POLICY 16.40

Section: **Aggravation and Reopening** **Effective:**

Title: **Policy 16.40 - Reopening Requests for Disability Benefits on Claims Closed Over Seven (Ten) Years** **Cancels:** **Interim Policy 16.40 dated 12-1-08**

See Also:
RCW 51.28.040 (change in compensation)
RCW 51.32.160 (aggravation)
WAC 296-14-100 (voluntary retirement)
WAC 296-14-400 (reopenings for benefits)
WAC 296-15-470 (self-Insurance, reopenings)
WAC 296-20-097 (reopenings)
Policy 5.91 (voluntary retirement)
Policy 16.20 (criteria for reopening)
Policy 16.31 (90-day limit)
Policy 16.35 (paying provisional time-loss)
Karniss v. Dept. of LNI
Self-Insurance Claims Adjudication Guidelines

Approved by: _____
Sandi Haerling for the Insurance Services Policy Council

This policy applies when the department or self-insured employer receives a request to reopen a claim more than seven years (or ten years for a claim for loss of vision or function of the eyes) after the first medically documented closure or reopening denial became final. For this policy adjudicator means a department adjudicator.

1. The adjudicator must determine if the request for reopening was received more than seven (ten) years after the first medically documented closure or reopening denial became final.

The seven (ten) year time limit begins with a medically recommended closure or reopening denial. Adjudicators determine the date the order became final by:

- Counting seven years plus 60 days from the department order if no protest or appeal was filed; **or**
- Counting seven years from the date of the last Board of Industrial Insurance Appeals or court decision or judgment if the department's order was appealed.

An application for reopening where a claim was closed without medical opinion is not subject to the seven (ten) year time limit. The first medically recommended closure or reopening denial starts the seven year period.

2. The adjudicator must determine whether to reopen an over seven (ten) claim for medical benefits.

When it's been over seven (ten) years since the first closure the adjudicator considers whether:

- There were any intervening accidents or injuries;
- The worsening is due to a new injury or exposure;
- The worsening is a natural progression of a preexisting condition; **and**
- All relevant records were obtained and reviewed.

3. Provisional time-loss benefits are <u>not</u> payable on a pending over seven (ten) reopening application.

4. The director has sole discretion to grant or deny, in whole or in part, payment of disability benefits on an over seven (ten) reopened claim.

Disability benefits include:

- Time-loss (TL);
- Loss of earning power (LEP);
- Vocational services;
- Permanent partial disability (PPD); **and**
- Total permanent disability (TPD) awards.

NOTE: For State Fund claims disability benefits are paid from the Accident Fund.

5. Payment of disability benefits is appropriate only in limited circumstances.

A recommendation to grant disability benefits should only be made when the worker meets all of the following criteria. The worker:

- Is attached to the workforce;
- Requires surgery as proper and necessary treatment relating to the original injury or exposure;
- Is unable to work as a direct result of the industrial injury or exposure verified by medical documentation; **and**
- Suffered financial hardship.

Additional factors which may be considered include but are not limited to:

- The worker has a life threatening need for treatment.
- The worker can benefit from a newly approved medical procedure that would significantly reduce the level of impairment.

Exceptions:

5a. To serve the interest of equity and good conscience the director may exercise discretion in an individual case even when the above guidelines haven't been met.

5b. Even if other benefits are denied the director may grant PPD if there is a significant increase due to the injury or exposure.

6. The adjudicator must prepare a recommendation memo for the director's consideration when disability benefits are contended on a reopened over seven (ten) claim.

Contended means the worker or their advocate has written to the director or the department specifically asking for this benefit. Under no circumstances should the adjudicator initiate the request.

7. The adjudicator must issue an order after the director's letter is sent.

A letter with the director's signature is sent to the worker either granting or denying benefits, in whole or in part. A copy of the letter is sent to the adjudicator. When this copy is received, the adjudicator issues an order reflecting the director's decision. The order must include protest and appeal rights.

For further information about this or other workers' compensation policies, you may contact the Insurance Services' policy program at (360) 902-5079.