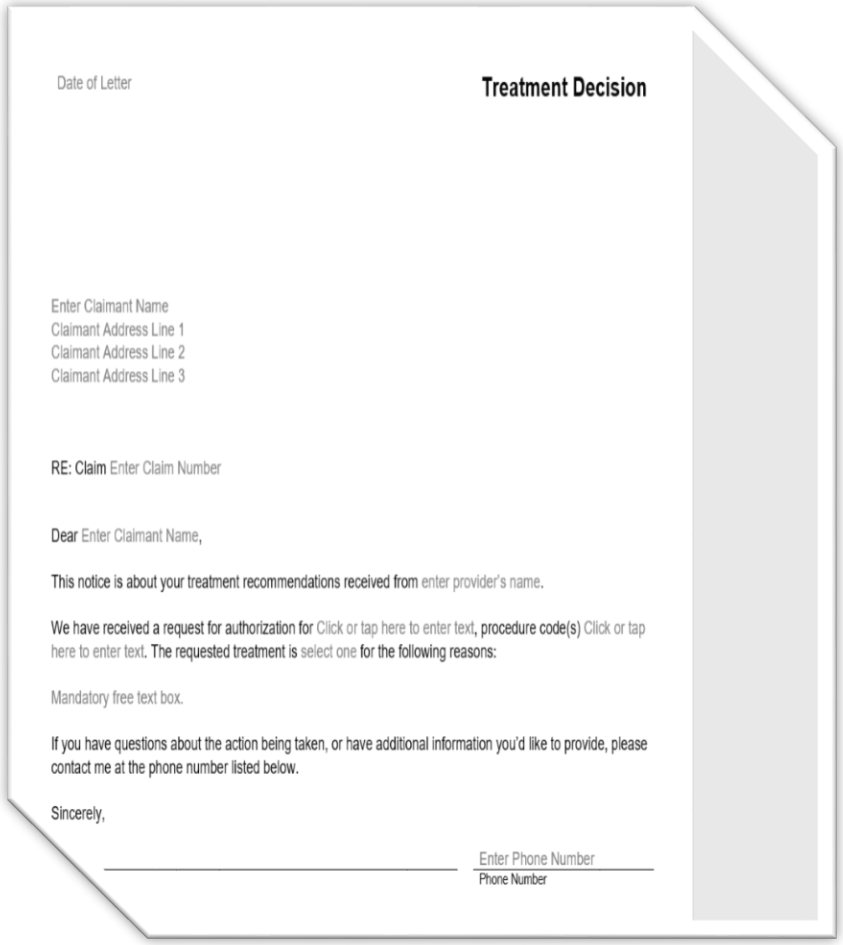
Washington State Department of
Labor & Industries



Date of Letter

Treatment Decision

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

This notice is about your treatment recommendations received from enter provider's name.

We have received a request for authorization for Click or tap here to enter text, procedure code(s) Click or tap here to enter text. The requested treatment is select one for the following reasons:

Mandatory free text box.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Enter Phone Number
Phone Number

Update 2020

Just the forms…

and templates

How did we get here?

Frustration with the current state:

- Concerns from worker advocates about inadequate communication to workers about claim decisions
- L&I as re-adjudicator, not regulator
- Requests for non-statutory orders creates backlogs and delays

Conclusion: Existing rules were outdated, leading to inefficient processes for workers, employers and L&I.

Forms and Templates

- 5 new forms – requests for action from L&I
- 8 new templates – letters communicating decisions at key points in a claim
- Used for 6 months then reevaluated and adjusted
- Use of updated forms and templates will be required 10/1/2020

Better communication to workers:

- Provides new templates for self-insured employers to more clearly inform injured workers of claim actions taken.
- Ensures self-insurers communicate key actions involving delivery of benefits.
- Explains to injured workers what to do if they dispute action taken by a self-insurer.

Greater certainty for employers:

- Encourages injured workers to contact self-insured employers with concerns at the time an action is taken.
- A new approach to unreasonable delay of benefits penalties that arise from wage calculation errors.

Adjudication between the bookends

Adjudication

Allowance

Closure

WAC 296-15-425

- Communication WAC for actions between the bookends
- Communication to Injured Workers during the course of the claim
- Provides a purpose and definition of department developed template

No Dispute?

- If there is no dispute to the actions, the department will not issue an order.

Form or a Template?

- Forms are sent to the department
  - Requesting an action from the department

- Templates are sent to the injured worker
  - Encourages the workers to contact the SIE or TPA (thus reducing dependency on the department)

Purpose driven forms

- Communication with the self-insured employer and the department
- Must be used when communicating a request to the department
- Requesting action from the department

Washington State Department of Labor & Industries

Claim Allowance Request

Self-Insurance
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Injured Worker Name	Claim Number	
Injured Worker Address		
City	State	Zip Code
Date of Injury or Manifestation	Date Form Completed	
Employer Name	UBI	Account ID
Prepared By	Preparer Phone Number (include extension if needed)	

SIF-2: Please ensure the completed SIF-2 is attached to this form, if not previously submitted to the claim file. This must be date stamped *(RCW 51.32.190)*.

Allowance Request and Compensation Paid

Type of Claim ☐ Specific Injury ☐ Occupational Disease ☐ Hearing Loss	Date of First Treatment
Has Time-Loss and/or LEP been started on this claim? ☐ Yes ☐ No ☐ KOS	
Condition(s) at Claim Allowance	

Attending Provider Information or Update

Please provide the current attending provider information.

Attending Provider Name	Attending Provider's Phone Number	
Attending Provider's Address		
City	State	Zip Code

Translation for Communicating the Decision

It is necessary the Employer and the Department ensure a means of communication to all parties per WAC 296-15-350.

Does the worker have a preferred language other than English? ☐ Yes ☐ No	If "Yes", what is the preferred language?

Templates

- Communication with self-insured employer and the injured worker
- Better communication with workers
- Must be used with communicating a key action to the injured worker
- Explains to worker how to dispute the actions taken.

Template

- Needs to be completed and sent to the worker within 5 days of taking the following actions:
  - Calculation of workers' monthly wage
  - Starting, stopping, or denying time-loss
  - Acceptance or denial of contended condition
  - Authorization or denial of treatment
  - Assessment of underpayment or overpayment

Two new templates

- A template that combines the Starting Compensation benefits and the Stop or Deny Compensation benefits.
- A new Provisional Compensation Benefits template created for use when starting provisional time loss or LEP benefits.
  - Can be used when paying ongoing benefits

Templates

- Letters communicating key benefit actions to the worker including:
  - Wage calculation
  - Starting, stopping, or denying time-loss or loss of earning power (LEP) benefits
  - Provisional payments
  - Accepting or denying newly contended conditions
  - Authorizing or denying treatment
  - Assessing underpayments or overpayments

Date of Letter

Calculation of Monthly Wage as a Basis for Time-Loss Compensation

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

I've attached a worksheet (SIF-5A), which has a detailed explanation of how your wages are calculated for paying your time-loss compensation. Please review the information carefully to ensure there are no errors.

How your benefits are calculated:

Your time-loss benefits are based on your monthly wage from all jobs at the time of your injury. If your wage is not fixed by the month, then it is determined by considering other factors, such as the hours you work per day. The monthly wage includes income earned from all employment. If you have income from any additional jobs, please let us know.

Wages may also include tips/gratuities, commission, mileage, piecework, bonuses, or the value of any employer-provided housing if appropriate. The loss of your employer's contributions to health care benefits is also considered part of your wages. Let us know if we didn't include a part of your wages.

Time-loss benefits are also based on your marital and dependent status. You will receive 60% of your gross wages if you are single with no dependents. If you are married, an additional 5% will be paid. 2% more is added for each dependent child up to five children, not to exceed the maximum time-loss rate.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name _____ Enter Phone Number _____
Name Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

Date of Letter

Start, Stop or Deny Compensation Benefits

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: **Claim** Enter Claim Number

Dear Enter Claimant Name,

Free Text Box
Examples:

- Time-loss compensation benefits started effective (date).
- Time-loss compensation benefits stopped effective (date), because you have been determined to be able to work based on transferable skills.
- Time-loss compensation benefits are denied effective (date), because you were kept of salary (KOS).
- Loss of Earning Power (LEP) started effective (date) because you returned to work on light duty.
- Loss of Earning Power is denied because you did not have a loss of earning power for the period of (date) through (date) exceeding five percent of wages at the time of injury.

General Information:

If you have been released to work or have returned to any type of work, you may not be entitled to this payment. If you have applied for, or are receiving Social Security Benefits, please notify me immediately. My goal is to help you heal and return to work and I welcome you to contact me to talk about how I may assist.

No compensation benefits are paid for the date of injury and the next three days, unless you have been disabled on the fourteenth calendar day from the date of injury. Attempts to return to work within fourteen days from the date of injury will not affect this entitlement.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name _____ Enter Phone Number _____
Name Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: (360) 902-6900

https://secure.lni.wa.gov/reportselfinsuredemployer/#

Date of Letter

Provisional Compensation Benefits

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

Provisional Choose an item **benefits started effective** Click or tap to enter a date.

Provisional compensation benefits are being paid to comply with the state industrial insurance laws, but this payment does not indicate the claim has been allowed or that you are eligible to receive the benefits. If your claim is ultimately rejected or you are deemed to not be entitled to the benefits, we have the authority to recover any compensation paid to you.

General Information:

If you have been released to work or have returned to any type of work, you may not be entitled to this payment. If you have applied for, or are receiving Social Security Benefits, please notify me immediately. My goal is to help you heal and return to work and I welcome you to contact me to talk about how I may assist.

No compensation benefits are paid for the date of injury, or the next three days, unless you have been disabled on the fourteenth calendar day from the date of injury. Attempts to return to work within fourteen days from the date of injury will not affect this entitlement.

Free text box. Delete if not needed.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name _____ Enter Phone Number _____
Name Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: (360) 902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

cc: Dept. of Labor & Industries

F207-224-000 Provisional Compensation Benefits 05-2020

Date of Letter

Accept Newly Contended Condition

Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: Claim Claim Number

Dear Enter Claimant Name,

A request for treatment was received for a newly contended condition that wasn't originally accepted on this claim.

The medical in the claim file supports the condition diagnosed as Enter diagnosis(s) as being related to the claim.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name _____ Enter Phone Number _____
Name Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

cc: Attending Provider

Date Letter Sent
Date Letter Sent

Deny Newly Contended Condition

Claimant Name
Address Line 1
Address Line 2
Address Line 3

RE: **Claim** Claim Number

Dear Enter Claimant Name,

A request for treatment was received for a newly contended condition that wasn't originally accepted on this claim.

Enter Employer Name **is not responsible for the condition(s) diagnosed as** Enter diagnosis(s), **because:**

☐ it was not caused or aggravated by the industrial injury or occupational disease for which the claim was filed.

☐ the worker did not have the condition as of Date.

This decision is based on the following documentation:

Click or tap here to enter text.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name
Name

Enter Phone Number
Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

cc: Attending Provider

Date of Letter
Date of Letter

Treatment Decision

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

This notice is about your treatment recommendations received from enter provider's name.

We have received a request for authorization for Click or tap here to enter text, procedure code(s) Click or tap here to enter text. The requested treatment is select one for the following reasons:

Mandatory free text box.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name _____ Enter Phone Number _____
Name Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

cc: Attending Provider

Date Letter Sent

Assessment of Overpayment

Claimant Name
Address Line 1
Address Line 2
Address Line 3

RE: Claim Claim Number

Dear Enter Claimant Name,

Information received reveals an overpayment in compensation benefits for the date(s) of Click or tap to enter a date through Click or tap to enter a date. The amount of the overpayment is $Enter amount of overpayment. Self-Insurers can assess overpayments in accordance with RCW 51.32.240. Overpayments can be deducted from future time-loss compensation or permanent partial disability benefits.

Mandatory free text box for explanation

Choose an item.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below. At that time, we can also make arrangements to repay the overpayment amount.

Sincerely,

Name
Name

Enter Phone Number
Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:
Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

Date Letter Sent

Notice of Underpayment

Enter Claimant Name
Claimant Address Line 1
Claimant Address Line 2
Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

Information received reveals an underpayment in compensation benefits for the date(s) of Click or tap to enter a date. through Click or tap to enter a date..

Mandatory free text box for explanation.

The amount of the underpayment is $Click or tap here to enter text.. Choose an item.

Choose an item.

If you have questions about the action being taken, or have additional information you'd like to provide, please contact me at the phone number listed below.

Sincerely,

Name — Name

Enter Phone Number — Phone Number

If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:

Department of Labor & Industries
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Or go to: http://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#

Substantially Similar

- What does that mean?
  - It is outlined in WAC 296-15-001
  - The text of the Department's document has not been altered or deleted
  - Text in approximately the same font size
  - Text with the same emphasis (bold, italics, underline)
  - Text in approximately the same location on the page as in Department document

WAC 296-15-420(1)

- Within 60 days of notice of a claim
- Claim allowance on a time-loss claim:
  - Send department developed template form requesting allowance.
  - Attach copies of the SIF-2 and SIF-5A.
  - If worker kept on salary, send copies of the department developed form and SIF-5A within 5 working days of when first TL payment would have been due.

Washington State Department of Labor & Industries

Claim Allowance Request

Self-Insurance
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Injured Worker Name	Claim Number	
Injured Worker Address		
City	State	Zip Code
Date of Injury or Manifestation	Date Form Completed	
Employer Name	UBI	Account ID
Prepared By	Preparer Phone Number (include extension if needed)	

SIF-2: Please ensure the completed SIF-2 is attached to this form, if not previously submitted to the claim file. This must be date stamped *(RCW 51.32.190)*.

Allowance Request and Compensation Paid

Type of Claim ☐ Specific Injury ☐ Occupational Disease ☐ Hearing Loss	Date of First Treatment
Has Time-Loss and/or LEP been started on this claim? ☐ Yes ☐ No ☐ KOS	
Condition(s) at Claim Allowance	

Attending Provider Information or Update

Please provide the current attending provider information.

Attending Provider Name	Attending Provider's Phone Number	
Attending Provider's Address		
City	State	Zip Code

Translation for Communicating the Decision

It is necessary the Employer and the Department ensure a means of communication to all parties per WAC 296-15-350.

Does the worker have a preferred language other than English? ☐ Yes ☐ No	If "Yes", what is the preferred language?

WAC 296-15-420(2)

- Requesting an interlocutory order:
  - Must use department form requesting interlocutory order.
  - Attach copies of SIF-2 and SIF-5A (only for TL).
  - Send entire copy of claim file.
  - Reasonable explanation of why interlocutory order needed.

- Form and Template Matrix
  - This will let you know what to say and when it needs to be sent.

Questions?