of the application to take the "self-insurance claims administrator" test; ((~~and~~))

(b) Have completed:

(i) A comprehensive goal-oriented curriculum approved by the department and resulting in a worker's compensation professional designation; or

(ii) An approved training program within the department.

(c) Take and pass the department's "self-insurance claims administrator" test. The department will provide annual reports to stakeholders. The department will report the results, identify and consider feasible alternative methods of test delivery, make any recommendations for improvements, seek comments from stakeholders, and subsequently make a determination on methods for further administration of the testing processes.

(i) If you have the requisite experience under (a) of this subsection, you may take the test without completing the training required under (b)(i) or (ii) of this subsection. If you do not pass the test, then you must wait a minimum of three months to retake the test at a date and time scheduled by the department. The provision to take the test for certification without completing the requisite training will expire two years from the effective date of this rule.

(ii) If you have already passed the test and are a certified claims administrator, you will maintain your certified claims administrator designation without completing the training required under (b)(i) or (ii) of this subsection, and you will need to fulfill the continuing education credits under subsection (6) of this section.

After passing the test, you are designated a certified claims administrator. ((~~The initial~~)) This is a lifetime certification ((~~is valid for five years~~)), provided that continuing education requirements are met.

(3) **How do I receive approval to take the test?** To be approved to take the "self-insurance claims administrator" test, you must apply using the department's online database no less than forty-five days prior to the next scheduled test date.

The department will review your application and determine if you meet the minimum requirements to take the test. ((~~We~~)) The department will respond to your application no less than fourteen days prior to the next scheduled test date.

(4) **What happens if I fail the test?** You may retest six months after the failed test.

If you are a certified claims administrator and you fail the test, your certification will be terminated until you retest and pass.

(5) **What must a department-approved curriculum for a worker's compensation professional designation include?** The curriculum must include:

(a) All phases of basic, intermediate, and advanced claim validity issues, including injury during the course of employment, occupational exposure and illness or disease, causal relationship of injury or illness, prima facie consideration, and submittal of claims to department;

(b) All phases of basic, intermediate, and advanced medical benefit management, including treatment authorization, surgery approval, aggravation of conditions, segregation of conditions, use of consultations and independent medical examinations (IMEs), and department medical guidelines;

(c) All phases of basic, intermediate, and advanced compensation management, including determining the wage as the basis of compensation, payment of temporary total disability payments, permanent partial disability payments, and loss of earning power compensation; and

(d) All phases of basic, intermediate, and advanced work disability prevention, including worker-centric return to work practices, modified or light duty jobs, other vocational recovery interventions, and medical provider collaboration on return to work, activity prescription forms, and job analyses.

(e) Training must include at least seventy-two credit hours as provided in subsection (6)(b) of this section.

(f) Curriculum submitters must provide their written core curriculum plan to the department with a table of contents listing the courses in the curriculum, and a detailed description of the content for each course. The curriculum advisory committee will review the submitters' proposed curriculum content and advise of any recommended adjustments, and the department will determine and provide notice of approval or denial within ninety days, or extend the time for approval or denial of the plan for another ninety days. The department may request additional materials, and require adjustments in the core curriculum plan prior to approval, as it deems necessary.

A department-approved curriculum must be reapproved every three years.

(6) **How does a certified claims administrator maintain their certified status ((~~beyond the initial five-year designation~~))?** A certified claims administrator may maintain certified status by((~~: (a) Retaking and passing the "self-insurance claims administrator" test as outlined in subsections (2) and (3) of this section;~~

~~or~~

~~(b) Remaining employed for a minimum of three of the last five years in the administration or oversight of claims under Title 51 RCW;~~

~~and~~)) earning the required continuing education credits as outlined in this subsection ((~~(6) of this section;~~

~~and~~

~~Applying to the department for renewal.~~

~~(6) **What is required if I choose to maintain my certified status using continuing education credits?**~~)).

(a) You must earn ((~~a minimum of seventy-five~~)) forty-five credits ((~~and submit your renewal application prior to lapse of the certified status. Extensions will not be granted~~)) every three years.

Credits earned within five years prior to the effective date of this rule may be carried forward and applied toward meeting the required continuing education credits for three years following the effective date of this rule up to a maximum of forty-five credits.

Credits ((~~must~~)) may be earned in the following ((~~categories~~)) areas:

(i) ((~~Forty claims management credits, defined as:~~

~~Instruction on any complex claim adjudication activity that is geared to an experienced adjudicator, containing information that goes beyond known, common everyday practices, including instruction on complex medical issues related to the adjudication of claims under Title 51 RCW;~~

~~and~~

~~That is not specific to the legal category.~~

~~(ii) Twenty legal credits, defined as:~~

~~Instruction on any recent changes to: Title 51 RCW, the *Washington Administrative Code*, significant board decisions, and case law. "Recent" will generally be considered decisions and changes that occurred within the eighteen-month period prior to course submittal.~~

~~(iii) Fifteen general claims education credits, defined as:~~

~~Instruction on common everyday claims and related practices such as refresher classes, industry specific training, safety, and injury prevention courses. For this category only, credit will be awarded one credit for every hour of instruction.~~

~~Excess claims management or legal credits may be applied toward the general claims education credit requirement.~~)) Instruction on relevant workers' compensation subjects that help injured workers heal and return to work, and focus on areas of recovery such as, but not limited to, medical benefit management, payment of compensation, and vocational services;

(ii) Instruction on existing or historical workers' compensation statutes, case law, rule, or departmental policy, which may assist with managing claims, answering questions, and addressing concerns in accordance with WAC 296-15-350(5);

(iii) Instruction on new developments in workers' compensation such as, but not limited to, changes in statute, case law, rule, or departmental policy, which may assist claims management personnel in remaining current in accordance with WAC 296-15-350(6); or

(iv) Credits may also be earned in injury prevention and safety, in addition to credits for injury recovery and claims administration.

The ((~~seventy-five~~)) forty-five credits must include any training designated as mandatory by the department. All training must be specific to Washington law, or describe in detail how the training is relevant to administering Washington law. If you fail to earn sufficient continuing education credits, you will be required to retake the written test to maintain your certified status.

(b) Continuing education providers must submit a training plan with a detailed outline of each area of training to the department when courses are offered. The curriculum advisory committee will review the submitters' proposed training plan and advise of any recommended adjustments, and assignment of course credit will be determined by the ((~~curriculum review committee~~)) department as follows: A maximum of one credit per hour of training will be awarded ((~~if all of the material submitted meets the definition of that category~~)). Credit will be assigned based on 0.5 increments; no credit will be awarded for increments less than 0.5. ((~~The curriculum review committee's decision will be final~~)).

(c) ((~~Courses approved for elective credits prior to the effective date of this rule change will be applied as general claims education credits.~~)) Department-approved continuing education courses must be reapproved biannually (every two years).

(d) You must track and report earned credits at the department's online database. You must obtain and retain signed verification of courses attended. Verification of earned credits must be received by the department by the date the certified claims administrator's certification date expires. Extensions will not be granted. If your certification lapses, you will not need to complete the comprehensive goal-oriented curriculum if you apply for reinstatement within two years of the lapse, and then take and pass the department's "self-insurance claims administrator" test.

(e) The department may audit the reported credits of any certified claims administrator at random, or "for cause." Falsification of reported credits will result in revocation of the individual's certified claims administrator status, and may result in the department's refusal of future applications to take the self-insurance claims administrator test.

(7) **How often must certified claims administrators notify the department of changes to their contact information?** Certified claims administrators must notify the department within thirty calendar days of the effective date of a change in mailing address, work location, or name. Changes must be reported using the department's online database.

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-400 Self-insured workers' rights and obligations. How must a self-insurer notify its workers of their rights and obligations under the industrial insurance laws?

Self-insurers must notify workers of their industrial insurance rights and obligations at the following times:

(1) Within thirty days of hire, provide a form substantially similar to the one page Workers' Compensation Filing Information L&I form F207-155-000, or if authorized by the worker provide a link to the form giving electronic access online in lieu of a paper form.

(2) When a worker files a claim, provide the following information in writing:

(a) The current edition of the department's ((~~pamphlet Employees of Self-Insured Businesses Guide to Industrial Insurance Benefits L&I~~)) pamphlet P207-085-000 ((~~or this same information in substantially similar format~~)), *A Guide to Workers' Compensation Benefits for Employees of Self-Insured Businesses*, or if authorized by the worker provide a link to the pamphlet giving electronic access online in lieu of a paper pamphlet; and

(b) The name, address, and phone number of the person or organization handling the worker's claim.

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-405 Filing a self-insured claim. (1) **What form is used to report a self-insured worker's industrial injury or occupational illness?**

The reporting form for a self-insured worker's industrial injury or occupational illness is the Self-Insurer Accident Report (SIF-2) L&I form F207-002-000. Self-insurers must obtain these forms from the department and must report their workers' industrial injuries and illnesses to the department with SIF-2s. The department tracks the claim numbers assigned to self-insurers.

When notified of injury or illness, the self-insurer must provide the worker with this prenumbered form and assistance in filing a claim. The self-insurer must provide the worker the designated copy of the completed SIF-2 (which includes an explanation of the worker's rights and responsibilities) within five working days of completion.

(2) **What form does a ((~~doctor~~)) health care provider use to report a self-insured worker's industrial accident or occupational illness?**

Physicians should report a self-insured claim with a ((~~Physician's~~)) Provider's Initial Report (PIR) L&I form F207-028-000 when a self-insured worker has an industrial injury or is notified of an occupational illness. Replacements are acceptable.

AMENDATORY SECTION (Amending WSR 06-06-066, filed 2/28/06, effective 4/1/06)

WAC 296-15-420 ((~~After a self-insured claim is filed.~~)) Requesting allowance or denial, or interlocutory order from the department—Providing claim file. ((~~(1) What must a self-insurer do when beginning time loss (TL) benefits on a claim?~~

~~When~~	~~Send to the worker~~	~~Send to the department~~	~~The department will~~
~~On the date of the first TL payment.~~	~~A complete and accurate SIF-5[1] and SIF-5A[2].~~		
~~Within 5 working days of first TL payment.~~		~~Copies of the SIF-2, SIF-5, and SIF-5A.~~	~~Allow the claim UNLESS a request for interlocutory order (see subsection (2)) or denial (see subsection (3)) has been received.~~
~~If kept on salary[3], within 5 working days of the date the first TL payment would have been due.~~	~~A complete and accurate SIF-5 and SIF-5A.~~	~~Copies of the SIF-2, SIF-5, and SIF-5A.~~	~~Allow the claim UNLESS a request for interlocutory order (see subsection (2) of this section) or denial (see subsection (3) of this section) has been received.~~

~~[1] The SIF-5 is the Self-Insurer's Report on Occupational Injury or Disease. Use a form substantially similar to L&I form F207-005-000.~~

~~[2] The SIF-5A is the Time Loss Calculation Rate Notice. Use a form substantially similar to L&I form F207-156-000.~~

~~[3] If the worker is kept on salary, report the amount of time loss the worker would have been entitled to on the SIF-5.~~

~~(2) How must a self-insurer request an interlocutory[1] order?~~

~~When requesting an interlocutory order from the department, a self-insurer must:~~

When	Send to the worker	Send to the department	The department will	And the self-insurer pays
Within 60[2] days of claim filing.	A complete and accurate SIF-5 and SIF-5A if TL was paid or if worker was kept on salary.	Copies of the SIF-2, SIF-5 (with the interlocutory order box checked), SIF-5A, AND all records excluding bills AND a reasonable explanation why an interlocutory order is needed.	If it agrees, issue an interlocutory order.	Provisional TL if the worker is eligible AND other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed.
			If it disagrees, issue an allowance order if the facts show the claim should be allowed.	TL if the worker is eligible, and other entitled benefits.

[1] An interlocutory order places a claim in provisional status while the self-insurer investigates the validity of the claim.
[2] When not specified, time is in calendar days.

(3) **How must a self-insurer request claim denial from the department?**

When requesting claim denial from the department, a self-insurer must:

When	Send to the worker	Send to the department	The department will	And the self-insurer pays
Within 60 days of claim filing.	SIF-4.[1] Copy to the attending or treating doctor.	SIF-4 AND all records excluding bills.	If it agrees, issue a denial order. The denial order will restate the self-insurer's right to request reimbursement of provisional TL from the worker.	For all medical evaluations and diagnostic studies used to make the determination.
			If it finds insufficient information to make a decision, issue an interlocutory order AND direct the employer to obtain the necessary information.	Provisional TL if the worker is eligible and other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed.
			If it disagrees, issue an allowance order if the facts show the claim should be allowed.	TL if the worker is eligible AND other entitled benefits.

[1] The SIF-4 is the Self-Insured Employer's Notice of Denial of Claim. Use a form substantially similar to L&I form F207-163-000.))

(1) **How must a self-insurer request claim allowance on a time-loss compensation claim?**

Within sixty days of notice of claim, a self-insurer must:

(a) Send a department-developed form[1] requesting allowance to the department (may be submitted electronically or paper copy), and attach copies of the SIF-2 and SIF-5A[2]. The department will allow the claim unless a request for interlocutory order (see subsection (2) of this section) or denial (see subsection (3) of this section) has been received.

(b) If the injured worker is kept on salary, send copies of the department-developed form[3] and SIF-5A within five working days of the date the first time-loss payment would have been due. The department will allow the claim UNLESS a request for interlocutory order (see subsection (2) of this section) or denial (see subsection (3) of this section) has been received.

[1]The department-developed form is the form used to request allowance (formerly SIF-5).
[2]The SIF-5A is the time-loss calculation rate notice. Use a form substantially similar to L&I form F207-156-000.
[3]If the worker is kept on salary, report the amount of time loss the worker would have been entitled to on the department-developed form.

(2) **How must a self-insurer request an interlocutory[1] order?**

When requesting an interlocutory order from the department, a self-insurer must send the department:

(a) A department-developed form requesting interlocutory status to the department (may be submitted electronically or paper copy), and attach copies of the SIF-2, and SIF-5A;

(b) The entire claim file excluding medical bills; and

(c) A reasonable explanation why an interlocutory order is needed.

A self-insurer must pay provisional time-loss if worker is eligible AND other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed. If the department disagrees with the request for an interlocutory order, it will issue an allowance order if the facts show the claim should be allowed.

[1]An interlocutory order places a claim in provisional status while the self-insurer investigates the validity of the claim.

(3) **How must a self-insurer request claim denial?**

(a) Within sixty days of notice of claim, a self-insurer must:

(i) Send a department-developed form requesting denial to the department (may be submitted electronically or paper copy) AND submit the entire claim file excluding bills. The employer will also notify the worker when a request for denial of the claim is sent to the department.

(ii) Pay for all medical evaluations and diagnostic studies used to make the determination.

(iii) Pay provisional time-loss if the worker is eligible and other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed.

(b) Upon receipt and after consideration of the request, the department will:

(i) If in agreement, issue a denial order. The denial order will restate the self-insurer's right to request reimbursement of provisional time-loss from the worker.

(ii) If information is insufficient to make a decision, issue an interlocutory order AND direct the employer to obtain the necessary information.

(iii) If it disagrees, issue an allowance order if the facts show the claim should be allowed.

[1]The department-developed form (formerly SIF-4) is the form used to request denial.

(4) **What if a self-insurer does not request allowance, denial, or an interlocutory order for a claim within sixty days?**

If a self-insurer does not request allowance, denial, or an interlocutory order within sixty days, the department will intervene and adjudicate the claim. The department may obtain additional medical information to make the determination. The claim remains in provisional status until the department makes the determination.

The exception to this requirement is the allowance of medical only claims. Self-insurers are not required to request allowance for medical only claims.

(5) **Must a self-insurer submit ((~~an~~)) a department-developed form (formerly SIF-5) each time the department requests one?**

Yes. A self-insurer must submit a complete and accurate department-developed form (formerly SIF-5) within ten working days of receipt of a written request from the department.

(6) **What must a self-insurer do when the department requests information on a claim by certified mail?**

A self-insurer must submit all requested information concerning the claim within ten working days of receipt of the department's request by certified mail.

(7) **How long does a self-insurer have to provide a copy of the claim file to the worker or worker's representative?**

A self-insurer must provide a copy of the claim file within fifteen days of receiving a written request from the worker or worker's representative. Unless the worker or representative requests a particular portion of the file, the self-insurer must provide a copy of the entire file.

(8) **When may a self-insurer charge a worker or his/her representative for a copy of the claim file?**

A self-insurer must provide the first copy of a claim file free of charge. Upon receipt of a subsequent written request, the self-insurer must provide any material not previously supplied free of charge. The self-insurer may charge the worker or any representative a reasonable fee for any material previously supplied.

((~~(9) **What must a self-insurer do when it terminates time loss?**~~

~~No later than the date of time loss termination, a self-insurer must notify the worker in writing of the reasons for time loss termination. If termination is based on a release to work not received directly from the worker, attach a copy of the release to the notice.~~))

NEW SECTION

WAC 296-15-425 Communicating to injured workers during the course of the claim. (1) **How does a self-insurer communicate claims administration actions to workers?**

The self-insurer must communicate in writing using a department-developed template to inform workers of actions involving delivery of benefits.

(2) **What is the purpose of the department-developed template?**

To provide timely and accurate delivery of benefits and prompt resolution of disputes during the course of a claim (between the allowance and closure of a claim); to promote efficient claims processing that is protective of workers and effective for employers by improving communications to workers, clarifying requirements and providing certainty of claims administration for self-insurers, and streamlining regulatory oversight by the department.

(3) **When must a department-developed template be completed and sent to the worker?**

Within five days of a claims administrator taking action on a claim involving:

(a) Calculation of the worker's monthly wage that forms the basis for time-loss compensation at time of payment;[1]

(b) Starting*, stopping, or denying time-loss compensation;

(c) Acceptance or denial of a condition contended under the claim;

(d) Authorization or denial of treatment requested by a medical provider with specified diagnosis and procedure codes for treatment requiring authorization under WAC 296-20-03001; or

(e) Assessment of an underpayment or overpayment of benefits (from date of knowledge).

*When starting time-loss compensation the self-insurer must send a copy of the department-developed template and SIF-2 to the department.

(4) **What is a department-developed template?**

A department-developed template is used by the self-insurer to inform a worker of administrative actions on the claim involving delivery of benefits. The template:

(a) Informs the worker of the action being taken, and that if the worker disputes the action the worker should within sixty days write and ask the department to intervene to adjudicate the dispute.

(b) Upon receipt of a dispute, the department will intervene to adjudicate the matter and issue an order in accordance with RCW 51.52.050.

(c) If no dispute is received, then the department will not issue an order, and when the condition of the injured worker has become fixed, the self-insurer may close the claim in accordance with RCW 51.32.055 and WAC 296-15-450. If an overpayment remains unpaid at the time of closure, then upon request, the department will issue an overpayment order in accordance with RCW 51.32.240.

[1]When communicating the worker's monthly wage, the department-developed template will serve as a cover letter to the SIF-5A, the time loss calculation rate notice under WAC 296-15-420.

AMENDATORY SECTION (Amending WSR 16-21-074, filed 10/18/16, effective 11/18/16)

WAC 296-15-4316 What must the self-insurer do when the worker declines further vocational rehabilitation services and elects option 2 benefits? When the department approves a rehabilitation plan, the department will notify the worker in writing of their right to decline further vocational rehabilitation services and elect option 2 benefits. The worker must make an election within the time frame required in WAC 296-19A-600. When the worker elects option 2 benefits, the self-insurer must take the following action within five working days of receiving the worker's request:

(1) ((~~Terminate time-loss benefits with proper notification to the worker as required in WAC 296-15-420(9);~~

~~(2) Establish the total amount of the option 2 award and a payment schedule for the option 2 benefits that begins the date time-loss is terminated;~~

~~(3)~~)) Submit a Self-Insurance Vocational Reporting Form to the department. The Self-Insurance Vocational Reporting Form must include:

(a) The total vocational services costs paid since the date the worker was found eligible for services; and

(b) The option 2 election form signed by the worker((~~; and~~

~~(c) Documentation that includes the total amount of the option 2 award and payment schedule~~)).

((~~(4)~~)) (2) Upon issuance of a department order confirming the option 2 election, terminate time loss benefits effective the date of the department order with proper notification to the worker as required in WAC 296-15-425, and commence payment of option 2 benefits to the worker according to the established payment schedule. The first payment must be made no later than fifteen days after the date time-loss is terminated. Option 2 benefits may be paid before the department issues an order.

AMENDATORY SECTION (Amending WSR 06-06-066, filed 2/28/06, effective 4/1/06)

WAC 296-15-450 Closure of self-insured claims. (1) **Who closes self-insured claims?**

The department has the authority to close all self-insured claims. Self-insurers have the authority to close certain claims.

Within two years of claim closure on a claim the self-insurer closed, the department may require a self-insurer to pay additional benefits ((~~on a claim the self-insurer closed~~)) if the self-insurer:

(a) Made ((~~an~~)) a clerical error in benefits paid; ((~~or~~))

(b) Paid benefits due to mistake of identity or innocent misrepresentation; or

(c) Violated the conditions of claim closure.

(2) **What claims may a self-insurer close?**

A self-insurer may close	**If the**	**With time loss?**	**Other requirements?**	**With PPD?**
Medical only (MO) claims	Claim was filed on or after 07/01/90 and before 08/01/97	Without	None.	Without[1]
Time loss (TL) claims	Claim was filed on or after 07/01/86 and before 08/01/97	With	1. Not if the department issued an order resolving a dispute; AND 2. Only if the worker returned to work with the employer of record at the same job or at a job with comparable wages and benefits.[2]	Without[1]
All claims: Medical only (MO) claims Time loss (TL) claims Permanent partial disability (PPD) claims	Claim was filed on or after 08/01/97	With or without	1. Not if the department issued an order resolving a dispute; AND 2. Only if the worker returned to work with the employer of record at the same job or at a job with comparable wages and benefits;[2] AND 3. Only if the closing medical report was sent to the attending or treating doctor and 14[3] days allowed for response.	With or without

1 A self-insurer may not close a claim with PPD if the injury or illness occurred before 08/01/97.

2 Comparable means the wages and benefits are at least ninety-five percent of the wages and benefits received by the worker at the time of injury.

3 When not specified, time is in calendar days.

(3) **When a self-insurer is closing a PPD claim, what must it do with the closing medical report?**

When a self-insurer is closing a PPD claim, it must send the closing medical report to the attending or treating doctor, and the

doctor must be allowed fourteen days to respond. When the attending or treating doctor responds:

Within 14 days	And the doctor AGREES with	And the doctor DISAGREES with	Then the self-insurer	
Within	Fixed and stable and PPD rating		MAY	Close the claim.
Does not respond			MAY	Close the claim
Within or before the order is issued		Fixed and stable	MUST	1. Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list; OR 2. Forward the claim to department for closure. The department may require additional medical examinations.
Within or before the order is issued	Fixed and stable	PPD rating	MUST	1. Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list; OR 2. Forward the claim to department for closure. The department may require additional medical examinations.
Not within, after the order is issued, but before the order is final		Fixed and stable and/or PPD rating	MUST	Forward the claim including the doctor's response to the department as a protest within five working days of receipt.

(4) **What must a self-insurer do with a closing medical report, regardless of who is closing the claim?**

A self-insurer must send the closing medical report to the attending or treating doctor. If the doctor responds that he/she does not concur with the results, the self-insurer must:

(a) Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list in order to do the closing action itself; OR

(b) Forward the claim to department for closure. The department may require additional medical examinations.

(5) **When a self-insurer is closing a claim, what written notice must it provide to the worker and attending or treating doctor?**

At claim closure, a self-insurer must send the closing order to the worker and attending or treating doctor.

(a) For a MO claim, use a Self-Insurer's Claim Closure Order and Notice substantially similar to F207-020-111.

(b) For a TL claim, use a Self-Insured Employers' Time Loss Claim Closure Order and Notice substantially similar to F207-070-000. Include a complete and accurate SIF-5 substantially similar to L&I form F207-005-000 with the worker's copy.

(c) For a PPD claim:

(i) When no TL or loss of earning power (LOEP) was paid, use a form substantially similar to L&I form F207-165-000 (MO with PPD). Include a complete and accurate SIF-5 with the worker's copy.

(ii) When TL or LOEP was paid, use a form substantially similar to L&I form F207-164-000 (TL with PPD). Include a complete and accurate SIF-5 with the worker's copy.

(6) **When a self-insurer is closing a claim, what information must it submit to the department?**

A self-insurer must submit to the department:

(a) MO claim closures by the end of the month following closure. These may be transferred electronically or reported by paper.

(i) Closures transferred electronically must be in the department's format.

(ii) Closures submitted in paper must include the SIF-2 L&I form F207-002-000 showing the date of closure and any vocational services provided.

(b) TL and PPD claim closures at the time of closure. Include copies of each of the following:

(i) SIF-2 if not previously submitted.

(ii) Closure order.

Note: If no one protests the self-insurer's closure order, it will become final and binding in sixty days, just like a department order.

(iii) A PPD Payment Schedule, if necessary, substantially similar to L&I form F207-162-000.

(A) A payment schedule is required when the amount of the award is more than three times the state's average monthly wage at the date of injury. At initial/down payment, send copies to the worker and the department.

(B) The first payment of the PPD award must be paid within five working days of claim closure. Continuing payments must be paid according to the established payment schedule.

(iv) A complete and accurate SIF-5 showing all requirements for closure have been met, any TL or LOEP paid, period of payment, and total amount paid.

(7) **((~~When the department is closing a claim,~~)) What must the self-insurer ((~~submit when requesting claim closure~~)) do to request closure of a claim by the department?**

When a self-insurer is asking the department to close the claim, it must submit:

(a) A complete and accurate ((~~SIF-5; and~~)) department-developed form;

(b) A transaction record of all time loss payments made; and

(c) All records not previously submitted to the department excluding bills.

(8) **When the department has closed a PPD claim, when must the self-insurer create a payment schedule?**

When the department has closed a PPD claim, the self-insurer must create a PPD Payment Schedule substantially similar to L&I form F207-162-000 when the amount of the award is more than three times the state's average monthly wage at the date of injury. At initial/down payment, send copies to the worker and the department.

(9) **When the department has closed a PPD claim, when must the self-insurer make the first payment of the award?**

When the department has closed a PPD claim, the self-insurer must make the first payment of the award without delay. Continuing payments must be paid according to the established payment schedule.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 296-15-200 Claims log—Evaluation.