WAC 296-15-420 Requesting allowance or denial, or interlocutory order from the department—Providing claim file. (1) **How must a self-insurer request claim allowance on a time-loss compensation claim?**

Within sixty days of notice of claim, a self-insurer must:

(a) Send a department-developed form[1] requesting allowance to the department (may be submitted electronically or paper copy), and attach copies of the SIF-2 and SIF-5A[2]. The department will allow the claim unless a request for interlocutory order (see subsection (2) of this section) or denial (see subsection (3) of this section) has been received.

(b) If the injured worker is kept on salary, send copies of the department-developed form[3] and SIF-5A within five working days of the date the first time-loss payment would have been due. The department will allow the claim UNLESS a request for interlocutory order (see subsection (2) of this section) or denial (see subsection (3) of this section) has been received.

[1]The department-developed form is the form used to request allowance (formerly SIF-5).
[2]The SIF-5A is the time-loss calculation rate notice. Use a form substantially similar to L&I form F207-156-000.
[3]If the worker is kept on salary, report the amount of time-loss the worker would have been entitled to on the department-developed form.

(2) **How must a self-insurer request an interlocutory[1] order?**

Within sixty days of notice of claim, a self-insurer must send the department:

(a) A department-developed form requesting interlocutory status to the department (may be submitted electronically or paper copy), and attach copies of the SIF-2, and SIF-5A;

(b) The entire claim file excluding medical bills; and

(c) A reasonable explanation why an interlocutory order is needed.

A self-insurer must pay provisional time-loss if worker is eligible AND other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed. If the department disagrees with the request for an interlocutory order, it will issue an allowance order if the facts show the claim should be allowed.

[1]An interlocutory order places a claim in provisional status while the self-insurer investigates the validity of the claim.

(3) **How must a self-insurer request claim denial?**

(a) Within sixty days of notice of claim, a self-insurer must:

(i) Send a department-developed form[1] requesting denial to the department (may be submitted electronically or paper copy) AND submit the entire claim file excluding bills. The employer will also notify the worker when a request for denial of the claim is sent to the department.

(ii) Pay for all medical evaluations and diagnostic studies used to make the determination.

(iii) Pay provisional time-loss if the worker is eligible and other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed.

(b) Upon receipt and after consideration of the request, the department will:

(i) If in agreement, issue a denial order. The denial order will restate the self-insurer's right to request reimbursement of provisional time-loss from the worker.

(ii) If information is insufficient to make a decision, issue an interlocutory order AND direct the employer to obtain the necessary information.

(iii) If it disagrees, issue an allowance order if the facts show the claim should be allowed.

[1]The department-developed form (formerly SIF-4) is the form used to request denial.

(4) **What if a self-insurer does not request allowance, denial, or an interlocutory order for a claim within sixty days?**

If a self-insurer does not request allowance, denial, or an interlocutory order within sixty days, the department will intervene and adjudicate the claim. The department may obtain additional medical information to make the determination. The claim remains in provisional status until the department makes the determination.

The exception to this requirement is the allowance of medical only claims. Self-insurers are not required to request allowance for medical only claims.

(5) **Must a self-insurer submit a department-developed form (formerly SIF-5) each time the department requests one?**

Yes. A self-insurer must submit a complete and accurate department-developed form (formerly SIF-5) within ten working days of receipt of a written request from the department.

(6) **What must a self-insurer do when the department requests information on a claim by certified mail?**

A self-insurer must submit all requested information concerning the claim within ten working days of receipt of the department's request by certified mail.

(7) **How long does a self-insurer have to provide a copy of the claim file to the worker or worker's representative?**

A self-insurer must provide a copy of the claim file within fifteen days of receiving a written request from the worker or worker's representative. Unless the worker or representative requests a particular portion of the file, the self-insurer must provide a copy of the entire file.

(8) **When may a self-insurer charge a worker or his/her representative for a copy of the claim file?**

A self-insurer must provide the first copy of a claim file free of charge. Upon receipt of a subsequent written request, the self-insurer must provide any material not previously supplied free of charge. The self-insurer may charge the worker or any representative a reasonable fee for any material previously supplied.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-420, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-420, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a). WSR 98-24-121, § 296-15-420, filed 12/2/98, effective 1/2/99.]