Workers Compensation - Rights & Responsibilities

Worker's Right to Choose A Medical Provider within the Medical Provider Network: Workers have the right to choose their attending physician. If you want to transfer your care to another medical provider send a written note to your claims manager. Make sure to keep a copy for your records. Please refer to: **www.FindADoc.Lni.wa.gov**

Keep copies of all correspondence, orders and notices. Start your own file.

Access Claim Information: Online at the Department's claim and Account Center – www.Claiminfo.LNI.wa.gov. If you are working for a self-insured company, the Department may not have your claim file, so you will need to request a copy of your file, in writing, from the claim manager. The Third Party Administrator (TPA) is required to send the file within fifteen days from receiving the request. The Self-Insurer or TPA must provide the first copy free of charge.

State Fund accident report is available at the provider's office or you can file online at www.FileFast.Lni.wa.gov . Make sure you get your copy of the accident report for your records. Make sure to inform your Employer that you have been injured on the job.

To obtain a Self-Insured accident report (SIF-2) request a claim form from your Self-Insured employer. The employer must, by law, give you an accident report form if requested.

If you work for a Self-Insured company, the company will either handle your claim themselves or they will hire a Third Party Administrator (TPA). The Self-Insurance section at the Department of Labor and Industries oversees Self-Insured programs and can also address claim issues. 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.

Time frames for filing claims: The worker has one year from the date of injury to file a claim. For an occupational disease claim (something that happens over a period of time), the worker has two years from the date they were notified in writing, by a

provider, that the disease is work related. Provide good detailed information on the report of accident. If you have an occupational disease, explain how the exposure happened over a period of time and what job functions or repetitive work caused your symptoms.

When you sign the accident report - you are signing a release of information for your previous medical history regarding that part of your body. Be cautious of expanded medical releases. The Department or Self-Insurer is entitled, by law, to medical information that was pre-existing for that condition or exposure. You do not have to provide your entire medical history. You do need to provide any medical information that is *relevant* to your injury or disease. When filling out the report of accident do not write down a date of injury or a time of injury. The date and time applies only to accident claims.

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.

Time-loss benefits (wage replacement): Time-loss benefits are not paid for the date of injury. Time-loss benefits are not paid for the first three days following the date of injury unless the worker is physically off the job on the fourteenth consecutive day off. That does not mean that a worker must be off the job for the entire fourteen days.

The insurer (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 fourteen days of notification, the injured worker can request a penalty from the Department for a delay of benefits. If the employer is penalized, the amount assessed is given to the worker.

Health Care Benefits: The amount the employer paid monthly or the hourly for the worker's health care is added to the workers wage rate when computing time-loss benefits, ***beginning the first day of the next month after the Employer stops contributing to the worker's health care benefits***. ***Be sure to review your wage order carefully to make sure it contains your hourly rate of pay, your employer paid health care contribution, marital status, and number of dependent children.***

Protests: 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.

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 five days prior to the exam if they cannot attend the exam.

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. Project HELP can provide you with an IME checklist to take with you to the exam.

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. The claims manager is under no obligation to send you a copy of the report based on a phone call. Remember to keep copies of 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 - you must ***protest to the Department within fifteen days***.

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 physician 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.

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.

Retraining: If a retraining plan has been approved, the cost of all books, tuition, fees, supplies, and equipment will be paid for under the program. Effective July 1,2018 training costs have been increased to $ 18,294.57 for up to two years of training.

Reopening a Claim: If there is a new incident of trauma or an accident at 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 all 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 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. If it has been over seven years since 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. You will need your provider's support for the claim to remain open.

Project Help - 1-800-255-9752

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