Chapter 296-14 WAC
INDUSTRIAL INSURANCE

Last Update: 1/20/26

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

296-14-010 Reciprocal agreements—Industrial insurance. [Statutory Authority: RCW 51.32.110 and 51.32.190(6). WSR 90-19-028, § 296-14-010, filed 9/12/90, effective 10/13/90. Statutory Authority: RCW 51.04.020(1). WSR 84-06-018 (Order 84-3), § 296-14-010, filed 2/29/84; Order 74-29, § 296-14-010, filed 5/29/74, effective 7/1/74.] Repealed by WSR 98-18-042, filed 8/28/98, effective 10/1/98. Statutory Authority: RCW 51.16.035.

296-14-015 Industrial insurance labor-management cooperation program. [Statutory Authority: 1991 c 172. WSR 92-03-053, § 296-14-015, filed 1/13/92, effective 2/13/92.] Repealed by WSR 98-18-042, filed 8/28/98, effective 10/1/98. Statutory Authority: RCW 51.16.035.

296-14-950 Appointment of attorney as special assistant. [Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-950, filed 3/31/88.] Repealed by WSR 93-23-060, filed 11/15/93, effective 1/1/94. Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304.

296-14-960 Limitations of appointment. [Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-960, filed 3/31/88.] Repealed by WSR 93-23-060, filed 11/15/93, effective 1/1/94. Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304.

WAC 296-14-100 Definition of voluntary retirement. (1) **What is voluntarily retired?** The worker is considered voluntarily retired if both of the following conditions are met:

(a) The worker is not receiving income, salary or wages from any gainful employment; and

(b) The worker has provided no evidence to show a bona fide attempt to return to work after retirement.

Time-loss compensation is not paid to workers who voluntarily retired from the work force.

(c) Payment of union dues or medical or life insurance premiums does not constitute attachment to the work force.

(2) **When is a worker determined not to be voluntarily retired?** A worker is not voluntarily retired when the industrial injury or occupational disease is a proximate cause for the retirement.

[Statutory Authority: RCW 51.04.020. WSR 99-18-062, § 296-14-100, filed 8/30/99, effective 9/30/99. Statutory Authority: RCW 51.32.060, 51.32.090, 51.32.160, 51.21.220(6) [51.32.220(6)] and 51.32.240 (1), (2) or (3). WSR 86-18-036 (Order 86-33), § 296-14-100, filed 8/28/86.]

WAC 296-14-150 Definition of gainful employment for wage. Gainful employment for wages for the purposes of RCW 51.32.160 shall mean performing work at any regular gainful occupation for income, salary or wages.

[Statutory Authority: RCW 51.32.060, 51.32.090, 51.32.160, 51.21.220(6) [51.32.220(6)] and 51.32.240 (1), (2) or (3). WSR 86-18-036 (Order 86-33), § 296-14-150, filed 8/28/86.]

WAC 296-14-200 Waiver of recovery for worker compensation benefits overpayments. Whenever the director determines whether to exercise the discretion granted by RCW 51.32.240 (1), (2) or (3) or 51.32.220(6) the following shall apply:

(1) The decision of the director shall apply to the state fund or to the self-insurer, as the case may be.

(2) In the case of recoupment of an overpayment from any future payments, the director will entertain a request to exercise his or her discretion to waive recovery up to 60 days after communication of the order and/or notice to the recipient that benefits are being withheld to satisfy the previous overpayment.

(3) A finding by the director that recovery of an overpayment would be against equity and good conscience shall be required before the overpayment can be waived in whole or in part. The director shall consider the following factors and any other factors relevant to the particular case:

(a) Whether the claimant was without fault in applying for and accepting benefits which gave rise to the overpayment;

(b) Whether recovery of the overpayment, in whole or in part, would defeat the purposes of Title 51 RCW;

(c) Whether the claimant reasonably relied upon the benefits, or notice that such benefits would be paid and relinquished a valuable right or changed his or her position for the worse;

(d) Whether the claimant reasonably relied upon misinformation from an official source (i.e., a representative of the department or self-insurer, as the case may be) in accepting the benefit payment which gave rise to the overpayment.

(4) The claimant's application for waiver of an overpayment contemplated under RCW 51.32.240 (1), (2), or (3), or 51.32.220(6) shall clearly set forth the reason(s) that he or she believes that recovery of the overpayment in whole or in part, as the case may be, is against equity and good conscience.

[Statutory Authority: RCW 51.32.060, 51.32.090, 51.32.160, 51.21.220(6) [51.32.220(6)] and 51.32.240 (1), (2) or (3). WSR 86-18-036 (Order 86-33), § 296-14-200, filed 8/28/86.]

WAC 296-14-300 Mental condition/mental disabilities. (1) Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease.

Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

(a) Change of employment duties;

(b) Conflicts with a supervisor;

(c) Actual or perceived threat of loss of a job, demotion, or disciplinary action;

(d) Relationships with supervisors, coworkers, or the public;

(e) Specific or general job dissatisfaction;

(f) Work load pressures;

(g) Subjective perceptions of employment conditions or environment;

(h) Loss of job or demotion for whatever reason;

(i) Fear of exposure to chemicals, radiation biohazards, or other perceived hazards;

(j) Objective or subjective stresses of employment;

(k) Personnel decisions;

(l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses of self-employed individuals or corporate officers.

(2)(a) Stress resulting from exposure to a single traumatic event will be adjudicated as an industrial injury. See RCW 51.08.100.

(b) Examples of single traumatic events include: Actual or threatened death, actual or threatened physical assault, actual or threatened sexual assault, and life-threatening traumatic injury.

(c) These exposures must occur in one of the following ways:

(i) Directly experiencing the traumatic event;

(ii) Witnessing, in person, the event as it occurred to others; or

(iii) Extreme exposure to aversive details of the traumatic event.

(d) Repeated exposure to traumatic events, none of which are a single traumatic event as defined in subsection (2)(b) and (c) of this section, is not an industrial injury (see RCW 51.08.100) or an occupational disease (see RCW 51.08.142). A single traumatic event as defined in subsection (2)(b) and (c) of this section that occurs within a series of exposures will be adjudicated as an industrial injury (see RCW 51.08.100).

(3) For certain firefighters, law enforcement officers, and direct care registered nurses there is a presumption that posttraumatic stress disorder (PTSD) is an occupational disease as provided by RCW 51.08.142, 51.32.185, and 51.32.395.

(4) For public safety telecommunicators, PTSD may be considered an occupational disease as provided by RCW 51.08.142.

(5) Mental conditions or mental disabilities that specify pain primarily as a psychiatric symptom (e.g., somatic symptom disorder, with predominant pain), or that are characterized by excessive or abnormal thoughts, feelings, behaviors or neurological symptoms (e.g., conversion disorder, factitious disorder) are not clinically related to occupational exposure.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.08.142, and 51.32.395. WSR 24-01-112, § 296-14-300, filed 12/19/23, effective 1/19/24. Statutory Authority: RCW 51.04.020, 51.08.142, and 51.32.185. WSR 23-08-063, § 296-14-300, filed 4/4/23, effective 5/5/23. Statutory Authority: RCW 51.04.020, 51.04.030, and 51.08.142. WSR 15-19-139, § 296-14-300, filed 9/22/15, effective 10/23/15. Statutory Authority: Chapters 51.08 and 51.32 RCW. WSR 88-14-011 (Order 88-13), § 296-14-300, filed 6/24/88.]

WAC 296-14-310 When does a presumption of occupational disease for certain members of firefighters' and law enforcement officers' retirement systems apply? RCW 51.32.185 specifies a presumption that certain medical conditions are occupational diseases. A presumption of occupational disease applies to firefighters and emergency medical technicians (EMTs) as defined in RCW 41.26.030 (17)(a), (b), (c), and (h) and fire investigators. The presumption also applies to law enforcement officers as defined in RCW 41.26.030 (19)(b), (c), and (e).

(1) For firefighters and EMTs those conditions are heart problems experienced within 72 hours of exposure to smoke, fumes, or toxic substances; or experienced within 24 hours of strenuous physical exertion due to firefighting activities; respiratory disease; specific cancers; infectious diseases; and posttraumatic stress disorder (PTSD).

(2) For fire investigators those conditions are heart problems experienced within 72 hours of exposure to smoke, fumes, or toxic substances, or experienced within 24 hours of strenuous physical exertion due to firefighting activities; respiratory disease; specific cancers; and infectious diseases.

(3) For law enforcement officers those conditions are heart problems experienced within 72 hours of exposure to smoke, fumes, or toxic substances, or experienced within 24 hours of strenuous physical exertion in the line of duty; infectious diseases; and PTSD.

(4) The presumption extends to covered members after the last date of employment for a period of three calendar months for each year of service. The presumption may not extend more than 60 months after the last date of employment.

(5) For consideration of a PTSD presumption, the active or former firefighter or law enforcement officer must work on or after July 7, 2018, and serve at least 10 years before the PTSD develops.

(6) For consideration of a cancer presumption, the active or former firefighter or fire investigator must serve at least 10 years before the cancer develops.

(7) For claims filed on or after July 1, 2003, the presumption may not apply to heart or lung conditions for users of tobacco products.

(8) When the presumption does not apply, the claim is not automatically denied. However, the burden is on the worker to prove that the condition is otherwise allowable as an injury or occupational disease.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.32.185. WSR 22-20-087, § 296-14-310, filed 10/4/22, effective 11/4/22. Statutory Authority: RCW 51.04.020, 51.32.185. WSR 03-12-046, § 296-14-310, filed 5/30/03, effective 7/1/03.]

WAC 296-14-315 Definitions. (1) **Tobacco products:** For purposes of this rule, tobacco products are limited to those that are smoked, including cigarettes, pipes and cigars.

(2) **User of tobacco products:** For the purposes of this rule, a user of tobacco products is a "smoker."

(3) **Current smoker:** A current smoker is a regular user of tobacco products, has smoked tobacco products at least 100 times in his/her lifetime, and as of the date of manifestation did smoke tobacco products at least some days.

(4) **Former smoker:** A former smoker has a history of tobacco use, has smoked tobacco products at least 100 times in his/her lifetime, but as of the date of manifestation did not smoke tobacco products.

[Statutory Authority: RCW 51.04.020, 51.32.185. WSR 03-12-046, § 296-14-315, filed 5/30/03, effective 7/1/03.]

WAC 296-14-320 Does the presumption apply to current smokers with heart or lung conditions? No. The presumption never applies to current smokers with heart or lung conditions.

[Statutory Authority: RCW 51.04.020, 51.32.185. WSR 03-12-046, § 296-14-320, filed 5/30/03, effective 7/1/03.]

WAC 296-14-325 When does the presumption apply to firefighters, emergency medical technicians (EMTs), fire investigators and law enforcement officers who are former smokers with heart or lung conditions? (1) **Heart problems:** The presumption for heart problems applies

if a firefighter or EMT as defined in RCW 41.26.030 (17)(a), (b), (c), and (h) or fire investigator is a former smoker and last smoked two years or more prior to the cardiac event. The presumption for heart problems also applies if a law enforcement officer as defined in RCW 41.26.030 (19)(b), (c), and (e) is a former smoker and last smoked two years or more prior to the cardiac event.

(2) **Lung conditions:** The presumption for lung conditions in firefighters, EMTs, and fire investigators will apply:

(a) For **asthma** if they are a former smoker and last smoked five years or more prior to the date of manifestation of the disease; or

(b) For **chronic obstructive pulmonary disease/emphysema/chronic bronchitis** if they are a former smoker who last smoked 15 years or more prior to the date of manifestation of the disease; or

(c) For **lung cancer** if they are a former smoker who last smoked 15 years or more prior to the date of manifestation of the disease.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.32.185. WSR 22-20-087, § 296-14-325, filed 10/4/22, effective 11/4/22. Statutory Authority: RCW 51.04.020, 51.32.185. WSR 03-12-046, § 296-14-325, filed 5/30/03, effective 7/1/03.]

WAC 296-14-330 What tobacco use may exclude a firefighter, emergency medical technician (EMT), fire investigator, or law enforcement officer from a presumption of coverage? The following table summarizes the situations listed in WAC 296-14-310 through 296-14-325 under which a presumption of coverage may not apply for firefighters and EMTs as defined in RCW 41.26.030 (17)(a), (b), (c), and (h) and fire investigators; and law enforcement officers as defined in RCW 41.26.030 (19)(b), (c), and (e) due to tobacco use.

Medical condition	Presumptions shall not apply	Presumption shall apply
Heart problems experienced within seventy-two hours of exposure to smoke, fumes, or toxic substance	Firefighters, EMTs, fire investigators, and law enforcement officers that are current smokers	Firefighters, EMTs, fire investigators, and law enforcement officers that never smoked tobacco
	Firefighters, EMTs, fire investigators, and law enforcement officers that are former smokers and last smoked **less** than two years prior to the cardiac event	Firefighters, EMTs, fire investigators, and law enforcement officers that are former smokers and last smoked two years or **more** prior to the cardiac event

Medical condition	Presumptions shall not apply	Presumption shall apply
Asthma	Firefighters, EMTs, and fire investigators that are current smokers	Firefighters, EMTs, and fire investigators that never smoked tobacco
	Firefighters, EMTs, and fire investigators that are former smokers and last smoked **less** than five years before date of manifestation of the disease	Firefighters, EMTs, and fire investigators that are former smokers and last smoked five years or **more** before date of manifestation of the disease
Chronic obstructive pulmonary disease/ emphysema/ chronic bronchitis	Firefighters, EMTs, and fire investigators that are current smokers	Firefighters, EMTs, and fire investigators that never smoked tobacco
	Firefighters, EMTs, and fire investigators that are former smokers and last smoked **less** than 15 years before date of manifestation of the disease	Firefighters, EMTs, and fire investigators that are former smokers and last smoked 15 years or **more** before date of manifestation of the disease
Lung cancer	Firefighters, EMTs, and fire investigators that are current smokers	Firefighters, EMTs, and fire investigators that never smoked tobacco
	Firefighters, EMTs, and fire investigators that are former smokers and last smoked **less** than 15 years before date of manifestation of the disease	Firefighters, EMTs, and fire investigators that are former smokers and last smoked 15 years or **more** before date of manifestation of the disease

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.32.185. WSR 22-20-087, § 296-14-330, filed 10/4/22, effective 11/4/22. Statutory Authority: RCW 51.04.020, 51.32.185. WSR 03-12-046, § 296-14-330, filed 5/30/03, effective 7/1/03.]

WAC 296-14-340 Frontline workers—Verification for contraction of an infectious or contagious disease that is the subject of a public health emergency—RCW 51.32.181. (1) Verification that an infectious or contagious disease has been contracted requires written documentation of:

(a) A diagnosis from a medical provider made by examination; or

(b) A positive test administered or verified by a medical facility, testing facility, pharmacy, or the employer's facility.

(2) The following cannot be used as verification that a worker has contracted an infectious or contagious disease:

(a) Symptoms only self-reported by the worker; or

(b) A report from a medical provider that solely relies on a worker's self-reported positive test results.

[Statutory Authority: RCW 51.04.020, 51.32.181, and 51.32.390. WSR 23-06-062, § 296-14-340, filed 2/28/23, effective 3/31/23.]

WAC 296-14-341 Health care workers—Verification for contraction or quarantine due to an infectious or contagious disease that is the subject of a public health emergency—RCW 51.32.390. (1) Verification that an infectious or contagious disease has been contracted requires written documentation of:

(a) A diagnosis from a medical provider made by examination; or

(b) A positive test administered or verified by a medical facility, testing facility, pharmacy, or the employer's facility.

(2) The following cannot be used as verification that a worker has contracted an infectious or contagious disease:

(a) Symptoms only self-reported by the worker; or

(b) A report from a medical provider that solely relies on a worker's self-reported positive test results.

(3) Verification that a worker has been quarantined due to exposure to the infectious or contagious disease that is the subject of a public health emergency requires written documentation of:

(a) A medical provider or public health official indicating the worker should remain away from work for a period of time after exposure; or

(b) Confirmation from the employer that it asked the worker to remain away from work for a period of time after exposure.

(4) Quarantine does not include:

(a) Self-quarantine by a worker without direction from a medical provider, public health official, or their employer;

(b) Quarantine without exposure; or

(c) Quarantine after exposure for a length of time exceeding accepted public safety and health guidelines at the time of quarantine, from the relevant agencies.

[Statutory Authority: RCW 51.04.020, 51.32.181, and 51.32.390. WSR 23-06-062, § 296-14-341, filed 2/28/23, effective 3/31/23.]

WAC 296-14-350 Claim allowance and wage determination in occupational disease cases. (1) The liable insurer in occupational disease cases is the insurer on risk at the time of the last injurious exposure to the injurious substance or hazard of disease during employment within the coverage of Title 51 RCW which gave rise to the claim for compensation. Such Title 51 RCW insurer shall not be liable, however, if the worker has a claim arising from the occupational disease that is allowed for benefits under the maritime laws or Federal Employees' Compensation Act.

(2) The compensation schedules and wage base for claims shall be based on the schedule in effect on the date of disease manifestation.

Compensation shall be based on the monthly wage of the worker as follows:

(a) If the worker was employed at the time the disease required medical treatment or became totally or partially disabling, whichever occurred first, compensation shall be based on the monthly wage paid on that date regardless of whether the worker is employed in the industry that gave rise to the disease or in an unrelated industry.

(b) If the worker was not employed, for causes other than voluntary retirement, at the time the disease required medical treatment or became totally or partially disabling, whichever occurred first, compensation shall be based upon the last monthly wage paid.

(3) Benefits shall be paid in accordance with the schedules in effect on the date of manifestation. Manifestation is the date the disease required medical treatment or became totally or partially disabling, whichever occurred first, without regard to the date of the contraction of the disease or the date of filing the claim.

[Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. WSR 93-23-060, § 296-14-350, filed 11/15/93, effective 1/1/94. Statutory Authority: Chapters 51.08 and 51.32 RCW. WSR 88-14-011 (Order 88-13), § 296-14-350, filed 6/24/88.]

WAC 296-14-400 Reopenings for benefits. The director at any time may, upon the workers' application to reopen for aggravation or worsening of condition, provide proper and necessary medical and surgical services as authorized under RCW 51.36.010. This provision will not apply to total permanent disability cases, as provision of medical treatment in those cases is limited by RCW 51.36.010.

The seven-year reopening time limitation shall run from the date the first claim closure becomes final and shall apply to all claims regardless of the date of injury. In order for claim closure to become final on claims where closure occurred on or after July 1, 1981, the closure must include documentation of medical recommendation, advice or examination. Such documentation is not required for closing orders issued prior to July 1, 1981. First closing orders issued between July 1, 1981, and July 1, 1985, shall for the purposes of this section only, be deemed issued on July 1, 1985.

The director shall, in the exercise of his or her discretion, reopen a claim provided objective evidence of worsening is present and proximately caused by a previously accepted asbestos-related disease.

In order to support a final closure based on medical recommendation or advice the claim file must contain documented information from a doctor, or nurse consultant (departmental) or nurse practitioner. The doctor or nurse practitioner may be in private practice, acting as a member of a consultation group, employed by a firm, corporation, or state agency.

For the purpose of this section, a "doctor" is defined in WAC 296-20-01002.

When a claim has been closed by the department or self-insurer for 60 days or longer, the worker must file a written application to reopen the claim. An informal written request filed without accompanying medical substantiation of worsening of the condition will constitute a request to reopen, but the time for taking action on the request shall not commence until a formal application is filed with the department or self-insurer as the case may be.

A formal application occurs when the worker and doctor complete and file the application for reopening provided by the department. Upon receipt of an informal request without accompanying medical substantiation of worsening of the worker's condition, the department or self-insurer shall promptly provide the necessary application to the worker for completion.

If, within seven years from the date the first closing order became final, a formal application to reopen is filed which shows by "sufficient medical verification of such disability related to the accepted condition(s)" that benefits are payable, the department, or the self-insurer, pursuant to RCW 51.32.210 and 51.32.190, respectively shall mail the first payment within 14 days of receiving the formal application to reopen. If the application does not contain sufficient medical verification of disability, the 14-day period will begin upon receipt of such verification. If the application to reopen is granted, compensation will be paid pursuant to RCW 51.28.040. If the application to reopen is denied, the worker shall repay such compensation pursuant to RCW 51.32.240.

Applications for reopenings filed on or after July 1, 1988, must be acted upon by the department within 90 days of receipt of the application by the department or the self-insurer. The 90 day limitation shall not apply if the worker files an appeal or request for reconsideration of the department's denial of the reopening application.

The department may, for good cause, extend the period in which the department must act for an additional 60 days. "Good cause" for such an extension may include, but not be limited to, the following:

(1) Inability to schedule a necessary medical examination within the 90 day time period;

(2) Failure of the worker to appear for a medical examination;

(3) Lack of clear or convincing evidence to support reopening or denial of the claim without an independent medical examination;

(4) Examination scheduled timely but cannot be conducted and a report received in sufficient time to render a decision prior to the end of the 90 day time period.

The department shall make a determination regarding "good cause" in a final order as provided in RCW 51.52.050.

The 90 day limitation will not apply in instances where the previous closing order has not become final.

[Statutory Authority: RCW 51.36.010, 51.04.020, and 51.04.030. WSR 19-15-121, § 296-14-400, filed 7/23/19, effective 7/23/19; WSR 12-06-066, § 296-14-400, filed 3/6/12, effective 4/6/12. Statutory Authority: 2004 c 65 and 2004 c 163. WSR 04-22-085, § 296-14-400, filed 11/2/04, effective 12/15/04. Statutory Authority: RCW 51.32.190 and 51.32.210. WSR 90-22-054, § 296-14-400, filed 11/5/90, effective 12/6/90. Statutory Authority: Chapters 34.04 [34.05], 51.04, 51.32 and 51.36 RCW. WSR 90-04-007, § 296-14-400, filed 1/26/90, effective 2/26/90. Statutory Authority: Chapters 51.08 and 51.32 RCW. WSR 88-14-011 (Order 88-13), § 296-14-400, filed 6/24/88.]

WAC 296-14-410 Reduction, suspension, or denial of compensation as a result of noncooperation. (1) **Can the department or self-insurer reduce, suspend or deny industrial insurance benefits from a worker?** The department or the self-insurer, after receiving the department's order, has the authority to reduce, suspend or deny benefits when a

worker (or worker's representative) is noncooperative with the management of the claim.

(2) **What does noncooperative mean?** Noncooperation is behavior by the worker (or worker's representative) which obstructs and/or delays the department or self-insurer from reaching a timely resolution of the claim.

(a) Noncooperation can include any one of the following:

(i) Not attending or cooperating with medical examinations or vocational evaluations requested by the department or self-insurer.

(ii) Failure to keep scheduled appointments or evaluations with the attending provider or vocational counselor.

(iii) Engaging in unsanitary or harmful actions that jeopardize or slow recovery.

(iv) Not accepting medical and/or surgical treatment that is considered reasonably essential for recovery from the industrial injury or occupational disease.

(3) **Are there ever exceptions to attending a scheduled examination or vocational evaluation?** The worker will not be considered uncooperative if refusal to attend a scheduled examination is for any one of the following reasons:

(a) The department or self-insurer did not mail notice to the worker and designated representative at least 14 but no more than 60 days prior to the examination. The notice must contain the date, time and location of the examination.

(b) If the worker is 30 or less minutes late for the appointment.

(c) If the worker has not been examined or evaluated and leaves after waiting for more than one hour after the scheduled time.

(4) **What actions are taken before reducing, suspending or denying industrial insurance benefits?**

(a) The department or self-insurer must first send a letter to the worker (or the worker's representative) advising that benefits may be suspended and asking for an explanation for the noncooperation, obstruction and/or delay of the management of the claim.

(b) The worker has 30 days to respond in writing to the letter. This written response should include the reason(s) the worker has for not cooperating with the department or self-insurer.

(5) **What are the actions the department can take if a worker (or a worker's representative) is determined to be noncooperative?** If the worker does not respond in 30 days to the letter asking for justification for not cooperating or it is determined there is no good cause the department or self-insurer, after receiving the department's order, may take the following action:

(a) Reduce current or future time-loss compensation by the amount of the charge incurred by the department or self-insurer for any examination, evaluation, or treatment that the worker failed to attend.

(b) Reduce, suspend or deny all or part of the time-loss benefits.

(c) Suspend or deny medical benefits.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.36.010. WSR 25-11-071, s 296-14-410, filed 5/20/25, effective 7/1/25. Statutory Authority: RCW 51.04.020. WSR 99-18-062, § 296-14-410, filed 8/30/99, effective 9/30/99. Statutory Authority: RCW 51.32.110 and 51.32.190(6). WSR 90-19-028, § 296-14-410, filed 9/12/90, effective 10/13/90.]

WAC 296-14-4121 What does the term "willful misrepresentation" mean with regard to the receipt of workers' compensation benefits? This term is found in RCW 51.32.240(5) which provides a 50 percent penalty, in addition to any overpayment, whenever any payment of benefits has been induced by "willful misrepresentation." The law goes on to state that it is willful misrepresentation for a person to obtain payments or other benefits in an amount greater than that to which he or she would have otherwise been entitled. Willful misrepresentation includes making a willful false statement or the willful misrepresentation, omission, or concealment of any material fact.

(1) Willful means a conscious or deliberate false statement, misrepresentation, omission, or concealment of a material fact with the specific intent of obtaining, continuing, or increasing workers' compensation benefits. Failure to disclose a work-type activity must be willful in order for a misrepresentation to have occurred.

(2) The assessment of the 50 percent penalty does not apply to those instances where the misrepresentation is not willful, as defined above. For example, a worker receives wages at the time of injury of $10.25 per hour, but he inadvertently indicates on the report of industrial injury or occupational disease that his pay is $10.75 per hour. The state fund employer fails to submit a completed report form and the time-loss compensation benefit rate is based on wages of $10.75 per hour. When this information is provided to the employer, worker, and medical provider by legal order, no interested party submits a protest within the statutory time frame, but further investigation later reveals the misinformation. An overpayment determination under RCW 51.32.240(1) may be appropriate upon discovery of the correct hourly pay rate, but the worker has not engaged in willful misrepresentation with specific intent to obtain benefits to which he would have otherwise not been entitled.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4121, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4122 For purposes of determining willful misrepresentation, what does the term "specific intent" mean? "Specific intent" means the commission of an act or the omission of information with the knowledge that such an act or omission will lead to wrongfully obtaining benefits. For example, a worker who completes a document knowingly misrepresenting that he/she is unable to perform work or work-type activities has committed an act. Submitting this document to the department or self-insurer in order to wrongfully receive workers' compensation benefits under Title 51 RCW represents specific intent.

Examples of the omission of information with the intent of obtaining benefits include, but are not limited to, failure of the worker to advise the department or self-insurer of a return to work or of self-employment; or failure to provide the department or self-insurer with complete information about skills and abilities that would have changed the outcome of a vocational assessment or the department's decision to provide vocational services. Not providing this information to the department or self-insurer represents specific intent because the omission of it can cause continued workers' compensation benefits to which the worker would not have been entitled had the information been provided.

The following is an example of a situation that does not represent "specific intent": An injured worker's wife is hired to manage

the mobile home park where they live. Wages were paid to her for the management duties. The injured worker would occasionally answer the telephone when his wife was not available and he opened and closed the park gates each morning. He did not engage in the maintenance work of the park, provide tours of the park to prospective customers or perform any other park management duties. The worker did not report this activity to the department, his physician or his vocational counselor. The worker's omission of information is not considered "willful misrepresentation" with "specific intent" to receive benefits to which he would not be otherwise entitled.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4122, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4123 What is meant by "work-type activity"? (1) Work-type activity means any activity for which a reasonable person would expect to be compensated or for which a reasonable employer would expect to pay compensation.

(2) Work-type activity does not mean exploration of a job for a short period of time to determine whether the worker can do the job so long as:

(a) The worker does not receive wages, income, or anything of value; and

(b) The worker or his/her family has no financial interest in or benefits from the worker's job exploration.

Activity done intermittently or as a hobby that does not generate income will not generally rise to the level of repeated work-type activity.

For example, a worker who is receiving wage replacement benefits volunteers two hours each day for a recognized charity greeting customers and operating the cash register. His treating physician is aware of this activity and encourages it to keep him more active, but does not release him to work or to perform this function more than two hours daily. The worker does not initially inform the department of his activity because he receives no compensation and would not expect to. The department learns of the volunteer work when the worker completes a worker verification form indicating the volunteer activity. No willful misrepresentation of a work-type activity has occurred in this case.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4123, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4124 What are considered as "wage replacement benefits"? Wage replacement benefits include temporary total disability (time-loss compensation benefits), temporary partial disability (loss-of-earning power benefits), and total permanent disability or survivor benefits (pension).

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4124, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4125 How does the department calculate the amount of overpayment charged to a claimant when a determination of "willful

misrepresentation" has been made in initial claim adjudication? Overpayments are assessed in cases where there has been willful misrepresentation.

When it is determined that a claim was initially accepted as an industrial injury or occupational disease based on willful misrepresentation, the overpayment calculation includes all wage replacement benefits, permanent partial disability benefits, medical benefits, vocational benefits, and other medical aid fund benefits paid on the claim.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4125, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4126 How does the department calculate the amount of overpayment charged to a claimant when a determination of "willful misrepresentation" has been made after initial claim adjudication? (1) Overpayments are assessed in cases where there has been willful misrepresentation. The overpayment calculation in these claims includes all or part of wage replacement benefits and may include permanent partial disability benefits, vocational, medical benefits, and/or other medical aid fund benefits paid on the claim for the period as described below.

(a) The period of overpayment will begin with either the first date of willful misrepresentation or the first date of the repeated pattern of work or work-type activities.

(b) Medical benefits: Medical benefits paid on a claim may be included when a treating physician's opinion of the need for further treatment related to the claim, or his/her opinion of a condition's maximum medical improvement was changed by the willful misrepresentation. Only those medical services to which the worker would not have been otherwise entitled are included in the overpayment.

(c) Vocational benefits: Vocational benefits may be included when it is determined, because of the willful misrepresentation, that the vocational services would not have been provided but for the misrepresentation.

(d) Permanent partial disability benefits: Permanent partial disability benefits will be included when the worker's willful misrepresentation results in the receipt of permanent partial disability benefits to which the worker would not otherwise have been entitled.

(e) Other medical aid fund benefits: Other medical aid fund benefits may be included such as travel and lodging.

(f) Wage replacement benefits:

(i) The overpayment will include all of the wage replacement benefits resulting from willful misrepresentation when the worker has:

(A) Misrepresented his/her physical restrictions or engaged in a repeated pattern of work or work-type activities; and

(B) The worker would have been released by a physician to return to the job of injury had the repeated pattern of work or work-type activities been disclosed. In cases where a treating physician is unwilling or unable to render an opinion in this situation, the opinion of a consulting physician or independent medical examiner may be used; or

(C) In the case of total permanent disability benefits, the work or work-type activity is such that the imputed wages are equivalent to gainful employment; or

(D) In the case of survivor benefits, the willful misrepresentation was such that the beneficiary would not have been entitled to benefits were it not for the misrepresentation.

(ii) The overpayment will include all or part of the wage replacement benefits to which the worker would not otherwise have been entitled were it not for the repeated pattern of work or work-type activities when the worker has:

(A) Misrepresented his/her physical restrictions or has engaged in a repeated pattern of work or work-type activities; and

(B) The department would have determined that the worker returned to work; or

(C) A vocational counselor would have determined that the worker was employable in accordance with department rules.

(2) In cases, other than pension, when the wages or imputed wages are less than the total wage at the time of injury, the wage replacement portion of the overpayment equals the wage replacement benefit paid less the entitled loss-of-earning power benefits. However, this reduction will cease either the date the department had evidence of or a physician would have determined the worker had reached maximum medical improvement (MMI) had the repeated pattern of work or work-type activity been disclosed. In cases where a treating physician is unwilling or unable to render an opinion in this situation, the opinion of a consulting physician or independent medical examiner may be used. From that date forward, the wage replacement portion of the overpayment includes all wage replacement benefits paid.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4126, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4127 How are penalties determined? As provided in RCW 51.32.240, the penalties equal fifty percent of the total overpayment amount.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4127, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4128 When may the department impute wages in cases where willful misrepresentation has been determined? The department may impute wages when:

- The worker is self-employed; or
- Appropriate payroll records are not available; or
- The employer is paying the worker in cash or material without maintaining appropriate payroll records; or
- There is no employer but the worker has engaged in a repeated pattern of work-type activities or has willfully misrepresented his or her physical restrictions.

[Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4128, filed 9/28/04, effective 11/1/04.]

WAC 296-14-4129 How will imputed wages be determined? (1) When the worker has performed work or work-type activities within the state of Washington, the department imputes wages based on information collected and reported by the department of employment security. This in-

formation may include wages for the same or similar jobs within the geographic area proximate to the worker and for the same or most proximate time period as the work or work-type activities performed.

(2) When the worker performed work or work-type activities outside the state of Washington for which wages are to be imputed, the department will use information collected and reported by the United States Department of Labor Statistics to determine the correct imputed wage.

(3) In no case shall the imputed wages equal less than the hourly minimum wage for the proximate time period and geographic area used.

(4) If the worker engaged in reduced work or work-type activities when compared to the employment at the time of injury, except in pension cases, the department shall calculate the loss-of-earning power benefits consistent with RCW 51.32.090(3) to which the worker would have been entitled based on the imputed wage.

Example of imputed wage: A worker received time-loss compensation benefits and contended he was unable to work in his regular job as a construction laborer. Investigation showed that he was working painting houses on a regular full-time basis. The work he performed was ongoing over an extended period of time. Payments for this work were reportedly on a cash basis and no records were kept.

Wages would be imputed based on the average wage of a painter in his local area as reported by the department of employment security.

Example of reduced work or work-type activity: A worker was receiving time-loss compensation benefits for a shoulder injury she suffered while working as a registered nurse. She contended she was unable to perform nursing duties. The department received evidence that she had in fact been working on a regular basis as a cashier in her husband's delicatessen. There were no wages reported for this work. The evidence also showed she had worked there for several months.

The medical and vocational providers were shown the investigative evidence and they determined the worker was able to work and had returned to work as a cashier.

The department would impute wages based on the average wage paid by the business owner to other employees in the same position. If there were no other employees, wages would be imputed based on the average wage of a cashier in the local area as reported by the department of employment security.

Example of release for work and no imputed wage: A worker, who was a carpenter on the date of injury, was receiving time-loss compensation benefits based on his alleged inability to return to work. He contended he had to use a wheelchair to get around.

Video evidence was obtained showing him performing extensive remodeling work on a rental home he owned. He did not use the wheelchair and there was no indication he had any difficulties performing the work. His activities included installing siding and windows, painting, and performing other activities inconsistent with his alleged level of disability. He received no wages as the work was done on his personal property.

The video was shown to his attending provider. That provider withdrew their certification of the worker's entitlement to time-loss compensation benefits and released him to return to work at his job of injury effective the first date of the video surveillance.

There is no need to impute wages because the release for work was to the job of injury.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.36.010. WSR 25-11-071, s 296-14-4129, filed 5/20/25, effective 7/1/25. Statutory Authority: RCW 51.04.010, 51.04.020, and 2004 c 243. WSR 04-20-024, § 296-14-4129, filed 9/28/04, effective 11/1/04.]

WAC 296-14-420 Payment of benefits—Aggravation reopening/new injury. (1) Whenever an application for benefits is filed where there is a substantial question whether benefits shall be paid pursuant to the reopening of an accepted claim or allowed as a claim for a new injury or occupational disease, the department shall make a determination in a single order. Where one of the claims is with a self-insured employer and another is with a state fund employer, such determination shall be made jointly by the program managers for claims administration and self insurance, or their respective designees.

(2) Pending entry of the order, benefits shall be paid promptly by the entity which would be responsible if the claim were determined to be a new injury or occupational disease.

(3) The department is required to act under this rule only if:

(a) There is substantial evidence that the worker will be determined to be entitled to benefits on one of the claims; and

(b) There is uncertainty regarding which of the entities is responsible.

(4) Time-loss compensation shall be paid at the lesser of the two entitlements that may apply to the claim until responsibility has been determined between state fund and self-insured employer, two self-insured employers, or two state fund employers.

(5) If, upon final determination of the responsible insurer, the entity that paid benefits under subsection (2) of this section is determined not to be responsible for payment of benefits, such entity shall be reimbursed by the responsible entity for all amounts paid.

[Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. WSR 93-23-060, § 296-14-420, filed 11/15/93, effective 1/1/94. Statutory Authority: RCW 51.32.110 and 51.32.190(6). WSR 90-19-028, § 296-14-420, filed 9/12/90, effective 10/13/90.]

WAC 296-14-520 Why is it important to establish the worker's monthly wage? The department or self-insurer is required to establish a monthly wage that fairly and reasonably reflects workers' lost wages from all employment at the time of injury or date of disease manifestation. This monthly wage, which is calculated using the formulas in RCW 51.08.178, represents the worker's lost earning capacity. This monthly wage is used to calculate the rate of the worker's total disability compensation or beneficiary's survivor benefits under Washington's Industrial Insurance Act.

[Statutory Authority: RCW 51.04.010, 51.04.020 and 142 Wn.2d 801 (2001). WSR 03-11-035, § 296-14-520, filed 5/15/03, effective 6/15/03.]

WAC 296-14-522 What does the term "wages" mean? The term "wages" is defined as:

(1) The gross cash wages paid by the employer for services performed. "Cash wages" means payment in cash, by check, by electronic transfer or by other means made directly to the worker before any mandatory deductions required by state or federal law. Tips are also considered wages but only to the extent they are reported to the employer for federal income tax purposes.

(2) Bonuses paid by the employer of record as part of the employment contract in the twelve months immediately preceding the injury or date of disease manifestation.

(3) The reasonable value of board, housing, fuel and other consideration of like nature received from the employer at the time of injury or on the date of disease manifestation that are part of the contract of hire.

Exception: Payments for items other than board, housing, fuel or other consideration of like nature made by the employer to a trust fund or other entity for fringe benefits do not constitute wages.

[Statutory Authority: RCW 51.04.010, 51.04.020 and 142 Wn.2d 801 (2001). WSR 03-11-035, § 296-14-522, filed 5/15/03, effective 6/15/03.]

WAC 296-14-524 How do I determine whether an employer provided benefit qualifies as "consideration of like nature" to board, housing and fuel? To qualify as "consideration of like nature" the employer provided benefit must meet all of the following elements:

(1) The benefit must be objectively critical to protecting the worker's basic health and survival at the time of injury or date of disease manifestation.

(a) The benefit must be one that provides a necessity of life at the time of injury or date of disease manifestation without which employees cannot survive a period of even temporary disability.

(b) This is not a subjective determination. The benefit must be one that virtually all employees in all employment typically use to protect their immediate health and survival while employed.

(c) The benefit itself must be critical to protecting the employee's immediate health and survival. The fact that a benefit has a cash value that can be assigned, transferred, or "cashed out" by an employee and used to meet one or more of the employee's basic needs is not sufficient to satisfy this element.

(2) The benefit must be readily identifiable. The general terms and extent of the benefit must be established through the employer's written policies, or the written or verbal employment contract between the employer and worker (for example, a collective bargaining agreement that requires the employer to pay a certain sum for the employee's health insurance).

(3) The monthly amount paid by the employer for the benefit must be reasonably calculable (for example, as part of the employment contract, the employer agrees to pay three dollars for each hour worked by the employee for that person's health insurance).

Examples of benefits that qualify as "consideration of like nature" are medical, dental and vision insurance provided by the employer.

Examples of benefits that do **not** qualify as "consideration of like nature" are retirement benefits or payments into a retirement

plan or stock option, union dues and life insurance provided by the employer.

[Statutory Authority: RCW 51.04.010, 51.04.020 and 142 Wn.2d 801 (2001). WSR 03-11-035, § 296-14-524, filed 5/15/03, effective 6/15/03.]

WAC 296-14-526 Is the value of "consideration of like nature" always included in determining the worker's compensation? (1) No. The value of other consideration of like nature is only included in the worker's monthly wage if:

(a) The employer, through its full or partial payment, provided the benefit to the worker at the time of injury or on the date of disease manifestation;

(b) The worker received the benefit at the time of injury or on the date of disease manifestation.

This section is satisfied if, at the time of injury or on the date of disease manifestation:

(i) The employer made payments to a union trust fund or other entity for the identified benefit; and

(ii) The worker was actually eligible to receive the benefit.

Example: At the time of the worker's industrial injury, the employer paid two dollars and fifty cents for each hour worked by the employee to a union trust fund for medical insurance on behalf of the employee and her family. If the employee was able to use the medical insurance at the time of her injury, the employer's monthly payment for this benefit is included in the worker's monthly wage, in accordance with (d) of this subsection. This is true even where the worker's eligibility for this medical insurance is based primarily or solely on payments to the trust fund from past employers.

(c) The worker or beneficiary no longer receives the benefit and the department or self-insurer has knowledge of this change.

If the worker continues to receive the benefit from a union trust fund or other entity for which the employer made a financial contribution at the time of injury or on the date of disease manifestation, the employer's monthly payment for the benefit is **not** included in the worker's monthly wage.

Example: An employer contributes two dollars and fifty cents for each hour an employee works into a union trust fund that provides the employee and her family with medical insurance. If the employer stops contributing to this fund, but the worker continues to receive this benefit, the employer's monthly payment for the medical insurance is not included in the worker's monthly wage.

(2) This rule does not permit the department or self-insurer to alter, change or modify a final order establishing the worker's monthly wage except as provided under RCW 51.28.040.

[Statutory Authority: RCW 51.04.010, 51.04.020 and 142 Wn.2d 801 (2001). WSR 03-11-035, § 296-14-526, filed 5/15/03, effective 6/15/03.]

WAC 296-14-528 How do I determine the value of a benefit that qualifies as "consideration of like nature"? The amount paid by the employer for the benefit at the time of injury or on the date of dis-

ease manifestation represents the amount that may be included in the worker's monthly wage.

[Statutory Authority: RCW 51.04.010, 51.04.020 and 142 Wn.2d 801 (2001). WSR 03-11-035, § 296-14-528, filed 5/15/03, effective 6/15/03.]

WAC 296-14-530 Is overtime considered in calculating the worker's monthly wage? (1) When the worker's monthly wage is computed under RCW 51.08.178(1), only the overtime hours the worker normally works are taken into consideration.

(2) When the worker's monthly wage is computed under RCW 51.08.178(2), the overtime pay is included in determining the worker's wages.

[Statutory Authority: RCW 51.04.010, 51.04.020 and 142 Wn.2d 801 (2001). WSR 03-11-035, § 296-14-530, filed 5/15/03, effective 6/15/03.]

WAC 296-14-600 Payment of benefits on asbestos-related disease claims. The department shall furnish the benefits provided under Title 51 RCW to any worker or beneficiary who may have a right or claim for benefits under the maritime laws of the United States resulting from an asbestos-related disease if there are objective clinical findings to substantiate that the worker has an asbestos-related claim for occupational disease; and the worker's employment history has a prima facie indicia of injurious exposure to asbestos fibers while employed in the state of Washington in employment covered under Title 51 RCW.

(1) A worker's employment history will be deemed to have a prima facie indicia of injurious exposure to asbestos fibers if the employment history as contained in the department's file permits a reasonable conclusion that the worker was exposed to asbestos fibers and that such exposure was of sufficient duration to be injurious. "Injurious" means impairing to either a partial or total extent, and may be either permanent or temporary.

(2) Whenever the department has determined to pay benefits pursuant to chapter 271, Laws of 1988, the department shall render a decision as to the liable insurer and shall continue to pay benefits until the liable insurer initiates payments or benefits are otherwise properly terminated.

The department shall render its decision in a final order as provided in RCW 51.52.050.

Initiation of payments by a liable insurer shall be deemed to occur on the date such insurer issues a check or warrant or otherwise remits to the worker, beneficiary, or any provider any payment of any benefits owed by such insurer on the claim for asbestos.

(3) Benefits shall be paid on all pending asbestos-related claims as of July 1, 1988. Pending claims are those which have not been finally adjudicated by order of the department or the board of industrial insurance appeals or by the entry of a judgment of a superior court or decision of the court of appeals or the supreme court.

If any order of the department granting such benefits is appealed, benefits shall continue, if otherwise available, until a final determination is made by the board of industrial insurance appeals or the courts, or upon initiation of payments by a liable insurer.

(4) If benefits are paid by the department from the medical aid fund on an asbestos-related claim, and it is determined by the department that such benefits are owed to the worker or beneficiary by an insurer under the maritime laws of the United States or by another federal program other than the Federal Social Security, Old Age Survivors and Disability Insurance Act, 42 U.S.C., the department shall pursue such insurer or program to recover such benefits as may have been paid by the department.

The determination by the department shall be expressed in a final order as provided by RCW 51.52.050.

(5) Whenever a self-insured employer is determined to be liable, the self-insured employer shall reimburse benefits to the department within 10 days after the department order becomes final and binding. Failure to do so shall subject the employer to a penalty as authorized in RCW 51.48.080.

(6) The director's discretion to waive recovery of the benefits paid to the claimant or beneficiary shall be exercised in accordance with WAC 296-14-200 (3)(c).

(7) No information obtained under this section is subject to release by subpoena or other legal process. The department will release information only to those persons authorized access to claim files by RCW 51.28.070.

[Statutory Authority: Chapters 51.08 and 51.32 RCW. WSR 88-14-011 (Order 88-13), § 296-14-600, filed 6/24/88.]

WAC 296-14-6200 What is a residence modification? A residence modification is a permanent change to an existing residence or a repair of a modification previously approved and paid for by the department or self-insured employer, or a modification made when constructing a new residence.

Household appliances such as refrigerators, washers, and dryers, are generally not residence modifications and the department or self-insured employer will approve them only under unique circumstances as approved by the supervisor.

Example: As part of an approved residence modification, the kitchen counters are lowered. To meet the needs of the worker, the department or self-insured employer may approve the purchase of a drop-in range or cooktop.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6200, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6202 What is the residence modification benefit? The residence modification benefit is a sum of money used to modify a worker's residence for purposes of safety, mobility and activities of daily living, when those modifications are made necessary by the nature of the worker's condition subsequent to a catastrophic injury. Activities of daily living are tasks required for self-care, communication and mobility and include, but are not limited to, bathing, bed mobility, dressing, eating, grooming, toileting and transfers.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6202, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6204 Which workers may be eligible to receive benefits for residence modifications? Residence modification benefits are only available to workers with an allowed catastrophic injury claim. Catastrophic injuries are the most serious of conditions and include, but are not limited to, head trauma, paralysis and amputation.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6204, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6206 Which residences may be eligible to be modified? Before the department or self-insured employer will consider an application for modification, the residence must meet the following criteria:

(1) The residence must be structurally sound and free of obvious structural defects. The department may request a safety inspection. The department or self-insured employer will not pay for a residence to be brought up to state and local code except as required to complete a necessary and approved modification.

(2) The residence can be adapted to be suitable for the worker's needs for purposes of daily living.

(3) In the opinion of the worker's health care providers, the worker can live in the residence after modification.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6206, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6208 When may the worker request residence modification benefits? The worker may request residence modification at any time when his or her allowed claim is either open or the worker has been determined to be permanently and totally disabled.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6208, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6210 What is the maximum amount of the residence modification benefit? The maximum amount of the benefit is the state's average annual wage at the time that each modification request is approved. The department or self-insured employer will not pay for modifications that exceed the maximum amount. The department or self-insured employer may make several payments, so long as the total paid does not exceed the maximum benefit.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6210, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6212 Can the worker receive additional modification benefits for the same residence? The department can pay for additional or subsequent residence modifications so long as the cost does not exceed the maximum benefit in effect at the time that each modification request is approved.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6212, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6214 Can a worker receive residence modification benefits for more than one house? No. The department or self-insured employer will pay for residence modifications on only one residence for each catastrophically injured worker.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6214, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6216 How can a worker begin the process of requesting residence modification benefits? The worker may inquire about residence modification benefits by contacting his or her adjudicator. The department or self-insured employer will then refer the worker to a residence modification consultant for evaluation.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6216, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6218 How does the department or self-insured employer determine the worker's residence for purposes of residence modification? The department or self-insured employer will consider modifying a residence when the worker lives in and considers the residence to be his or her permanent residence. It is not required that the worker own or rent the residence.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6218, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6220 What type of residence may the department or self-insured employer modify? The department or self-insured employer may modify a standard house, a residential unit in a multiunit dwelling, or a manufactured/mobile residence.

The department or self-insured employer will only authorize modification of manufactured/mobile residences when the factory assembled structures division of the department reviews and approves the plans in advance.

The department or self-insured employer will not approve modification of commercial coaches.

The department or self-insured employer will not approve modification of recreational vehicles or recreational park trailers used as permanent residences, unless the local jurisdiction allows recreational vehicles or recreational park trailers to be used as a dwelling, and the factory assembled structures division of the department reviews and approves the plans in advance.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6220, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6222 What is a residence modification consultant, and how are they involved in the process of residence modification? When the worker has notified the department or self-insured employer of his or her intention to request a residence modification, the department or self-insured employer will require an on-site evaluation by a residence modification consultant.

A residence modification consultant must be either a licensed physical or occupational therapist, or licensed nurse, and must be trained or experienced in both rehabilitation of catastrophic injuries and in modifying residences. The department or self-insured employer will pay for the services of the residence modification consultant pursuant to department provider rules.

The residence modification consultant will assist the worker, the contractor and the worker's health providers to determine what modifications will be requested and submit a written report to the department or self-insured employer and the worker. If modifications are approved, the residence modification consultant may assist the worker and the contractor if requested by the department or self-insured employer.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6222, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6223 Will the department pay for professional services needed to design a residence modification? Yes. However, the department or self-insured employer will not pay for professional services prior to approval of the residence modification.

If approved, the cost of architectural, engineering, predesign and planning services will be included in the residential modification benefit. The cost for services should be included in the residence modification request.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6223, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6224 What must the worker submit to the department in a completed request for a residence modification? For the department to process a residence modification request, the worker must provide the adjudicator with at least the following information:

(1) Documentation of residence ownership. If the worker does not own the residence, he or she must submit the actual owner's proof of ownership and written legal permission signed by the actual owner to modify the residence as indicated in the proposed plan; and

(2) A report signed by the residence modification consultant for all necessary modifications; and

(3) Competing and detailed bids from two licensed, registered and bonded contractors.

Exceptions: If it is not possible to obtain two bids, a written explanation of the circumstances must be provided.
If family or friends will perform free labor, they need not be licensed, registered and bonded, but must still submit a bid for the cost of materials.

(4) A copy of the acknowledgment of responsibilities letter signed by both the worker and the contractor. A copy of this form can be obtained from the department.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6224, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6226 What other information must be submitted to the department in a completed application for a residence modification? (1) The attending provider may need to submit medical documentation

verifying the worker's condition and the necessity for any residence modification.

(2) The residence modification consultant must submit an evaluation, based on an in-home inspection, of the worker's needs for safety, mobility and activities of daily living. This evaluation must be in the form of a written report with pictures or drawings.

(3) Any additional information requested by the department or self-insurer that might be needed to evaluate a specific request.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.36.010. WSR 25-11-071, s 296-14-6226, filed 5/20/25, effective 7/1/25. Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6226, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6228 Who will approve or deny a request for residence modification? The department will pay the benefit only with the approval of the supervisor of industrial insurance. A self-insured employer may pay the benefit without the supervisor's approval, but may not deny the benefit. The supervisor of industrial insurance alone has the authority to deny a residence modification benefit.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6228, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6230 What will the supervisor consider when approving or denying a residence modification request? The supervisor will consider requests for residence modifications on a case-by-case basis. The supervisor may approve all or part of the requested modifications, based on what is reasonable and necessary for the individual worker.

In order to determine what is reasonable and necessary, the supervisor will review the completed application and will consider at least the following:

(1) Whether the worker is eligible to receive a residence modification benefit; and

(2) The needs and preferences of the individual worker, based on information provided by the injured worker; and

(3) Whether the proposed residence is appropriate for modification; and

(4) Whether the proposed modifications are appropriate for the style, nature and condition of the residence; and

(5) The attending provider's opinions of the medical condition, physical needs of the worker and whether the worker can reside in the residence after the modifications are complete; and

(6) The residence modification consultant's evaluation of whether the proposed modification is necessary to meet the worker's current need for safety, mobility and activities of daily living; and

(7) Whether the contractor's proposed plan will satisfy the necessary modification; and

(8) Whether the proposed plans submitted by the contractors are consistent with state guidelines for specially adapted residential housing, if any; and

(9) The contractor's proposed modification plan is consistent with the guidelines established by the United States Department of Veterans Affairs in their publication entitled "*Handbook for Design: Specially Adapted Housing*," or the recommendations published in "*The*

Accessible Housing Design File" by Barrier Free Environments, Inc.; and

(10) Whether the proposed modifications are being provided at the least cost while maintaining quality.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.36.010. WSR 25-11-071, s 296-14-6230, filed 5/20/25, effective 7/1/25. Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6230, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6232 What happens if the residence modification costs exceed the maximum benefit? The department or self-insured employer may approve a payment of a portion of a residence modification request, not to exceed the maximum benefit. The department or self-insured employer will identify the portions of the residence modification for which payment will be approved based on the worker's current need for safety, mobility and activities of daily living.

If the costs of the proposed modifications of an existing residence exceed the benefit, the worker is responsible for payment of the balance of the costs. The worker must choose one of the following options:

(1) Adjust their request for modifications to remain within the benefit; or

(2) Obtain additional financing. If the worker chooses to obtain additional financing, he or she must submit to the department written verification of the additional financing from the funding source. The supervisor will deny the residence modification if the worker is unable to cover the additional costs.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6232, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6234 Can a worker apply the residence modification benefit to the cost of building a new residence? Yes. However, the benefit may be applied only to the cost difference between a standard residence structure and the modified structure.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6234, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6236 How is a worker advised that the supervisor has approved or denied the request for residence modification benefits? The department will notify the worker, contractors, homeowner (if not the worker), residence modification consultant, attending provider and employer of the supervisor's decision in writing.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.36.010. WSR 25-11-071, s 296-14-6236, filed 5/20/25, effective 7/1/25. Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6236, filed 2/28/06, effective 4/1/06.]

WAC 296-14-6238 Who receives payment from the department? The department will pay the contractor directly and/or reimburse the work-

er for any payment already made to the contractor for approved and completed residence modifications. In order to determine that modifications have been satisfactorily completed, the department will require the following documents to be submitted before releasing final payment:

(1) A signed letter of satisfaction from the worker; and

(2) A positive report of a final inspection from the appropriate inspection authorities, if required; and

(3) A report of an inspection from the residence modification consultant if requested by the department; and

(4) A release of lien form signed by the contractors or subcontractors or both.

[Statutory Authority: RCW 51.04.010, 51.04.020, 51.32.240, and 2005 c 411. WSR 06-06-065, § 296-14-6238, filed 2/28/06, effective 4/1/06.]

WAC 296-14-8810 Pension tables, pension discount rate and mortality tables. (1) The department uses actuarially determined pension tables for calculating pension annuity values, required pension reserves, and actuarial adjustments to monthly benefit amounts.

(a) The department's actuaries calculate the pension tables based on:

(i) Mortality tables from nationally recognized sources;

(ii) The department's experience with rates of mortality, disability, and remarriage for annuity recipients;

(iii) A pension discount rate of 4.0 percent for state fund pensions;

(iv) A pension discount rate of 5.3 percent for self-insured pensions, including the United States Department of Energy pensions; and

(v) The higher of the two pension discount rates so that pension benefits for both state fund and self-insured recipients use the same reduction factors for the calculation of death benefit options under RCW 51.32.067.

(b) The department's actuaries periodically investigate whether updates to the mortality tables relied on or the department's experience with rates of mortality, disability, and remarriage by its annuity recipients warrant updating the department's pension tables.

(2) To obtain a copy of any of the department's pension tables, contact the department of labor and industries actuarial services.

[Statutory Authority: RCW 51.04.020, 51.44.070, and 51.44.080. WSR 26-03-079, s 296-14-8810, filed 1/20/26, effective 4/1/26. Statutory Authority: RCW 51.04.020, 51.44.070(1), and 51.44.080. WSR 25-03-113, s 296-14-8810, filed 1/21/25, effective 4/1/25; WSR 24-02-069, § 296-14-8810, filed 1/2/24, effective 4/1/24; WSR 23-04-078, § 296-14-8810, filed 1/31/23, effective 4/1/23; WSR 22-05-075, § 296-14-8810, filed 2/15/22, effective 4/1/22; WSR 21-02-066, § 296-14-8810, filed 1/5/21, effective 4/1/21; WSR 20-02-114, § 296-14-8810, filed 1/2/20, effective 4/1/20; WSR 19-01-096, § 296-14-8810, filed 12/18/18, effective 4/1/19; WSR 18-05-081, § 296-14-8810, filed 2/20/18, effective 4/1/18; WSR 17-05-096, § 296-14-8810, filed 2/14/17, effective 4/1/17; WSR 16-05-087, § 296-14-8810, filed 2/16/16, effective 4/1/16; WSR 15-02-061, § 296-14-8810, filed 1/6/15, effective 4/1/15.]

WAC 296-14-900 Authority to use special assistant attorneys general. WAC 296-14-900 through 296-14-940 implement RCW 51.12.102 and 51.24.110, which authorize the department to use private attorneys as special assistant attorneys general.

[Statutory Authority: RCW 51.24.110 and 51.12.102. WSR 98-19-001, § 296-14-900, filed 9/2/98, effective 10/5/98. Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. WSR 93-23-060, § 296-14-900, filed 11/15/93, effective 1/1/94. Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-900, filed 3/31/88.]

WAC 296-14-910 Lists of special assistant attorneys general. (1) The department must determine from the application and other sources if an attorney qualifies to be placed on the lists of attorneys eligible to represent the department as special assistant attorneys general. The department may consult with the Washington State Bar Association and the office of the attorney general to make the determination.

(2) The office of the attorney general must appoint qualified attorneys as special assistant attorneys general. Once appointed, these attorneys become eligible to represent the department. Appointed attorneys serve at the pleasure of the office of the attorney general, and the appointments may be canceled without cause.

(3) The department must compile and maintain lists of attorneys eligible to represent the department as special assistant attorneys general. Referrals may be made from the lists and contracts entered into.

(4) Once a year, the department must provide a current copy of its lists of attorneys to the office of the attorney general and to the Washington State Bar Association.

[Statutory Authority: RCW 51.24.110 and 51.12.102. WSR 98-19-001, § 296-14-910, filed 9/2/98, effective 10/5/98. Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. WSR 93-23-060, § 296-14-910, filed 11/15/93, effective 1/1/94. Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-910, filed 3/31/88.]

WAC 296-14-920 Qualifications of special assistant attorneys general. To be eligible for placement on the department's lists of attorneys, an attorney must:

(1) Be an active member of the Washington State Bar Association;

(2) Meet bar association requirements of the state the action is in, if other than Washington;

(3) Maintain a trust account in compliance with the rules of professional conduct; and

(4) Have and maintain in force professional liability insurance.

[Statutory Authority: RCW 51.24.110 and 51.12.102. WSR 98-19-001, § 296-14-920, filed 9/2/98, effective 10/5/98. Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-920, filed 3/31/88.]

WAC 296-14-930 Applying for special assistant attorney general. (1) Application forms may be obtained from the office of the attorney general, the Washington State Bar Association, or the department.

(2) The applicant must:

(a) Complete the form and send it to the department; and

(b) Inform the department and the office of the attorney general immediately of any changes in his or her qualifications.

[Statutory Authority: RCW 51.24.110 and 51.12.102. WSR 98-19-001, § 296-14-930, filed 9/2/98, effective 10/5/98. Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. WSR 93-23-060, § 296-14-930, filed 11/15/93, effective 1/1/94. Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-930, filed 3/31/88.]

WAC 296-14-940 Removal of special assistant attorneys general. (1) RCW 51.12.102 and 51.24.110 and WAC 296-14-900 through 296-14-940 do not give private attorneys on the special assistant attorneys general lists any right to expect employment.

(2) Private attorneys, unless representing the department in a specific case, must not:

(a) Refer to themselves as "special assistant attorney general"; or

(b) Include this designation on any correspondence or pleadings relating to services.

(3) The department, in conjunction with the office of the attorney general and the Washington State Bar Association, may remove an attorney for cause from the lists of attorneys eligible to represent the department. Cause includes, but is not limited to:

(a) Misuse of the designation "special assistant attorney general";

(b) Lapse of any qualification; or

(c) Failure to meet performance requirements of the department contract.

(4) After one year an attorney may write to the department and request to be placed on the lists of attorneys eligible to represent the department again. The department in its discretion may place the attorney on its lists again.

(5) If the department removes an attorney from the lists a second time, or if the department decides not to place a removed attorney on its lists again, the department must notify the office of the attorney general to cancel the appointment. The department may refer the attorney to the Washington State Bar Association for consideration of disciplinary action. The attorney must reapply for appointment.

[Statutory Authority: RCW 51.24.110 and 51.12.102. WSR 98-19-001, § 296-14-940, filed 9/2/98, effective 10/5/98. Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24 and 51.32 RCW and 117 Wn.2d 122 and 121 Wn.2d 304. WSR 93-23-060, § 296-14-940, filed 11/15/93, effective 1/1/94. Statutory Authority: RCW 51.24.110. WSR 88-08-026 (Order 88-03), § 296-14-940, filed 3/31/88.]

WAC 296-14-955 Attorney's fees. (1) The department of labor and industries (hereinafter department) shall fix a reasonable attorney fee to be paid by the worker, crime victim, or beneficiary for serv-

ices rendered with the department if written application therefor is made by the attorney, worker, crime victim, or beneficiary, as provided in RCW 51.52.120.

(a) Fees will be set only for services rendered prior to the notice of appeal;

(b) On closed claims, fees will only be set if written application is received by the department within one year from the claim closure date as indicated on the department order.

(c) If such application for fixing of a fee is made by the attorney, it shall set forth therein the monetary amount which the attorney considers reasonable for all services rendered with the department, the reason such fee is considered to be reasonable, and a detailed breakdown of the time spent by the attorney in representing the injured worker.

(d) In all instances, the department shall afford to all parties affected a minimum of ten days in which to submit comment and material information which may be helpful to the department in setting a fair and reasonable fee.

(e) The department will provide copies of information sent to the department to the attorney, worker, crime victim, or beneficiary upon request.

(f) Informal contact may be made with the parties to determine the feasibility of reaching an agreement on the amount of the fees.

(g) Additional information necessary to reach a decision may be requested by the department.

(2) *Fee fixing criteria.* All attorney fees fixed by the department where application therefor has been made shall be established in accordance with the following general principles:

(a) Only one fee shall be fixed for legal services in any one claim regardless of the number of attorneys representing the worker, crime victim, or beneficiary, except that in cases of multiple beneficiaries represented by one or multiple attorneys the department has the discretion to set more than one attorney fee if so requested.

(b) The department shall defer fixing a fee until such time as information, which it deems sufficient upon which to base a fee, is available.

(c) A fee shall be fixed only in those cases where the attorney's services are instrumental in securing additional benefits to the worker, crime victim, or beneficiary.

(d) Where increased compensation is obtained, the fee may be fixed without regard to any medical benefits secured.

(e) In setting all fees, the following factors shall be carefully considered and weighed:

(i) Nature of the claim.

(ii) Novelty and complexity of the issues presented or other unusual circumstances.

(iii) Time and labor expended.

(iv) Skill and diligence in resolving the claim.

(v) Extent and nature of the relief.

(vi) The prevalent practice of charging contingency fees in the department.

(vii) The worker's or crime victim's circumstance and the remedial social purposes of the Industrial Insurance Act and of the Crime Victims Compensation Act, which are intended to provide sure and adequate relief to injured workers and crime victims and their families.

(3) The manager of the claims consultant division of the department is the director's designee to process all petitions to set attor-

ney's fees and to issue orders setting those fees for services rendered by attorneys in securing industrial insurance benefits. The supervisor of the crime victims section of the department is the director's designee to process all petitions to set attorney's fees and to issue orders setting those fees for services rendered by attorneys in securing crime victims benefits.

[Statutory Authority: Chapters 51.04, 51.08, 51.12, 51.24, and 51.32 RCW. WSR 06-04-025, § 296-14-955, filed 1/24/06, effective 2/24/06.]

WAC 296-14-970 Worker's review of claim file. (1) Pursuant to RCW 51.28.070, workers may be allowed to review their claim file(s) upon written request to the department or self-insurer. The written request should contain the worker's name, claim number, signature, and the information requested. If the request is approved, the department or self-insurer shall provide a copy of the claim file to the worker.

(2) Reasons for denying release of a claim file, to a worker shall include, but not be limited to the following:

(a) Presence of psychological, mental health, or physical treatment records, investigative reports or other records, release of which may not be in the interest of the worker.

(b) Medical opinion or other documented information indicates the worker is a danger to himself or herself or others.

(3) If, pursuant to the criteria established under subsection (2) of this section, the self-insured employer determines that release of the claim file, in whole or in part, may not be in the worker's interest, the employer must submit a request for denial with explanations along with a copy of that portion of the claim file not previously submitted to the self-insurance section within 20 days after receipt of the request from the worker.

(4) If the request for the claim file is denied, in whole or in part, a written order of denial will be issued by the department and mailed to the worker. The worker may appeal the order to the board of industrial insurance appeals.

(5) The provisions of this rule will apply to all claims regardless of the date of injury.

[Statutory Authority: RCW 51.28.070. WSR 90-18-002, § 296-14-970, filed 8/23/90, effective 9/23/90.]