Worker Compensation Claims

Post Traumatic Stress

First Responder PTSD Presumption

- PTSD- Is a presumed occupational injury for firefighters if diagnosed
  - Rebutted by evidence showing not work related

Who Qualifies For PTSD Presumption

- Must have ten years as a professional firefighter
- Must have exposures
  - Triggering event must be after June 7, 2018
  - Leads to diagnosis of PTSD

Presumption Is:

- A shifting of the legal burden onto the employer
  - Must have diagnosis by MD psychiatrist or Psychiatric ARNP
  - Try to get the provider to say the PTSD is "MORE PROBABLE THAN NOT" related to the performance of job duties.

Presumption Is Not:

- It’s not a guaranteed approval
- Assumption that just because 10+ years on the job PTSD is present
- PTSD is not considered an occupational disease if it is attributed to disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action.
- * Don’t rule out PTSD caused the above
  - Be an advocate

Less Than 10 Years On The Job

- Still qualifies for workers compensation "Occupational Disease"
- RCW- 51.28.055, RCW-51.08.140
  - PTSD arouse proximately out of employment
  - 2 years to file claim from written notice by medical provider
  - Provider must state, **on a "more probable than not"** basis the PTSD is related to work activities.
    - **"MORE PROBABLE THAN NOT"** – It's vitally important the provider uses this language in non-presumptive illness cases.
  - Burden of proof is on the worker

Starting Off Right- Documentation

- WSCFF- PIIERS reporting
  - Encourage members to download at union meetings
  - Make it a habit
- Exposure forms
  - Keep copies
    - Paper & electronic
    - Request complete files at retirement

Starting Off Right- Peer Support

- Peer support teams
- Consider training on claim process
  - Familiarity with L&I claim forms
    - State-
    - Self-insurance- SIF-2

Starting Off Right- Peer Support

- Interviewing L&I preferred providers-
  - https://www.lni.wa.gov/claims/for-workers/find-a-doctor/
  - Quick access to treatment
    - Relationships matter!
      - Extremely hard getting into timely treatment
  - Advocates
    - Create a list for quick reference
      - Keep on your websites for private member access
    - Establish a personal relationship
      - Offer a ride-out, take them to coffee or lunch

Union Rep & Peer Support Roles

- Best when different individuals- Set roles and expectations early
- Union Rep-
  - Members with PTSD can be complex
    - Work Comp claim
    - Employment issues
    - Criminal problems
- Peer Support-
  - Help find providers
  - Someone to talk with

Starting Off Right- Treatment Providers

- Must be a physician (MD or DO)
  - Files the diagnosis claim
    - Preferably a MD psychiatrist or Psychiatric ARNP
  - Who cannot file a claim
    - Masters level counselors (LMHC)- But can treat in state fund cases
    - Psychologists (Ph.D., Psy. D.)- But can treat in both state fund and self-insurance

Starting Off Right- Timely Filing

- Claims for occupational disease must be filed within two years following the date the worker had written notice from a doctor that an occupational disease exists and a claim for disability benefits may be filed. The provider must file the written notice with the department. The department has no authority to waive the statutory filing time limit. (See *Nygaard v. Dept. of L&I*.)

WA State L&I Claim Form

Report of Accident (Workplace Injury, Accident or Occupational Disease)

Claim No. BG 85546

Language preference (check one) ❑ English ❑ Español/Spanish ❑ русский/Russian ❑ Tiếng Việt/Vietnamese ❑ 繁體中文/Chinese Traditional ❑ 简体中文/Chinese Simplified ❑ 한국어/Korean ❑ ខ្មែរ/Cambodian ❑ Soomaali/Somali ❑ Other: ______

Worker Information

1. Name (First-Middle-Last)
2. ❑ Male ❑ Female
3. Social Security Number
4. Home phone ( )
5. Birth date month / day / year
6. Home address — City, State, ZIP Code
7. Height (Ft-In.)
8. Weight
9. Mailing address (if different from home address) — City, State, ZIP Code
10. Family status: ❑ Married ❑ Widowed ❑ Separated ❑ Single ❑ Divorced ❑ Registered Domestic Partner

Dependent Information

Family and dependent eligibility: *You may be required to show proof of marriage, domestic partnership registration, or dependent eligibility.*

11. Dependent children Include unborn/estimate birth date. Benefits will be based in part on number of legally dependent children. If you don't have legal custody, complete Box 13.
12. Name of Spouse or Registered Domestic Partner:

Name	Relationship	Legal Custody	Birth date
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /
		❑ YES ❑ NO	/ /

13. Name & address of children's legal guardian — Name, Address, City, State, ZIP Code

Injury Information

14. Date of injury or last occupational exposure / /
15. Time of injury: : ❑ AM ❑ PM
16. Shift (check one) ❑ Day ❑ Swing ❑ Night
17. Have you ever been treated for the same or similar condition? ❑ YES ❑ NO
18. Is this condition due to a specific incident? ❑ YES ❑ NO

19a. Body parts injured or exposed:

19b. Describe in detail how your injury or exposure occurred. (include tools, machinery, chemicals or fumes that may have been involved)

20. Were you doing your regular job? ❑ YES ❑ NO
21. Where did the injury or exposure occur? ❑ Employer Premises ❑ Jobsite ❑ Other: ______
22. Where did the injury/exposure occur? Name of business: — Address, City, County, State, ZIP
23. Injury caused by a faulty machine, product or person other than my employer or co-worker? ❑ YES ❑ NO ❑ POSSIBLY
24. List any witnesses:
25. When will you return to work? / /
26. When did you last work? / /
27. Did you report the incident to your employer? ❑ YES ❑ NO If "yes" write name and title:
28. Date you reported it: / /
29. Did you have employer-paid health care benefits on the day injured? ❑ YES ❑ NO

Employment Information

30. Business name of your employer
31. Type of business
32. How long have you worked there? ____ Years ____ Months ____ Weeks ____ Days
33. Employer's phone ( )
34. Your employer's address — City, State, ZIP Code
35. List your job title and describe your job duties
36. Rate of pay at this job (check one) $ ❑ Hour ❑ Week ❑ Day ❑ Month ❑ More than 1 rate of pay
37. Hours per day
38. Days per week
39. Additional earnings (daily average) $ (check all that apply) ❑ Piecework ❑ Regular overtime ❑ Commission ❑ Tips ❑ Shift diff. ❑ Bonuses in the last 12 months
40. How many paying jobs do you have?
41. I am a: ❑ Owner ❑ Partner ❑ Corp. Officer ❑ Corp. Shareholder ❑ Corp. Director ❑ Optional Coverage ❑ Does not apply to me

42. Signature **Note: READ LEGAL NOTICES ON THE WORKER'S COPY OF THIS FORM**
I declare these statements are true to the best of my knowledge and belief. In signing this form, I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.
X Today's date / /

43. Signature
I authorize the Department of Labor & Industries, or others acting on their behalf, to obtain confidential employment records from the Employment Security Department (ESD) to help determine workers' compensation benefits.
X Today's date / /

Health Care Provider Information

Claim No. BG 85546

1. Diagnosis | 2. ICD Codes | 1. Diagnosis | 2. ICD Codes
3. Date you first saw patient for this condition. / /
4. Is the condition due to a specific incident? ❑ YES ❑ NO
5. Objective findings supporting your diagnosis (include physical, lab and X-ray findings)
6a. Is more treatment needed? ❑ YES ❑ NO ❑ POSSIBLY
6b. Treatment and diagnostic testing recommendations:
7. Was the diagnosed condition caused by this injury or exposure? **Check one.** ❑ YES ❑ NO ❑ PROBABLY (51% or more) ❑ POSSIBLY (Less than 50%)
8. Will the condition cause the patient to miss work? ❑ YES ❑ NO If yes, estimate the number of days: ______
9. Is there any pre-existing impairment of the injured area? ❑ YES ❑ NO If YES, describe briefly or attach report.
10. Has patient ever been treated for the same or similar condition? ❑ YES ❑ NO If YES, provider name, city & year: Name, City, Year
11. Are there any conditions that will prevent or slow recovery? ❑ YES ❑ NO If YES, describe briefly or attach report.
12. Did you refer the patient to an L&I medical network provider for follow-up? ❑ YES ❑ NO Referred to:
13. Name of attending health care provider (Please print) — Patient's ID number, if available:
14. **IMPORTANT: L&I Provider Number or NPI of provider listed in Box 13.**
15a. Name of hospital or clinic where patient was treated: Name, Phone ( ), Address, City, State, ZIP
15b. This exam date / /
16. Signature (NOTE: Licensed health care provider must sign report.) X Today's date / /

F242-130-000 Report Of Accident (Workplace Injury, Accident or Occupational Disease) 12-17

PROVIDER'S COPY

L&I Self-Insurance Claim Form

- SIF-2

Worker Start Here (Select one)
Language preference ☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other

SELF INSURER ACCIDENT REPORT (SIF-2)

UBI | Risk Class | CLAIM NUMBER SM

Self-Insured Rep: Eberle Vivian
206 Railroad Ave N.
Kent, WA 98032

Name of injured employee (First, middle, last) | Employee's home phone
Mailing address | Employer's phone number
City | State | ZIP | Social security number

Dependent Children: Include unborn, estimate birthdate. Benefits will be based, in part, on number of legally dependent children. Please indicate custody status of each child.

Name	Relationship	Legal custody (Select one)	Date of birth
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Family Status (Select one): ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Registered Domestic Partner

Sex ☐ M ☐ F | Date of birth | Height | Weight
Job title when injured
Date of hire | Shift hours | When did you last work?
Date of injury /exposure | Time of injury, Select one ☐ AM ☐ PM | When did you return to work?

Name of children's legal guardian, if other than self. | Phone
Address
City | State | ZIP

Part of body injured or exposed ☐ Right ☐ Left
Where did the injury or exposure occur? ☐ Employer premises ☐ Jobsite ☐ Parking Lot ☐ Other
Were you doing your regular job? ☐ Yes ☐ No
Was this incident caused by failure of a machine or product OR someone who is not a co-worker? (Select one) ☐ Yes ☐ No ☐ Possibly
Did you report the incident to your employer? ☐ Yes ☐ No
Name/title of person reported to: | Date reported
If reporting of incident was delayed, why?
Business name and address where injury or exposure occurred
Address | County
City | State | ZIP

Describe in detail how your injury or exposure occurred:
(include tools, machinery, chemicals or fumes that may have been involved)

List any witnesses

Was your employer contributing to your and/or your family's medical, dental and/or vision insurance on the date you were injured? ☐ Yes ☐ No
Do you consistently work overtime? ☐ Yes ☐ No
Do you have more than one rate of pay? ☐ Yes ☐ No
How many paying jobs do you have?

Have you ever been treated for the same or similar condition before? ☐ Yes ☐ No If so, when?
Rate of pay at this job. Write amount, $ (Select one) ☐ Hour ☐ Week ☐ Day ☐ Month
Hours/day | Days/week
Additional earnings (daily average) Write amount. (Select one) $ ☐ Tips ☐ Piecework ☐ Commissions
Did you receive a bonus within the last 12 months? ☐ Yes ☐ No $

Name of attending health care provider
Address
City | State | ZIP

Medical Release authorization: Pursuant to RCW 51.36.060, I hereby authorize my health care provider, hospital, agency or organization to disclose to my employer or my employer's representative or the Department of Labor and Industries any relevant medical records or other information regarding treatment which has previously been furnished to me.
Worker's signature X | Today's date

I have read the legal notice. I declare that these statements are true to the best of my knowledge and belief.
Worker's signature X | Today's date

Employer Start Here
Hourly rates of pay $ /hr hrs/day days/wk
Will you pay this employee's full salary or wages during the period of disability? Select one ☐ Yes ☐ No
Date returned to work
Was the employee engaged in the regular course of employment when injured? (Select one) ☐ Yes ☐ No
Monthly Salary? $ Other, explain
Average monthly value of all bonuses paid 12 months prior to injury $
Do you agree with employee's description of the accident? If not, explain
Average hours including OT worked ☐ Day ☐ Month Hours
Average daily earnings from piecework, tips, and commissions as reported to IRS $
L&I Use Only
If seasonal, part time or intermittent, provide 12 months gross wages $
Fatality ☐ Yes ☐ No | Date reported to employer | 3rd party involved? ☐ Yes ☐ No
Were you contributing to the worker's and/or family's medical, dental and/or vision insurance on the date of injury? ☐ Yes ☐ No
If so, how much did you pay? $ per month
When will your contributions end?
Worker's copy mailed? ☐ Yes ☐ No
Treatment only ☐ Yes ☐ No
Date closure mailed
Treatment only ROR
Lt duty provided Yes ☐ No ☐
Associated costs
I declare that the foregoing statements are true to the best of my knowledge and belief.
Date | Signature

F207-002-000 (SIF-2) SELF INSURER ACCIDENT REPORT 09-2017

L&I COPY

L&I Claim Adjudication Guidelines

- Google- WA State LNI Self-Insurance Claims Adjudication Guidelines
  - https://lni.wa.gov/insurance/self-insurance/claims-management/claims-adjudication-guidelines

SELF-INSURANCE

About Self-Insurance

Look Up Self-Insured Employers / TPAs

Self-Insurance Claims Management

Claims Adjudication Guidelines

Claims Management Tools

Loss of Earning Power

Self-Insurance Compliance Penalties

Self-Insured Form

The Self-Insurance Claims Adjudication Guidelines (CAG) is a claims management resource for new and experienced claim administrators. The CAG provides detailed instructions to support claims administrators in the completion of common tasks as listed below.

Sections are frequently updated to incorporate WAC changes or clarify content. If you have questions please contact SITrainerQuestions@lni.wa.gov.

Download chapters:

- Introduction
- Recent Updates
- Management of Claims
- Claim Validity
- Loss of Earning Power
- Medical Treatment
- Miscellaneous Claim Issues
- Pensions and Fatalities
- Permanent Partial Disabilities
- Protests and Appeals
- Reopenings
- Time-Loss Compensation
- Vocational Rehabilitation
- Wages

IME

- **May I bring a friend or relative to the exam?**
- Yes, but he or she cannot be paid or have expenses reimbursed**. If you are scheduled for a psychiatric exam, your companion will not be allowed in the examination room.**
- You should not bring minor children to an IME exam.

Sample Description Of Injury- PTSD

- Describe in detail how your injury or exposure occurred:
  - Cumulative exposure to traumatic incidents in the line of duty as a Firefighter/Paramedic. This includes responding to emergency calls of death, serious bodily injury, and threatened death.

Accuracy Of Forms

- Accurate description of injury
- Correct dates
- Secondary employment
- Signed/Dated

When To Call Attorney

- When the injured member can’t manage timelines and paperwork
- Missed paperwork and timelines jeopardizes claims
- Claim is denied- 60 days to protest/appeal
- When the injury appears to be career ending

Attorneys- WSCFF Website

- **Clark County**
  Hamrick Palmer
  Doug Palmer, 360-553-0207

- **Thurston County**
  Dustin Dailey, Putnam Lieb Potvin Dailey, Attorneys at Law, (360)754-7707
  Brandi.m@putnamlieb.com for PTSD intake 360-508-1288