

Washington State Labor & Industries Workers' Compensation at Hanford

Hanford Site Points of Contact :

Patty Hicks, Penser, Third Party Administrator
509-420-7290

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Compensation
509-438-3383

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Rights & Responsibilities

- As a member of the Washington State self-insurance community, DOE is required to follow all Washington State rules and regulations that govern the L&I process
- Workers are notified of their right to obtain off-site medical treatment and file a workers' compensation claim at HPMC with the workers' compensation advisory form at the clinic and by their specific contractor's Workers' Compensation Representative
- The self-insurance section at L&I provides oversight of DOE's self-insurance program, and DOE is subject to audits by L&I's self-insurance program compliance department as well

RCW & WAC

- RCW Title 51 - Revised Code of Washington
- WAC - Washington Administrative Codes

How Claims Are Administered

- Penser administers claims filed by Hanford workers per Title 51 of the Revised Code of Washington
- Only L&I has the authority to approve or deny claims (Not Penser, DOE, or contractors)



Compensability

- For both an injury and occupational disease claims, a medical condition must be diagnosed and the medical condition diagnosed must be related to the incident and/or job duties on a “more probable than not basis”
- It is not sufficient that a physician indicate “possibly” or “may” be the cause

Self – Insured Claim

- Report the injury to your employer
- Request a Self Insurer Accident Report (SIF2) from your Worker’s Compensation Representative (WCR)
- See a doctor of your choice
- The doctor will complete the Physician’s Initial Report (PIR) form
- The doctor mails the completed PIR to the Third Party Administrator (TPA)

SIF2 – Self Insured Accident Report

Worker Start Here
 (circle one) English Spanish Russian Korean Chinese Vietnamese
 Language Preference Laotian Cambodian Other

SELF INSURER ACCIDENT REPORT (SIF-2)
 UBI Risk class CLAIM NUMBER SD72152

Business name of self insured employer
 Employer's address City State ZIP
 Name of injured employee (First-middle-last) Mailing address City State ZIP
 Employee's home phone ()
 Employee's phone # ()
 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 Yes No	Date of birth
		Yes No	/ /
		Yes No	/ /
		Yes No	/ /

Marital status select one: Married Widowed Separated Divorced Single
 Sex M F Date of birth
 Job title when injured
 Date of hire Shift hrs When did you last work?
 Date of injury/exposure Time of injury Select one AM PM When did you return to work?
 Part of body injured or exposed Right Left

Name of children's legal guardian, if other than self Address City State ZIP
 Phone # ()

Where did the injury or exposure occur?
 Employer premises Jobsite Parking 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 City State ZIP code

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
 Have you ever been treated for 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
 Name of attending physician Address City State ZIP
 Worker's signature X Today's date / /

Do you consistently work overtime? Yes No
 Do you have more than one rate of pay? Yes No
 Do you have more than one employer? Yes No
 Additional earnings (daily average) Write amount, select one \$ / / / /
 Tips Piecework last 12 months? Commission Yes No \$
 Did you receive a bonus within the last 12 months? Yes No \$

Medical Release authorization: I hereby authorize my physician, hospital, agency or organization to disclose to my employer or their representative or the Dept. of Labor & Industries any 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 on the reverse side of employee's copy. I declare that these statements are true to the best of my knowledge and belief.
 Worker's signature / / Today's date / /

Employer Start here
 Date returned to work / /
 Was employee engaged in the regular course of employment when injured? select one Yes No
 Do you agree with employer's description of the accident? If not, explain. Yes No
 Hourly rates of pay \$ / / hr hrs/dy
 Monthly Salary \$ / / hrs/dy days/wk
 Other, explain: / / / /
 Average hrs including O/T worked Hrs: / / Day Mo
 Average daily earnings from piecework, tips and commissions as reported to IRS \$ / /
 If seasonal part time or intermittent, provide 12 months gross wages \$ / / / /
 Will you pay this employee full salary or wages during period of disability? select one Yes No
 Average monthly value of all bonuses paid 12 months prior to injury \$ / /
 L & I use only

Were you contributing to this worker's and/or family's medical, dental and/or vision insurance on date of injury? Yes No
 If so, how much did you pay? Per Mo. / /
 Was this medical insurance in effect on the day of injury? Yes No
 When will coverage end? / /
 Fatality Yes No Date reported to employer / / 3rd party involved? Yes No

Worker's copy mailed Yes No
 Treatment only date closure mailed Yes No
 Treatment only KOR: 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 / /

F207-003-000 self insurer accident report - employer (sif-2) 11-03
 LABOR & INDUSTRIES COPY

PIR – Physician's Initial Report

(Circle one) English Spanish Russian Korean Chinese
 Language Preference Vietnamese Laotian Cambodian Other

PHYSICIANS INITIAL REPORT

MAIL TO SELF INSURED COMPANY

1. NAME OF SELF-INSURED EMPLOYER _____

ADDRESS _____
 CITY _____ STATE _____ ZIP _____

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE _____

ADDRESS _____
 CITY _____ STATE _____ ZIP _____

EMPLOYER'S TELEPHONE NO. _____ EMPLOYER'S SERVICE REP PHONE _____

Physician -- START HERE

3. Date patient first seen by you for this injury/condition _____

a. ICDM-9 CODE _____ b. Diagnosis - Specify Right / Left _____

4. Are there objective findings to support this diagnosis?
 No Yes, Specify _____

5. Referred for Diagnostic Studies
 No Yes, Specify _____

6. Treatment Recommendations _____

7. Referred to: Dr. _____
 Address: _____
 Phone: _____

Distribution: White - Employer, Canary - Worker, Pink - Physician
 F267-028-000 Physician Initial Report 03-2007

1. CLAIM NUMBER _____

Instructions on reverse side

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST _____

3. WORKER'S TELEPHONE NO. _____

4. MAILING ADDRESS _____

5. SOCIAL SECURITY NUMBER _____

6. CITY _____ STATE _____ ZIP CODE _____

7. DATE OF BIRTH _____

8. INJURY DATE _____

9. TIME _____
 A.M. P.M.

10. Have you missed work due to your injury? If so, what dates were you out? From: _____ To: _____

11. SEX _____ 12. MARITAL STATUS - NUMBER OF DEPENDENTS _____

13. Describe in detail how your injury or exposure occurred: _____

14. MEDICAL RELEASE AUTHORIZATION: I HEREBY AUTHORIZE MY PHYSICIAN, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY MEDICAL RECORDS FURNISHED TO ME.
 Worker's Signature _____ Date _____

15. I have read this statement of Responsibility and the Legal Notice on the reverse side of this form.
 Worker's Signature _____ Date _____

8. a. Has the worker ever been treated for the same or similar condition? Select one. If YES, describe briefly or attach report.
 No Yes _____

b. Is there any pre-existing impairment of the injured area? Select one. If YES, describe briefly or attach report.
 No Yes _____

c. Are there any conditions that will prevent or retard recovery? Select one. If YES, describe briefly or attach report.
 No Yes _____

d. Was the diagnosed condition caused by this injury or exposure on a more probable than not basis? No Yes _____

9. a. Have you released this worker to return to regular work?
 No Yes effective date _____

b. Have you released this worker to return to light duty?
 No Yes effective date _____

c. What restrictions are placed on light duty return to work?
 Lifting _____ Bending _____
 Standing _____ Sitting _____
 Other _____

d. If not released for work, estimate number of days of time loss: _____

Licensed Physician must sign before report is accepted

10. Signature _____

11. Phone _____ 12. Date _____

13. Physician Name (print or type) _____

14. Address _____
 City _____ State _____ ZIP _____

15. Payee LAI Account Number / NPI _____ 16. IFS Account # _____

DO NOT SEND THIS FORM TO LABOR & INDUSTRIES

Department of Labor & Industries

Order & Notice

FROM:
STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
DIVISION OF INDUSTRIAL INSURANCE
SELF-INSURANCE SECTION
PO BOX 44892
OLYMPIA WA 98504-4892
FAX (360) 902-6900

MAILING DATE: 05/19/10
CLAIM ID : SF41270
CLAIMANT :
EMPLOYER : U S DEPT OF ENERGY
INJURY DATE : 4/06/10
SERVICE LOC : KENNEWICK
UBI NUMBER : 601-319-923
ACCOUNT ID : 706178-00
RISK CLASS : 7002-00

U S DEPT OF ENERGY
C/O PENSER NORTHAMERICA INC
1818 TERMINAL DRIVE
RICHLAND WA 99354

WORK LOCATION ADDRESS:
NO ADDRESS REPORTED

ORDER AND NOTICE (SELF INSURING EMPLOYER)

* THIS ORDER BECOMES FINAL 60 DAYS FROM THE DATE IT IS COMMUNICATED *
* TO YOU UNLESS YOU DO ONE OF THE FOLLOWING: FILE A WRITTEN REQUEST *
* FOR RECONSIDERATION WITH THE DEPARTMENT OR FILE A WRITTEN APPEAL *
* WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS. IF YOU FILE FOR *
* RECONSIDERATION, YOU SHOULD INCLUDE THE REASONS YOU BELIEVE THIS *
* DECISION IS WRONG AND SEND IT TO: DEPARTMENT OF LABOR AND *
* INDUSTRIES, PO BOX 44892, OLYMPIA, WA 98504-4892. WE WILL REVIEW *
* YOUR REQUEST AND ISSUE A NEW ORDER. IF YOU FILE AN APPEAL, SEND *
* IT TO: BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, *
* OLYMPIA WA 98504-2401 OR SUBMIT IT ON AN ELECTRONIC FORM FOUND AT *
* HTTP://WWW.BIIA.WA.GOV/. *

The worker sustained an injury or occupational disease while in the course of employment with a self insured employer.
This claim is allowed. The worker is entitled to receive medical treatment and other benefits as appropriate under the industrial insurance laws.

Workers Responsibility

- You need to tell the doctor if you feel the injury or disease is work related
- Respond timely to requests for information from the WCR or Penser:
 - prior medical
 - attending physician contact information
 - correct personal contact information
 - work history
- Communication with your claims examiner will help you understand the process

Benefits Covered

- Medical treatment/bills
- Wage compensation
- Vocational services
- Permanent partial disability

Medical Treatment

The cost of all hospital, surgical and other medical services necessary for the treatment of the work place injury or disease is covered.

Wage Compensation

- Temporary Total Disability (TTD)
 - TTD is payable when an injury or disease temporarily and totally disables an employee's ability to return to work
- Loss of Earning Power Benefits (LEP)
 - LEP is payable when an employee has returned to light duty and the light duty results in a wage reduction greater than 5%
- Permanent Total Disability (PTD)
 - PTD is payable when an injury or disease permanently and totally disables an employee's ability to return to the work force

Permanent Partial Disability

When a work place injury or disease results in a permanent physical impairment, a rating evaluation is conducted by either the treating physician or an independent medical examiner. Once the percentage of impairment is determined the Washington State Department of Labor & Industries will issue a closing order that stipulates the impairment award associated with the percentage of loss.

A Key Point of Workers' Compensation

Washington State Workers' Compensation is ruled, regulated and legislated by the State and is separate from EEOICPA (Department of Labor, Federal Program)

Resources For Information:

- Hanford Workers' Compensation - Questions or concerns about your claim or just need additional information on our Self-Insurance for Workers' Compensation at the Hanford Site
 - Phone: 509-376-1525 (Juli Yamauchi, Program Manager Hanford Workers' Compensation)
 - Website: <http://www.hanford.gov>
- Self insurance section of the Washington State Department of Labor & Industries.
 - Phone: 360-902-6901
 - Website: <http://www.lni.wa.gov/Main/WorkerTopics.asp>
- To locate a L&I provider:
 - Website: findadoc@lni.wa.gov
- Department of Labor & Industries/Office of the Self Insured Ombudsman
 - Phone: 1-888-317-0493