Washington Workers' Compensation - Claims Process

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Workers' compensation is a system of no-fault insurance that provides monetary and medical benefits to employees or their survivors for work-related injuries, diseases and deaths. Workers' compensation is governed by state law.

In Washington, employers must provide workers' compensation coverage for all employees by either participating in a state-run insurance pool called the Washington State Fund (State Fund) or by becoming an authorized self-insurer.

The Washington Industrial Insurance Law (IIL) and state regulations govern how workers' compensation claims are processed in the state. The Washington Department of Labor & Insurance (L&I) handles and pays claims for employers who participate in the State Fund. Self-insured employers handle and pay their own claims, but the L&I oversees the handling and enforces the IIL.

This Employment Law Summary makes note of the different rules and processes that may apply depending on whether an employer participates in the State Fund or self-insures.

EMPLOYEE'S CLAIM FOR BENEFITS

A workers' compensation claim is initiated when an employee (or someone on his or her behalf) submits a written report of injury or illness to the L&I or to a self-insured employer. Medical treatment providers are responsible for helping employees complete and submit these reports. If an injury or disease limits the employee's ability to work, the medical provider must also submit an Activity Prescription Form to the L&I or the self-insured employer.

STATE FUND EMPLOYERS

If an employer has State Fund insurance, an employee may obtain a Report of Industrial Injury form from his or her medical provider at the initial medical visit following a workplace accident. The IIL requires medical providers to provide this form and to help each employee complete it. A medical provider must also submit the form to the L&I within **five days** after the treatment. If a medical provider does not submit an employee's claim, the employee may file it through the L&I's website or by telephone.

For occupational diseases, a diagnosing medical provider must give the employee written notice that he or she has the occupational disease and that he or she may file a claim for disability benefits with the L&I. The medical provider must also file a copy of the notice with the L&I. The employee may then need to complete and file an Occupational Disease & Employment History and other forms to provide more information about the disease.

SELF-INSURED EMPLOYERS

If an employer is self-insured, its employees initiate workers' compensation claims by completing a Self-Insurer Accident Report and submitting it to the self-insured employer. Self-insured employers are responsible for supplying this form and for assisting employees with its completion, if necessary. However, an employee's claim is not officially established until a medical provider submits a Physicians Initial Report form to the self-insured employer. Self-insured employers must promptly send copies of any completed claim forms to the L&I.

TIME LIMITS FOR INITIATING CLAIMS

Employees (or their survivors in cases of death) lose their rights to receive benefits if they do not initiate claims within:

- **One year** after:
  - A workplace accident that causes injury; or
  - An employee's death caused by a workplace accident; or
- **Two years** after:
  - A doctor's diagnosis of an occupational disease;
  - Death of an employee who had an occupational disease; or
  - An employee's last injurious workplace exposure that caused hearing loss.

CLAIM ADMINISTRATION

For every claim involving a State Fund employer, the L&I makes the decision to either allow or deny benefits under the IIL. Once it makes this decision on a claim, it will send a formal written order to both the employer and the employee. If the L&I accepts a claim, it will also begin paying any time-loss benefits to the employee within 14 days after it received the claim.

State Fund employers can stay informed about an employee's claim through their online accounts with the L&I. If a State Fund employer questions a claim, it may either outline its reasons when it files its initial notice of injury with the L&I or submit information to the L&I any time thereafter.

SELF-INSURED EMPLOYERS

Self-insured employers must begin paying time-loss benefits within **14 days** after receiving an employee's valid claim for lost work time. When a self-insured employer makes an initial payment of income benefits, it must notify the L&I of the payment within **five days**.

Within 60 days after receiving an employee's claim, a self-insured employer must send a request to the L&I for either:

- An allowance order (though this is not required for claims involving medical treatment only);
- An interlocutory order to allow more time for a compensability determination; or
- A denial order.

A request for an allowance order indicates that a self-insured employer is accepting a claim. A self-insured employer that accepts a claim must also file:

- A copy of the Self-Insurer Accident Report form; and
- A completed Wage and Time Loss Calculations form.

If a self-insured employer denies a claim, it must file a Claim Denial Request form with the L&I and provide a copy of the completed form to the employee.

After receiving one of the above requests, the L&I may investigate a claim and will ultimately issue a formal compensability decision.

Effective July 1, 2019, self-insured employers must also use an L&I form to inform employees of any actions that involve delivery of benefits. The appropriate form must be sent within **five days** after a claims administrator takes action on a claim involving:

- Calculation of the employee's monthly wage (Form 207-227-400);
- Starting (Form 207-224-000) or stopping or denying (Form 207-225-000) time-loss or loss of earning power compensation;
- Acceptance (Form 207-220-000) or denial (Form 207-221-000) of a condition contended under the claim;
- Authorization or denial of treatment requested by a medical provider with specified diagnosis and procedure codes for treatment requiring authorization (Form 207-226-000); or
- Assessment of an underpayment (Form 207-223-000) or overpayment (Form 207-222-000) of benefits (from date of knowledge).

During the claims process, employees of self-insured employers may receive assistance from the Office of the Ombudsman. The duties of this office include acting as an employee's advocate and helping resolve disputes involving self-insured employers.

PROTESTING AN L&I DECISION

Any party that disagrees with an L&I order allowing or denying benefits may request L&I reconsideration by filing a letter of protest within **60 days** of the order. If the L&I's order pertains to vocational benefits, however, the written protest is due within **15 days**. Following its receipt of a protest letter, the L&I may issue a second decision either changing or affirming the first one.

BOARD OF INDUSTRIAL INSURANCE APPEALS

Any party dissatisfied with the L&I's initial order or with an order the L&I issued after a reconsideration can appeal for review by the Board of Industrial Insurance Appeals (Board) within **60 days**. The Board is a three-member panel that is independent of the L&I and conducts its own hearings on claim issues. Once it completes the hearing process, the Board issues a written decision either affirming or changing the L&I's order.

STATE SUPERIOR COURT APPEALS

Decisions issued by the Board may be appealed to the State Superior Court, which provides the highest level of review for workers' compensation determinations in the state.

MORE INFORMATION

Contact Heffernan Insurance Brokers or visit the L&I's website for more information on workers' compensation laws in Washington.