Chapter 296-15 WAC
WORKERS' COMPENSATION SELF-INSURANCE RULES AND REGULATIONS

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

296-15-010 Preamble and authority. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-010, filed 7/1/86; Order 71-15, § 296-15-010, filed 12/1/71.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-020 Certification to self-insure. [Statutory Authority: RCW 51.04.020. WSR 94-05-042, § 296-15-020, filed 2/9/94, effective 3/14/94; WSR 90-14-036, § 296-15-020, filed 6/29/90, effective 7/30/90; WSR 88-12-096 (Order 88-07), § 296-15-020, filed 6/1/88; WSR 86-14-079 (Order 86-25), § 296-15-020, filed 7/1/86. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-020, filed 12/1/83, effective 1/1/84; Order 77-19, § 296-15-020, filed 9/26/77; Order 71-15, § 296-15-020, filed 12/1/71.] Repealed by WSR

99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-022 Corporate guarantee. [Statutory Authority: RCW 51.04.020. WSR 93-11-064, § 296-15-022, filed 5/14/93, effective 6/14/93; WSR 88-12-096 (Order 88-07), § 296-15-022, filed 6/1/88. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-022, filed 12/1/83, effective 1/1/84.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-023 Entities included in certification. [Statutory Authority: RCW 51.04.020. WSR 93-11-064, § 296-15-023, filed 5/14/93, effective 6/14/93; WSR 88-12-096 (Order 88-07), § 296-15-023, filed 6/1/88; WSR 86-14-079 (Order 86-25), § 296-15-023, filed 7/1/86. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-023, filed 12/1/83, effective 1/1/84.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-024 Additional certification requirements. [Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-024, filed 2/28/06, effective 4/1/06.] Repealed by WSR 21-13-136, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.020 and 51.14.020(7).

296-15-025 Joint venture. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-025, filed 7/1/86; WSR 82-07-019 (Order 82-8), § 296-15-025, filed 3/10/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-026 Group self-insurance application. [Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-026, filed 12/1/83, effective 1/1/84. Statutory Authority: RCW 51.14.150 and 51.14.160. WSR 83-01-076 (Order 82-43), § 296-15-026, filed 12/17/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-02601 Group self-insurers admission of new members, termination of individual members. [Statutory Authority: RCW 51.04.020. WSR 94-17-069, § 296-15-02601, filed 8/15/94, effective 9/15/94. Statutory Authority: RCW 51.04.020(1). WSR 84-06-031 (Order 83-38), § 296-15-02601, filed 3/1/84, effective 4/1/84; WSR 83-24-027 (Order 83-22), § 296-15-02601, filed 12/1/83, effective 1/1/84. Statutory Authority: RCW 51.14.150 and 51.14.160. WSR 83-01-076 (Order 82-43), § 296-15-02601, filed 12/17/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-02602 Group self-insurance reports. [Statutory Authority: RCW 51.14.150 and 51.14.160. WSR 83-01-076 (Order 82-43), § 296-15-02602, filed 12/17/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-02603 Group self-insurance trustee responsibilities. [Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-02603, filed 12/1/83, effective 1/1/84. Statutory Authority: RCW 51.14.150 and 51.14.160. WSR 83-01-076 (Order 82-43), § 296-15-02603, filed 12/17/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-02604 Group self-insurance funds—Surplus distribution—Deficit. [Statutory Authority: RCW 51.14.150 and 51.14.160. WSR 83-01-076 (Order 82-43), § 296-15-02604, filed 12/17/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-02605 Reserves. [Statutory Authority: RCW 51.14.150 and 51.14.160. WSR 83-01-076 (Order 82-43), § 296-15-02605, filed 12/17/82.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-02606 Self-insured employee rights. [Statutory Authority: RCW 51.04.020. WSR 94-05-042, § 296-15-02606, filed 2/9/94, effective 3/14/94.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).

296-15-030 Surety requirement. [Statutory Authority: RCW 51.04.020. WSR 94-05-042, § 296-15-030, filed 2/9/94, effective 3/14/94; WSR 93-11-064, § 296-15-030, filed 5/14/93, effective 6/14/93; WSR 90-24-039, § 296-15-030, filed 11/30/90, effective 12/31/90; WSR 88-12-096 (Order 88-07), § 296-15-030, filed 6/1/88; WSR 87-05-008 (Order 87-02), § 296-15-030, filed 2/9/87; WSR 86-14-079 (Order 86-25), § 296-15-030, filed 7/1/86; WSR 85-06-031 (Order 85-6), § 296-15-030, filed 3/1/85; Order 77-19, § 296-15-030, filed 9/26/77; Order 72-4, § 296-15-030, filed 4/25/72; Order 71-15, § 296-15-030, filed 12/1/71.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-031 Employee stock ownership plan self insurance application. [Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-031, filed 11/17/99, effective 12/27/99.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.

296-15-040 Payment of deficit. [Order 77-19, § 296-15-040, filed 9/26/77; Order 73-24, § 296-15-040, filed 11/23/73; Order 71-15, § 296-15-040, filed 12/1/71.] Repealed by WSR 81-10-052 (Order 81-8), filed 5/1/81. Statutory Authority: RCW 51.04.020(1) and 51.14.020(4).

296-15-041 Joint venture self insurance application. [Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-041, filed 11/17/99, effective 12/27/99.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.

296-15-044 Payment of deficit. [Statutory Authority: RCW 51.04.020(1) and 51.14.020(4). WSR 81-10-052 (Order 81-8), § 296-15-044, filed 5/1/81, effective 6/1/81.] Repealed by WSR 83-07-075 (Order 83-9), filed 3/23/83. Statutory Authority: RCW 51.14.020(1).

296-15-045 Payment of deficit. [Statutory Authority: RCW 51.14.020(1). WSR 83-07-075 (Order 83-9), § 296-15-045, filed 3/23/83.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-050 Reinsurance. [Statutory Authority: RCW 51.04.020. WSR 85-06-031 (Order 85-6), § 296-15-050, filed 3/1/85; Order 77-19, § 296-15-050, filed 9/26/77; Order 71-15, § 296-15-050, filed 12/1/71.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-051 Public entity self insurance application. [Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-051, filed 11/17/99, effective 12/27/99.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.

296-15-060 Administrative cost assessment. [Statutory Authority: RCW 51.04.020. WSR 94-17-069, § 296-15-060, filed 8/15/94, effective 9/15/94; WSR 93-11-064, § 296-15-060, filed 5/14/93, effective 6/14/93; WSR 86-14-079 (Order 86-25), § 296-15-060, filed 7/1/86; Order 77-19, § 296-15-060, filed 9/26/77; Order 75-28, § 296-15-060, filed 8/29/75, effective 1/1/76; Order 74-38, § 296-15-060, filed 11/18/74, effective 1/1/75; Order 73-24, § 296-15-060, filed 11/23/73; Order 71-15, § 296-15-060, filed 12/1/71.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-061 Employer group self insurance application. [Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-061, filed 11/17/99, effective 12/27/99.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.

296-15-065 Self-insurers' insolvency trust. [Statutory Authority: RCW 51.04.020. WSR 93-11-064, § 296-15-065, filed 5/14/93, effective 6/14/93; WSR 88-12-096 (Order 88-07), § 296-15-065, filed 6/1/88; WSR 86-24-014 (Order 86-40), § 296-15-065, filed 11/24/86.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-070 Accident reports and claims procedures. [Statutory Authority: RCW 51.32.190 and 51.14.090. WSR 96-21-145, § 296-15-070, filed 10/23/96, effective 11/25/96. Statutory Authority: RCW 51.04.020. WSR 94-17-069, § 296-15-070, filed 8/15/94, effective 9/15/94; WSR 90-14-009, § 296-15-070, filed 6/25/90, effective 8/1/90; WSR 88-12-096 (Order 88-07), § 296-15-070, filed 6/1/88; WSR 86-18-037 (Order 86-35), § 296-15-070, filed 8/28/86. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-070, filed 12/1/83, effective 1/1/84. Statutory Authority: RCW 51.04.020 and Title 51 RCW. WSR 82-12-035 (Order 82-23), § 296-15-070, filed 5/27/82, effective 7/1/82; WSR 81-24-040 (Order 81-29), § 296-15-070, filed 11/30/81; Order 77-19, § 296-15-070, filed 9/26/77; Order 72-15, § 296-15-070, filed 8/4/72; Order 71-15, § 296-15-070, filed 12/1/71.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).

296-15-072 Employer claim closures. [Statutory Authority: RCW 51.04.020. WSR 94-17-069, § 296-15-072, filed 8/15/94, effective 9/15/94; WSR 86-18-037 (Order 86-35), § 296-15-072, filed 8/28/86.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).

296-15-080 Statement of financial condition. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-080, filed 7/1/86. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-080, filed 12/1/83, effective 1/1/84; Order 77-19, § 296-15-080, filed 9/26/77; Order 74-38, § 296-15-080, filed 11/18/74, effective 1/1/75; Order 74-29, § 296-15-080, filed 5/29/74, effective 7/1/74.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-090 Application of supplemental moneys in payment of compensation. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-090, filed 7/1/86; Order 77-19, § 296-15-090, filed 9/26/77; Order 74-38, § 296-15-090, filed 11/18/74, effective 1/1/75.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-100 Permanent partial disability awards. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-100, filed 7/1/86; Order 77-19, § 296-15-100, filed 9/26/77; Order 74-38, § 296-15-100, filed 11/18/74, effective 1/1/75.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).

296-15-110 Contract with a service organization. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-110, filed 7/1/86; Order 74-38, § 296-15-110, filed 11/18/74, effective 1/1/75.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-120 Log of occupational injuries and illnesses. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-120, filed 7/1/86; Order 74-38, § 296-15-120, filed 11/18/74, effective 1/1/75.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.

296-15-130 Administration of self-insurance. [Order 74-38, § 296-15-130, filed 11/18/74, effective 1/1/75.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.

296-15-135	Contact person. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-135, filed 7/1/86.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-145	Expense of withdrawn certificate audit. [Order 74-38, § 296-15-145, filed 11/18/74, effective 1/1/75.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-150	Accident prevention program. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-150, filed 7/1/86; Order 74-38, § 296-15-150, filed 11/18/74, effective 1/1/75.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-160	Order on self-insured claims. [Statutory Authority: RCW 51.04.020. WSR 94-17-069, § 296-15-160, filed 8/15/94, effective 9/15/94; WSR 86-14-079 (Order 86-25), § 296-15-160, filed 7/1/86; Order 77-19, § 296-15-160, filed 9/26/77; Order 75-28, § 296-15-160, filed 8/29/75, effective 1/1/76.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-170	Cessation of business—Change of status. [Statutory Authority: RCW 51.04.020. WSR 94-05-042, § 296-15-170, filed 2/9/94, effective 3/14/94; WSR 88-12-096 (Order 88-07), § 296-15-170, filed 6/1/88; Order 75-28, § 296-15-170, filed 8/29/75, effective 1/1/76.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-180	Examinations for rating disability. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-180, filed 7/1/86; Order 75-28, § 296-15-180, filed 8/29/75, effective 1/1/76.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-190	Notification of rights and obligations. [Statutory Authority: RCW 51.32.190 and 51.14.090. WSR 96-21-145, § 296-15-190, filed 10/23/96, effective 11/25/96. Statutory Authority: RCW 51.04.020. WSR 88-12-096 (Order 88-07), § 296-15-190, filed 6/1/88; Order 75-28, § 296-15-190, filed 8/29/75, effective 1/1/76.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-200	Claims log—Evaluation. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-200, filed 7/1/86; WSR 83-07-009 (Order 83-8), § 296-15-200, filed 3/8/83; Order 77-19, § 296-15-200, filed 9/26/77; Order 75-28, § 296-15-200, filed 8/29/75, effective 1/1/76.] Repealed by WSR 19-01-095, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.04.020.
296-15-210	Supplementation of temporary total disability compensation by self-insured employers. [Order 77-19, § 296-15-210, filed 9/26/77; Order 75-36, § 296-15-210, filed 10/28/75.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-21001	Form—SIF #3—Self-insured employer's notice of acceptance of claim. [Order 71-15, Form SIF #3 (codified as WAC 296-15-21001), filed 12/1/71.] Repealed by WSR 84-06-031 (Order 83-38), filed 3/1/84, effective 4/1/84. Statutory Authority: RCW 51.04.020(1).
296-15-21002	Form—SIF #4—Self-insured employer's notice of denial of claim. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), §296-15-21002, filed 7/1/86; Order 71-15, Form SIF #4 (codified as WAC 296-15-21002), filed 12/1/71.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-21003	Form—SIF #5—Supplemental or final report on occupational injury or disease. [Order 71-15, Form SIF #5 (codified as WAC 296-15-21003), filed 12/1/71.] Repealed by WSR 86-18-037 (Order 86-35), filed 8/28/86. Statutory Authority: RCW 51.04.020.
296-15-215	Cash, bond or assignment of account alternative for death or permanent total disability. [Statutory Authority: RCW 51.04.020. WSR 88-12-096 (Order 88-07), § 296-15-215, filed 6/1/88; WSR 85-06-031 (Order 85-6), § 296-15-215, filed 3/1/85. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-215, filed 12/1/83, effective 1/1/84. Statutory Authority: RCW 51.04.020 and Title 51 RCW. WSR 81-23-047 (Order 81-27), § 296-15-215, filed 11/18/81.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-220	Second injury fund. [Order 77-19, § 296-15-220, filed 9/26/77.] Repealed by WSR 99-23-107, filed 11/17/99, effective 12/27/99. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150.
296-15-230	Third party actions. [Statutory Authority: RCW 51.04.020. WSR 85-06-031 (Order 85-6), § 296-15-230, filed 3/1/85. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-230, filed 12/1/83, effective 1/1/84; Order 77-19, § 296-15-230, filed 9/26/77.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-240	Procedure in cases appealed to the superior court. [Statutory Authority: RCW 51.04.020. WSR 86-14-079 (Order 86-25), § 296-15-240, filed 7/1/86; Order 77-19, § 296-15-240, filed 9/26/77.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-250	Representation in self-insured appeals. [Statutory Authority: RCW 51.04.020. WSR 88-12-096 (Order 88-07), § 296-15-250, filed 6/1/88. Statutory Authority: RCW 51.14.020(1). WSR 83-18-038 (Order 83-28), § 296-15-250, filed 9/1/83.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).

296-15-265	Penalties. [Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-265, filed 12/1/83, effective 1/1/84.] Repealed by WSR 98-24-121, filed 12/2/98, effective 1/2/99. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a).
296-15-430	Vocational services. [Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-430, filed 2/28/06, effective 4/1/06.] Repealed by WSR 08-06-058, filed 2/29/08, effective 3/31/08. Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72).
296-15-500	What vocational rehabilitation reports are required for self-insured employers? [Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.36.100, 51.36.110. WSR 00-18-078, § 296-15-500, filed 9/1/00, effective 12/1/00.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.
296-15-510	What is the process used for vocational rehabilitation with regard to self-insured employers? [Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.36.100, 51.36.110. WSR 00-18-078, § 296-15-510, filed 9/1/00, effective 12/1/00.] Repealed by WSR 06-06-066, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095.

WAC 296-15-001 Definitions. (1) "Self-insurance electronic data reporting system (SIEDRS)": SIEDRS is a computer system that collects claim data electronically from self-insurers. Effective July 1, 2008, all self-insurers must send timely and accurate claim data to SIEDRS in the required format.

(2) "Substantially similar":

(a) The text of the department's document has not been altered or deleted; and

(b) The self-insurer's document has the text:

(i) In approximately the same font size;

(ii) With the same emphasis (bolding, italics, underlining, etc.); and

(iii) In approximately the same location on the page as the department's document.

(3) "Third-party administrator (TPA)" is a business entity that contracts with one or more self-insured employers to handle self-insured employer's claims under WAC 296-15-350. TPAs who handle Washington claims must be licensed by the department of labor and industries. A business entity that is majority owned by a self-insured employer it contracts to handle claims for will not be considered a TPA of that self-insured employer.

(4) "Claims management entity": All individuals designated by the self-insured employer to administer workers' compensation claims, including self-administered organizations and third-party administrators.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-001, filed 5/18/21, effective 7/1/21. Statutory Authority: RCW 51.14.110. WSR 09-01-177, § 296-15-001, filed 12/23/08, effective 1/23/09. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-001, 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, § 296-15-001, filed 12/2/98, effective 1/2/99.]

WAC 296-15-021 Self-insurance qualifications. (1) **What factors does the department consider whether an employer qualifies for self-insurance certification?** The department will consider whether:

(a) An employer satisfactorily demonstrates:

(i) Stability: Has been in business for three years prior to applying for self-insurance without substantial changes in principle ownership, structure, or operations.

(ii) Safety: Has a written accident prevention program in place in accordance with DOSH standards in Washington state for at least six months prior to making application.

(iii) Sufficiency: Has net worth of twenty-five million dollars, or revenue of fifty million dollars, or annual workers compensation premium payments or loss costs of one million dollars, to be adjusted once every five years as indexed to the U.S. Consumer Price Index beginning in 2025. This subsection does not apply to cities and counties, or groups, authorized under RCW 51.14.150.

(b) Credit ratings of investment grade or higher, or, in the case of authorized groups, an actuarially determined low likelihood of default:

(i) A publicly traded business' credit analysis shows a credit rating of investment grade or higher (Moody's Baa3 or higher, Standard and Poor's BBB- or higher), and carries excess insurance.

(ii) A privately held business' credit analysis shows a credit rating of investment grade or higher as determined by self-insurance credit rating procedures, and carries excess insurance.

(iii) A public entity, such as a county or city, that shows a credit rating of investment grade or higher as determined by self-insurance credit rating procedures, has adequate monetary reserves as determined under accepted actuarial practices, and carries excess insurance.

(iv) An authorized group such as a hospital district, or an educational service district, has adequate monetary reserves as determined under accepted actuarial practices, and carries excess insurance.

(c) In addition, other factors can be considered to establish, to the director's satisfaction, the employer has the ability to make certain the prompt payment of all compensation under Title 51 RCW, and all assessments that may become due to the department from the employer. For publicly traded companies, this may require providing up to one hundred twenty-five percent of the initial surety amount when credit ratings are below investment grade.

(2) **What factors does the department consider when determining whether an employer qualifies for self-insurance if there are special circumstances with principle ownership, structure, or operations?** If there are special circumstances, the department will consider the factors in subsection (1)(a) through (c) of this section, and an analysis that includes the following for:

(a) **Joint venture:** A joint venture is defined as two or more employers that have signed a contractual agreement to operate as a single unit for a specified period of time for the completion of a specific task. The department will consider a joint venture's application for self-insurance if the joint venture is sponsored by a current self-insurer. Applications must include:

(i) The name of a sponsoring party. The sponsoring party must be a certified self-insurer in good standing with the department and have a majority financial interest in the assets and profits of the joint venture.

(ii) A list of named participants. Each named participant must also demonstrate that it has at least twenty percent interest in the joint venture.

(iii) Submit three years' worth of audited financial statements prepared by certified independent accountants.

(iv) A written acknowledgment from each named participant of its joint and several liability for continuing compensation if any partic-

ipant of the joint venture defaults. This responsibility continues until the department grants a written release to the joint venture or the remaining participant(s) of the joint venture. A written release from the department is granted only after the contract has been completed and final settlement of the joint venture account has been made.

(v) A written description of the obligations of each participant for the industrial insurance program of the joint venture.

(vi) A written acknowledgment of the sponsoring party's responsibilities for the management of all claims and payment of all compensation incurred during the period of the joint venture's self-insurance certification and after the joint venture is dissolved. This acknowledgment must include the sponsor's continuation of benefits if the joint venture or any of the other parties of the joint venture defaults.

(b) **Employee stock ownership program (ESOP)**: An employee stock ownership program is defined as a firm in which the employees have purchased a majority of the financial interest. If the employees purchase an existing self-insured company, that company would be required to return to the state industrial insurance fund for a minimum of one year before the department would consider its application for self-insurance.

(c) **Partnership**: A partnership is defined as a business operation between two or more individuals who share management and profits. Applications must include:

(i) A copy of the partnership agreement; and

(ii) An explanation of allowed withdrawal of funds by partners.

(d) **Group**: A group is defined as a group of employers authorized under chapter 51.14 RCW to form self-insurance groups. Applications must include:

(i) A copy of the group's bylaws;

(ii) A current audited consolidated financial statement of the group (if the group exists at the time of the application);

(iii) An indemnity agreement jointly and severally binding the group and each member to comply with the provisions of Title 51 RCW; and

(iv) A detailed budget of all projected administrative revenues and expenses for the first year of operation.

(e) When the application for a group is tentatively approved, the applicant must submit the following:

(i) Initial surety, established at one hundred twenty-five percent of the standard industrial insurance premiums; and

(ii) A copy of the excess insurance coverage policy and a copy of any aggregate stop loss coverage policy.

[Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-021, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.110. WSR 09-01-177, § 296-15-021, filed 12/23/08, effective 1/23/09. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-021, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-021, filed 11/17/99, effective 12/27/99.]

WAC 296-15-027 Additional requirements for subsidiaries and acquisitions. (1) **What if an individual firm is a subsidiary of a corporation?**

(a) If an individual self-insured firm has a parent (owner of fifty percent and/or having controlling financial interest), the parent must provide the department with its written guarantee, L&I form F207-040-000, to assume responsibility for all workers' compensation liabilities of the subsidiary if the subsidiary defaults on its liabilities.

(b) If a parent fails to provide a guarantee, the department will require the subsidiary to provide surety at one hundred twenty-five percent of its actual requirement. The subsidiary must continue to provide surety at the higher level as long as it has no parental guarantee.

(c) Certification of an individual self-insurer will include all of its subsidiaries (fifty percent owned and/or financial interest controlled by) or divisions doing business in Washington, as well as new acquisitions after certification becomes final. One certificate will be issued to an approved self-insurer. The subsidiaries or divisions will be considered one self-insurer for all industrial insurance purposes.

(2) **What if a certified self-insurer is acquired by another entity?**

(a) If it is an asset only acquisition, the certified self-insurer must surrender its certification and would retain the self-insurance liabilities and must continue to provide benefits. The new owner would be required to obtain industrial insurance coverage through the state fund. If the new owner wishes to become self-insured, it must meet the department's minimum requirements and submit an application according to the normal certification process.

(b) If the acquisition is a stock acquisition, the new owner must either provide a parental guarantee in accordance with WAC 296-15-024(4), or if it wishes to have the self-insurance certification transferred to the new parent organization, it must:

(i) Provide proof of financial capabilities by furnishing three years of audited financial statements; and

(ii) Furnish evidence of an acceptable claim administration program to oversee a self-insurance program; and

(iii) Demonstrate the existence of an acceptable accident prevention program covering all of its operations in Washington.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-027, filed 2/28/06, effective 4/1/06.]

(Effective until July 1, 2024)

WAC 296-15-121 Surety for a self-insurance program. (1) **What is surety?** Surety is the legal financial guarantee each self-insurer must provide to the department for its self-insured workers' compensation program. Failure to provide surety in the amount required by the department will result in the withdrawal of the self insurer's certification. If a self-insurer defaults on (stops payment of) benefits and assessments, the department will use its surety to cover these costs.

(a) Surety for all entities must be provided on the department's form. The original will be kept by the department. Surety must cover

all self-insurance claims liabilities associated with the claims occurring during the time an employer functions as a self-insurer. Excluding public entities and groups. Surety amounts for public entities and groups are covered by WAC 296-15-151 and 296-15-161 respectively.

(b) Surety may not be used by a self-insurer to:

(i) Pay its workers' compensation benefits; or

(ii) Serve as collateral for any other banking transactions.

(c) Surety is not an asset of the self-insurer and will not be released by the department if the self-insurer files a petition for dissolution or relief under bankruptcy laws.

(d) The department will determine the amount of surety each self-insurer must provide annually. Surety can also be determined by an independent qualified actuary (associate or fellow of the casualty actuarial society). The surety estimate is subject to the approval of the department's actuary.

(e) Surety may be increased by a maximum of twenty-five percent of the estimated claim liabilities. These increases will be based on the self-insurer's credit rating or the director's discretion.

(f) Surety for privately held entities are required to submit audited financial reports prepared by a certified public accountant annually. Failure to provide timely updates will result in increased surety requirements. If the latest financial reports are older than twelve months past their fiscal year, surety will be increased by ten percent over the required surety calculated by the department. If the latest financial reports are older than twenty-four months, surety will be increased by twenty-five percent over the required surety calculated by the department and the department will proceed to decertify the employer from self-insurance.

(2) **What types of self-insurance surety will the department accept?** The department will accept the following types of surety:

(a) Cash, corporate, or governmental securities deposited with a department approved escrow agent and administered by a written agreement L&I form F207-039-000 between the department, self-insurer and escrow agent. Use L&I form F207-137-000 for any rider/amendment to the escrow account.

An escrow account may not be used by the self-insurer to satisfy any other obligation to the bank which maintains the escrow account.

(b) A bond on L&I form F207-068-000 written by a company approved to transact surety business in Washington. Use L&I form F207-134-000 for any rider/amendment to the bond.

(c) An irrevocable standby letter of credit (LOC) on L&I form F207-112-000 if the self-insurer has a net worth of at least 500 million dollars. Use L&I form F207-111-000 for any rider/amendment. LOCs are subject to acceptance by the department. Acceptance includes, but is not limited to, approval of the financial condition of the issuing or confirming bank.

(i) The issuing or confirming bank must have a location in Washington. The bank must provide the department with an audited financial statement or call report made to the banking regulatory agencies for the most recent fiscal year. An audited statement/call report is due at LOC issuance and annually while the LOC is in effect.

(ii) The self-insurer must provide the department a memorandum of understanding on L&I form F207-113-000 showing the self-insurer's agreement with the following conditions:

(A) The department will automatically extend an LOC for an additional year unless notified otherwise by registered mail at least sixty days prior to expiration.

(B) If the department is notified an LOC will not be replaced, and the self-insurer fails to provide acceptable replacement surety within thirty days of notice:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department;

(II) Accrued interest in excess of the surety requirement will be returned semiannually to the self-insurer; and

(III) If acceptable replacement surety is later provided, the proceeds of the LOC and accrued interest will be returned to the self-insurer.

(C) If the self-insurer defaults on the payment of workers' compensation benefits and has failed to provide acceptable replacement surety for an expired LOC:

(I) The title to the proceeds will be transferred to the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(D) If the self-insurer defaults on the payment of workers' compensation benefits and has an LOC in force:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(iii) If the self-insurer provides another acceptable type of surety in the amount required by the department, the department's interest in the LOC will be released.

(iv) All legal proceedings regarding a self-insurer's LOC will be subject to Washington laws and courts.

(3) **When could a self-insurer's surety level change?**

(a) Surety will be maintained at the current level unless the department's estimate or an independent qualified actuary's estimate of the self-insurer's outstanding claim liabilities changes by more than one hundred thousand dollars.

(b) Surety changes are due by July 1 of each year.

(4) **How does the department determine the required surety level?** The department analyzes each self-insurer's loss history using incurred development, paid development or other department approved actuarial methods of loss development.

(5) **What is considered reinsurance?** For the purposes of Title 51 RCW, excess insurance and reinsurance mean the same thing.

(6) **May a self-insurer reinsure part of its liability?**

(a) A self-insurer may reinsure up to eighty percent of its liability under Title 51 RCW.

(b) The reinsuring company and its personnel are prohibited from participating in the administration of the responsibilities of the self-insurer.

(c) Reinsurance policies issued after July 1, 1975, must include endorsements which state (a) and (b) of this subsection.

(d) The self-insurer must:

(i) Notify the department of the name of the insurance carrier, the extent and coverage period of the policy; and

(ii) Submit copies of all reinsurance policies in force including all modifications and renewal provisions.

(e) The department may accept a certificate of insurance on L&I form F207-095-000 in place of the policy if the certificate certifies all coverage conditions and exceptions and that the reinsurance compa-

ny and its personnel do not participate in the administration of the responsibilities of the self-insurer under Title 51 RCW.

(7) **What if a self-insurer ends its self-insured workers' compensation program?** If a self-insurer voluntarily surrenders certification or has its certificate involuntarily withdrawn by the department, the former self-insurer must continue to do all of the following:

(a) Pay benefits on claims incurred during its period of self-insurance. Claim reopenings and new claims filed for occupational diseases incurred during the period of self-insurance remain the obligation of the former self-insurer.

(b) File quarterly and annual reports as long as quarterly reporting is required. A former self-insurer may ask the department to release it from quarterly reporting after it has had no claim activity with the exception of pension or death benefits for a full year.

(c) Provide surety at the department required level. The department may require an increase in surety based on annual reports as they continue to be filed. Surety will not be reduced from the last required level (while self-insured) until three full calendar years after the certificate was terminated. A bond may be canceled for future obligations, but it continues to provide surety for claims occurring prior to its cancellation.

(d) Pay insolvency trust assessments for three years after surrender or withdrawal of certificate.

(e) Pay all expenses for a final audit of its self-insurance program.

(8) **When could the department consider releasing surety to a former self-insurer or its successor?**

(a) The department may consider releasing surety to a former self-insurer or its successor when all of the following have occurred:

(i) All claims against the self-insurer are closed; and

(ii) The self-insurer has been released from quarterly reporting for at least ten years.

(b) If the department releases surety, the former self-insurer remains responsible for claim reopenings and new claims filed for occupational disease incurred during the period of self-insurance.

[Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-121, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-121, filed 11/17/99, effective 12/27/99.]

(Effective July 1, 2024)

WAC 296-15-121 Surety for a self-insurance program. (1) **What is surety?** Surety is the legal financial guarantee each self-insurer must provide to the department for its self-insured workers' compensation program. Failure to provide surety in the amount required by the department will result in the withdrawal of the self-insurer's certification. If a self-insurer defaults, the department will use its surety to cover these costs.

(a) Surety for all entities must be provided on the department's form. The original will be kept by the department. Surety must cover all self-insurance claims liabilities associated with the claims occurring during the time an employer functions as a self-insurer. Ex-

cluding public entities and groups. Surety amounts for public entities and groups are covered by WAC 296-15-151 and 296-15-161 respectively.

(b) Surety may not be used by a self-insurer to:

(i) Pay its workers' compensation benefits; or

(ii) Serve as collateral for any other banking transactions.

(c) Surety is not an asset of the self-insurer and will not be released by the department if the self-insurer files a petition for dissolution or relief under bankruptcy laws.

(d) The department will determine the amount of surety each self-insurer must provide annually. Surety can also be determined by an independent qualified actuary (associate or fellow of the casualty actuarial society). The surety estimate is subject to the approval of the department's actuary.

(e) Surety may be increased by a maximum of 25 percent of the estimated claim liabilities. These increases will be based on the self-insurer's credit rating or the director's discretion.

(f) Surety for privately held entities are required to submit audited financial reports prepared by a certified public accountant annually. Failure to provide timely updates will result in increased surety requirements. If the latest financial reports are older than 12 months past their fiscal year, surety will be increased by 10 percent over the required surety calculated by the department. If the latest financial reports are older than 24 months, surety will be increased by 25 percent over the required surety calculated by the department and the department will proceed to decertify the employer from self-insurance.

(2) **What types of self-insurance surety will the department accept?** The department will accept the following types of surety:

(a) Cash, corporate, or governmental securities deposited with a department approved escrow agent and administered by a written agreement L&I form F207-039-000 between the department, self-insurer and escrow agent. Use L&I form F207-137-000 for any rider/amendment to the escrow account.

An escrow account may not be used by the self-insurer to satisfy any other obligation to the bank which maintains the escrow account.

(b) A bond on L&I form F207-068-000 written by a company approved to transact surety business in Washington. Use L&I form F207-134-000 for any rider/amendment to the bond.

(c) An irrevocable standby letter of credit (LOC) on L&I form F207-112-000 if the self-insurer has a net worth of at least $500,000,000. Use L&I form F207-111-000 for any rider/amendment. LOCs are subject to acceptance by the department. Acceptance includes, but is not limited to, approval of the financial condition of the issuing or confirming bank.

(i) The issuing or confirming bank must have a location in Washington. The bank must provide the department with an audited financial statement or call report made to the banking regulatory agencies for the most recent fiscal year. An audited statement/call report is due at LOC issuance and annually while the LOC is in effect.

(ii) The self-insurer must provide the department a memorandum of understanding on L&I form F207-113-000 showing the self-insurer's agreement with the following conditions:

(A) The department will automatically extend an LOC for an additional year unless notified otherwise by registered mail at least 60 days prior to expiration.

(B) If the department is notified an LOC will not be replaced, and the self-insurer fails to provide acceptable replacement surety within 30 days of notice:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department;

(II) Accrued interest in excess of the surety requirement will be returned semiannually to the self-insurer; and

(III) If acceptable replacement surety is later provided, the proceeds of the LOC and accrued interest will be returned to the self-insurer.

(C) If the self-insurer defaults on the payment of workers' compensation benefits and has failed to provide acceptable replacement surety for an expired LOC:

(I) The title to the proceeds will be transferred to the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(D) If the self-insurer defaults on the payment of workers' compensation benefits and has an LOC in force:

(I) The department will draw the full value of the LOC. All proceeds of the LOC will be deposited with the department; and

(II) The proceeds and accrued interest will be used to pay the self-insurer's workers' compensation benefits.

(iii) If the self-insurer provides another acceptable type of surety in the amount required by the department, the department's interest in the LOC will be released.

(iv) All legal proceedings regarding a self-insurer's LOC will be subject to Washington laws and courts.

(3) **When could a self-insurer's surety level change?**

(a) Surety will be maintained at the current level unless the department's estimate or an independent qualified actuary's estimate of the self-insurer's outstanding claim liabilities changes by more than $100,000.

(b) Surety changes are due by July 1st of each year.

(4) **How does the department determine the required surety level?** The department analyzes each self-insurer's loss history using incurred development, paid development or other department approved actuarial methods of loss development.

(5) **What is considered reinsurance?** For the purposes of Title 51 RCW, excess insurance and reinsurance mean the same thing.

(6) **May a self-insurer reinsure part of its liability?**

(a) A self-insurer may reinsure up to 80 percent of its liability under Title 51 RCW.

(b) The reinsuring company and its personnel are prohibited from participating in the administration of the responsibilities of the self-insurer.

(c) Reinsurance policies issued after July 1, 1975, must include endorsements which state (a) and (b) of this subsection.

(d) The self-insurer must:

(i) Notify the department of the name of the insurance carrier, the extent and coverage period of the policy; and

(ii) Submit copies of all reinsurance policies in force including all modifications and renewal provisions.

(e) The department may accept a certificate of insurance on L&I form F207-095-000 in place of the policy if the certificate certifies all coverage conditions and exceptions and that the reinsurance compa-

ny and its personnel do not participate in the administration of the responsibilities of the self-insurer under Title 51 RCW.

(7) **What if a self-insurer ends its self-insured workers' compensation program?** If a self-insurer voluntarily surrenders certification or has its certificate involuntarily withdrawn by the department, the former self-insurer must continue to do all of the following:

(a) Manage and pay benefits on claims incurred during its period of self-insurance. Claim reopenings and new claims filed for occupational diseases incurred during the period of self-insurance remain the obligation of the former self-insurer.

(b) File quarterly and annual reports as long as quarterly reporting is required; and submit audited financial reports prepared by a certified public accountant annually. A former self-insurer may ask the department to release it from quarterly reporting after it has had no claim activity with the exception of pension or death benefits for a full year.

(c) Provide surety at the department required level. The department may require an increase in surety based on annual reports as they continue to be filed. Surety will not be reduced from the last required level (while self-insured) any sooner than three full calendar years after the certificate was terminated. A bond may be canceled for future obligations, but it continues to provide surety for claims occurring prior to its cancellation.

(d) Pay insolvency trust assessments for three years after surrender or withdrawal of certificate.

(e) Pay all expenses for a final audit of its self-insurance program.

(8) **When could the department consider releasing surety to a former self-insurer or its successor?**

(a) The department may consider releasing surety to a former self-insurer or its successor when all of the following have occurred:

(i) All claims against the self-insurer are closed; and

(ii) The self-insurer has been released from quarterly reporting for at least 10 years.

(b) If the department releases surety, the former self-insurer remains responsible for claim reopenings and new claims filed for occupational disease incurred during the period of self-insurance.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-121, filed 5/21/24, effective 7/1/24. Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-121, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-121, filed 11/17/99, effective 12/27/99.]

WAC 296-15-123 Monitoring certification. (1) To maintain certification, a self-insured employer must remain in good standing with department reporting requirements and payment of assessments, and continue to demonstrate they have the ability to promptly provide benefits to its injured workers based on an analysis of the audited financial statements and related information for that employer.

(2) Credit rating evaluation for financial monitoring.

(a) Credit rating equal to or below B+/B1: Self-insurer must increase their surety by ten percent of estimated claim liabilities.

(b) Credit rating equal to or below CCC+/Caa1: Self-insurer must increase their surety by twenty-five percent of estimated claim liabilities.

(c) Credit rating equal to or below CCC-/Caa3: Self-insurer will be placed on corrective action for one year. If no improvement in credit rating, then certification may be withdrawn.

(d) To assess an employer's ability to promptly provide any and all required benefits to its injured workers, the department will utilize these and other financial information. The department may also utilize industry standards and other relevant information in its analysis.

(e) In addition to the actions and other relevant information utilized in (a) through (d) of this subsection, the department, with the director's discretion, may consider general economic conditions to evaluate whether a self-insurer's certification may be maintained or withdrawn.

[Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-123, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-07-141, § 296-15-123, filed 3/21/06, effective 5/1/06.]

(Effective until July 1, 2024)

WAC 296-15-125 Default by a self-insurer. (1) What is a default? A default occurs when a self-insured employer no longer provides benefits to its injured workers in accordance with Title 51 of the Revised Code of Washington. A default can be a voluntary action of the self-insured employer, or an action brought on by the employer's inability to pay the obligation.

(2) What happens when the department first learns a self-insured employer has defaulted on its obligation? The department first corresponds with the self-insured employer to determine if the self-insurer will resume the provision of benefits. If the self-insurer does not respond to the department and resume the provision of benefits within ten days, the self-insured employer is determined to have defaulted.

(3) What happens when the department confirms that a self-insurer has defaulted on its obligation? There are two actions that the department takes when a default by a self-insured employer is confirmed:

(a) First, the department assumes jurisdiction of the claims of the defaulting self-insurer and begins to provide benefits to those injured workers.

(b) Second, the department makes demand upon the surety provided by that self-insurer for the full amount of the surety. The proceeds of the surety are deposited with the department and accrue interest, which will be used to supplement the surety in providing benefits to those injured workers.

(4) What happens to a self-insured employer's certification when it defaults? The employer surrenders its self-insurance certification when it defaults. Any remaining employment in the state would need industrial insurance coverage through the state fund effective with the default by the employer.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-07-141, § 296-15-125, filed 3/21/06, effective 5/1/06.]

(Effective July 1, 2024)

WAC 296-15-125 Default by a self-insurer. (1) What is a default? A default occurs when a self-insured employer no longer provides benefits to its injured workers in accordance with Title 51 of the Revised Code of Washington, or is determined to otherwise fail to meet the requirements of a self-insured employer under Title 51 RCW. A default can be a voluntary action of the self-insured employer, an action brought on by the employer's inability to pay the obligation, or an action brought on by the department.

(2) What happens when the department first learns a self-insured employer has discontinued meeting its obligations under Title 51 RCW? The department will send notice to the self-insurer that if it does not send confirmation within 10 calendar days that it intends to continue to meet its obligations under Title 51 RCW, the department will determine that the self-insurer has defaulted. If the self-insurer does not respond to the department and resume meeting its obligations under Title 51 RCW within 10 days, the self-insured employer is determined to have defaulted.

(3) What happens when the department determines that the self-insured employer has defaulted? The following actions occur when a default by a self-insured employer is determined:

(a) The department assumes jurisdiction of the claims of the defaulting self-insurer and begins to provide benefits to those injured workers.

(b) If the self-insurer is a private entity, or a public entity or group that has provided surety consistent with WAC 296-15-121, the department makes demand upon the surety provided by that self-insurer for the full amount of the surety. The proceeds of the surety are deposited with the department and accrue interest, which will be used to supplement the surety in providing benefits to those injured workers.

(4) What happens to a self-insured employer's certification when it defaults? The employer surrenders its self-insurance certification when it defaults. Any remaining employment in the state would need industrial insurance coverage through the state fund effective with the default by the employer.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-125, filed 5/21/24, effective 7/1/24. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-07-141, § 296-15-125, filed 3/21/06, effective 5/1/06.]

WAC 296-15-140 Expense of out-of-state audit. (1) **When is a self-insurer charged for audit expenses?** The self-insurer must reimburse the department for all travel, per diem and documented expenses as related to the audit when the department representative travels outside the state of Washington.

(2) **How much will the self-insurer be charged?** The self-insured employer is billed the actual costs that the department incurred.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-140, filed 2/28/06, effective 4/1/06; Order 74-38, § 296-15-140, filed 11/18/74, effective 1/1/75.]

WAC 296-15-151 Surety for a public entity's self-insurance program. (1) Surety for public entities must be provided on a department developed form consistent with WAC 296-15-121(2). The original will be kept by the department. Required surety must cover at a minimum one hundred twenty-five percent of the expected workers' compensation claim costs occurring in the next calendar year or five hundred thousand dollars, whichever is higher. The surety required may be increased up to the total outstanding liabilities associated with claims occurring during the time an employer functions as a self-insurer based on the credit rating of the employer.

(2) Public entities must provide a public entity surety certification which will provide an estimate of the next calendar year's expected claim costs and the current estimate of the outstanding claim liabilities.

(3) Credit rating evaluation for financial monitoring.

(a) For entities with acceptable credit ratings above B+/B1, the surety requirement will be one hundred twenty-five percent of the next calendar year's expected claim costs or five hundred thousand dollars, whichever is higher.

(b) For entities with credit ratings at or below B+/B1, the surety requirement will be the highest of the above amount, but not less than fifty percent of the current estimate of outstanding claim liabilities.

(c) For entities with credit ratings at or below CCC+/Caa1, the surety requirement will be the highest of the above amount, but not less than one hundred percent of the current estimate of outstanding claim liabilities.

(d) In addition to the actions and other relevant information utilized in (a) through (c) of this subsection, the department, with the director's discretion, may consider general economic conditions to evaluate whether a self-insurer's certification may be maintained or withdrawn.

[Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-151, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-151, filed 11/17/99, effective 12/27/99.]

WAC 296-15-161 Surety for a group self-insurance program. (1) **How does the department determine the required surety level for a group self-insurer?**

The department will require that each group provide an actuarial report prepared by an independent qualified actuary (associate or fellow of the casualty actuarial society) that shows the following:

(a) Development of the next year's rates and allocation to members;

(b) Calculation of outstanding claims liabilities cover all years after being certified to self-insure; and

(c) Statement of the adequacy of the group's contingency reserve (assets and liabilities).

(2) **May a group self-insurer pay expenses from its reserve fund?** A group self-insurer may pay only the following items from its cash reserve fund:

(a) Administrative expenses for operating the group self-insurance program, including claims handling expenses, legal, investigative or administrative costs and department administrative assessments.

(b) Claim expenditures. Supplemental pension fund (SPRF) benefits may also be paid from the reserve fund if the group redeposits SPRF reimbursements into the reserve account. Interest earned by the reserve account must remain in the account while this method is in effect.

(c) Reinsurance premiums. All recoveries from these policies must be redeposited into the reserve fund. Within eighteen months of premium payment, the group must return the amount paid for premiums if reinsurance recoveries were not sufficient to return the account to its original amount.

(3) **How can a group self-insurer assess its members for reserve fund costs?** A group self-insurer may determine how it will assess members for required reserve fund costs. The group's bylaws must describe the procedures it will use to collect these costs.

(4) **Must a group self-insurer purchase reinsurance?** A group self-insurer must obtain reinsurance for each year of operation to ensure adequate protection against catastrophic or unexpected loss.

(5) **What if a group self-insurer collects excess premiums during a fund year and has a surplus?** A group self-insurer may refund surplus money from a fund year if it retains sufficient money to fulfill all of its workers' compensation obligations. This includes maintaining the required reserve fund.

(6) **What if a group self-insurer collects insufficient premiums during a fund year and has a deficit?** The department will demand a group self-insurer to cover a deficit by:

(a) Unencumbered surplus from a different fund year;

(b) An alternative method; or

(c) Assessing the membership.

[Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-161, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-161, filed 11/17/99, effective 12/27/99.]

WAC 296-15-171 Surety for a self insured pension or fatality claim. (1) **When must a self insurer provide funding for a permanent total disability (pension) or fatality claim?** Within sixty days of receipt of the department's order, the self insurer must fund the pension or fatality claim.

(2) **What types of funding may a self insurer use for a pension or fatality claim?** A self insurer may fund a pension or fatality claim with cash, a bond on L&I form F207-065-000, annuity on L&I form F207-129-000 or assignment of account on L&I form F207-058-000. If the pension benefit level increases, the self insurer must increase the surety level or provide additional surety to cover the deficiencies.

(3) **What is an annuity?** An annuity is a contract with an insurance company where the insurance company agrees to pay to the department a specific amount covering the lifetime of a claimant.

(4) **What is an assignment of account?** A self insurance assignment of account/certificate of deposit is a legal instrument executed by the self insurer and an approved commercial banking institution in Washington. The assignment of account must:

(a) Identify an existing account on deposit with the approved banking institution in the name of the self insurer. The existing assigned account must contain the amount determined necessary by the department to cover the pension benefits on the specific claim beyond all other assignments on that account. A separate assignment of account must be established for each pension.

(b) Bind the self insurer to maintain a balance in the assigned account at least equal to the current present cash value of the pension benefits on the claim and beyond all other assignments on the account for the life of the claim. Present cash values of the assigned account/certificate of deposit will be revised annually by the department. Quarterly pension payments made from the assigned account must not reduce the account balance below the present cash value of the pension beyond all other assignments on the same account.

(c) Authorize the department, if the self insurer defaults, to immediately withdraw up to the entire amount assigned to the pension claim from the assigned account/certificate of deposit. The department will take this action without notifying the defaulting self insurer.

(d) If the bank holding the assignment of account/certificate of deposit fails, the self insurer is responsible for the entire amount of the pension or fatality obligation. Within thirty days, the self insurer must:

(i) Establish a new assignment of account/certificate of deposit, bond; or

(ii) Deposit cash into the reserve fund.

(e) If the self insurer ends its self insurance status, the assignment of account/certificate of deposit will be placed with the department. The department will determine the required reserve for the pension or fatality claim, and any excess will be returned to the former self insurer.

[Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-171, filed 11/17/99, effective 12/27/99.]

WAC 296-15-181 Funding the benefits of an insolvent self-insurer. (1) **What happens when a self-insurer defaults on (stops paying) workers' compensation benefits and assessments?** When a self-insurer stops paying workers' compensation benefits or assessments, and the default is not due to a claims administration decision, the department will take over its surety and claims.

(2) **If a defaulting self-insurer has multiple types of surety, who determines the order in which surety will be used?** The department has the sole authority to determine the order in which surety types will be used.

(3) **What happens if the defaulting self-insurer's surety is exhausted?** When surety is exhausted, the insolvency trust (all self-insurers except school districts, cities and counties) will be assessed quarterly to cover the claim costs paid on behalf of the defaulted self-insurer.

(4) **Who is on the insolvency trust board?** The insolvency trust board consists of the director or designee, three representatives of self-insured employers and one representative of workers. Representatives are nominated by the self-insured and labor communities and are appointed by the director for overlapping two year terms.

(5) **What does the insolvency trust board do?** The board advises the department on insolvency trust matters. The department makes all final decisions.

(6) **What annual report is provided on the insolvency trust fund?** The department provides an annual written status report on the insolvency trust fund as of the end of the previous calendar year to the workers' compensation advisory committee. The report is presented at the committee's first quarterly meeting no later than March 31.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-181, filed 2/28/06, effective 4/1/06. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-181, filed 11/17/99, effective 12/27/99.]

WAC 296-15-221 Self-insurers' reporting requirements. (1) **What information must self-insurers report to the department?** Each self-insurer must provide the department:

(a) The name, title, address and phone number of the single contact person who is the liaison with the department in all self-insurance matters. This contact will be sent all department correspondence and is responsible for forwarding information to appropriate parties for timely action.

(b) A copy of its current policy of applying sick leave, health and welfare benefits or any other compensation in conjunction with, or as a substitute for, time loss benefits.

(2) **When must self-insurers notify the department of business status changes?** Self-insurers must notify the department in writing:

(a) Immediately, of any plans to:

(i) Cease business entirely or cease business in Washington; or

(ii) Dispose of controlling financial interest of the original self-insurer. The self-insurer must surrender its certificate for cancellation if requested by the department.

(b) Within thirty days, of any:

(i) Amendment(s) or modification(s) to the self-insurer's articles, charter or agreement of incorporation, association, copartnership or sole proprietorship which will materially change the business identity or structure originally certified.

(A) The department may require additional documentation.

(B) If the self-insurer becomes a subsidiary to another firm, the parent must provide the department with its written guarantee on L&I form F207-040-001 to assume responsibility for all workers' compensation liabilities of the subsidiary if the subsidiary defaults on its liabilities. See WAC 296-15-021 for additional information.

(ii) Separation (for example, divestiture or spinoff) of any part of the original self-insurer.

(A) The original self-insurer remains responsible for claims liability of the separated part up to the date of separation unless the department approves an alternative.

(B) If the separating part wishes to continue being self-insured, it must submit an application for self-insurance certification (L&I Form F207-001-000) to the department at least thirty days before separation.

(C) If certification cannot be granted before separation, industrial insurance coverage must be purchased from the state fund effective the date of separation.

(iii) Relocation, addition or closure of physical locations.

(3) **When must self-insurers notify the department of administrative changes?** A self-insurer must notify the department in writing within ten days, of any change to its:

(a) Single contact person who is the liaison with the department in all self-insurance matters. The self-insurer must include the contact's title, address and phone number.

(b) Contract with a service organization or third party administrator independent of the self-insurer which will participate in the self-insurer's responsibilities. The self-insurer must submit a copy of the new or updated service contract. See WAC 296-15-021 for additional information.

(c) Administrator of its workers' compensation program, if the self-insurer is self-administered instead of contracting with a service organization or third party administrator.

(4) **What reports must self-insurers submit to the department?** Each self-insurer must submit:

(a) Complete and accurate quarterly reports summarizing worker hours and claim costs paid the previous quarter. Self-insurers must use a form substantially similar to the preprinted Quarterly Report for Self-Insured Business, L&I form F207-006-000, form sent by the department. This report is the basis for determining the administrative, second injury fund, supplemental pension, asbestosis and insolvency trust assessments. Payment is due by the date specified on the preprinted report sent by the department.

(i) Worker hours must be reported as defined in chapter 296-17 WAC General reporting rules, audit and recordkeeping, rates and rating system for Washington workers' compensation insurance.

(ii) Claim costs include, but are not limited to:

(A) Time loss compensation. Include the amount of time loss the worker would have been entitled to if kept on full salary.

(B) Permanent partial disability (PPD) awards.

(C) Medical bills.

(D) Prescriptions.

(E) Medical appliances.

(F) Independent medical examinations and/or consultations.

(G) Loss of earning power.

(H) Travel expenses for treatment or rehabilitation.

(I) Vocational rehabilitation expenses.

(J) Penalties paid to injured workers.

(K) Interest on board orders.

(b) A complete and accurate annual report of all claim costs paid for each year of liability with an estimate of future claim costs. The self-insurer must use a form substantially similar to the Annual Report for Self-Insured Businesses (SIF-7), L&I form F207-007-000. This report is due March 1 of each year. The department uses this for the annual determination of each self-insurer's surety requirement.

(c) Privately held entities are required to submit annually audited financial statements within six months of their fiscal year end, unless the department grants an extension. Failure to provide financial statements will result in increased surety requirements and may result in decertification as a self-insured.

(i) This statement must be prepared by a certified public accountant.

(ii) A self-insurer with a parental guarantee may submit the parent's fully audited financial statement if the parent's audited

statement includes the financial condition of all subsidiaries, including the self-insurer.

(iii) A political subdivision of the state may submit a state auditor's report if it includes the self-insurer's audited financial statement. If the state auditor does not audit the self-insurer annually, the self-insurer must submit financial statements prepared internally for any year a report by the state auditor is not available.

[Statutory Authority: RCW 51.14.020 and 51.14.020(7). WSR 21-13-136, § 296-15-221, filed 6/22/21, effective 7/23/21. Statutory Authority: RCW 51.14.077, 51.14.150, 51.14.160, 51.44.040, 51.44.070, and 51.44.150. WSR 09-13-018, § 296-15-221, filed 6/5/09, effective 7/6/09. Statutory Authority: RCW 51.14.077, 51.14.120(7), 51.14.150(4), 51.14.160, 51.44.040(3), 51.44.070 and 51.44.150. WSR 99-23-107, § 296-15-221, filed 11/17/99, effective 12/27/99.]

WAC 296-15-223 Self-insurance administrative assessment. (1) The administrative assessment covers the department's administrative costs, including direct and indirect expenses of each department division, the University of Washington environmental research facility, and the board of industrial insurance appeals. The assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(2) The administrative assessment rate is determined annually for each fiscal year. Each self-insured employer uses one of three rates:

(a) The base administrative rate is based on the actual costs of the previous fiscal year and the anticipated costs of the upcoming fiscal year. This rate is used by any active self-insured employer certified after the fiscal year used for calculation.

(b) The adjusted administrative assessment rate includes the base rate with adjustments for over or under collections from prior periods. This rate is used by any active self-insured employer certified during or prior to the fiscal year used for calculation.

(c) Employers who have voluntarily surrendered their self-insurance certificate must pay the inactive rate until one year after all self-insurance liabilities and responsibilities are terminated. Usually, administrative assessment payments for inactive self-insurers can stop after reporting total claims costs of zero dollars for four consecutive quarters. Payments may again be due if any future costs are reported.

(3) The total administrative assessment due each quarter is calculated by multiplying the self-insurer's rate by their total claims costs during that quarter.

(4) The minimum quarterly administrative assessment for all self-insured employers is twenty-five dollars, unless the self-insurer is not required to make payment (see subsection (2)(c) of this section).

[Statutory Authority: RCW 51.14.077, 51.14.150, 51.14.160, 51.44.040, 51.44.070, and 51.44.150. WSR 09-13-018, § 296-15-223, filed 6/5/09, effective 7/6/09.]

WAC 296-15-225 Self-insurance second injury fund assessment. (1) The second injury fund assessment is based on anticipated second injury fund costs. The fund is used to relieve employers' costs related to pensions that result from the combined effects of the industri-

al injury and another prior injury, preferred worker claims, and job modifications. The second injury fund assessment is experience rated based on a self-insurer's actual usage of the second injury fund in the previous three fiscal years. See RCW 51.44.040 for more information about experience rating. The department may estimate claims cost data when actual data from an employer has yet to be provided.

The department determines a self-insurer's second injury fund assessment rate annually for each fiscal year. The assessment is paid by active and inactive self-insurers quarterly at the same time a self-insurer submits its quarterly report.

(2) Self-insurers' relief from and contributions to the second injury fund will be recorded in an account separate from the state fund account. The self-insurers' second injury fund must maintain a two hundred thousand dollar minimum balance.

(3) The department uses the following process to determine the second injury fund assessment.

Definitions:

"A" = Individual self-insurer's total second injury fund costs (usage) for the previous three fiscal years.

"B" = All self-insurer's total second injury costs (usage) for the previous three fiscal years.

"C" = Individual self-insurer's claim costs for the previous three fiscal years.

"D" = Total self-insured claim costs for the previous three fiscal years.

"E" = Individual self-insurer's experience factor.

"F" = Individual self-insurer's claim costs for the previous fiscal year.

"G" = Total self-insured claim costs for the previous fiscal year.

(a) The department calculates the **preliminary base rate** necessary to ensure collection of adequate funds. The preliminary base rate is the estimated usage of the second injury costs for the coming fiscal year divided by the total estimated claims costs. The preliminary base rate is assessed to self-insurers certified after the fiscal year used for calculation.

(b) The department calculates the **preliminary adjusted rate**, by adjusting the preliminary base rate for over or under collections from prior periods. This rate is assessed to any self-insurer certified during or prior to the fiscal year used for calculation, and to any self-insurer who has voluntarily surrendered its self-insurance certificate.

(c) The department determines an **experience factor** for each self-insurer.

(i) The department calculates the self-insurer's **second injury fund usage share** by dividing the self-insurer's total second injury fund costs (usage) for the previous three fiscal years by the total second injury fund costs (usage) for all self-insurers in the previous three fiscal years.

Second injury fund usage share = A/B

(ii) The department calculates the self-insurer's **claims cost usage share** by dividing a self-insurer's claim costs over the previous three fiscal years by the total claim costs for all self-insurers in the previous three fiscal years.

Claims cost usage share = C/D

(iii) The department calculates the self-insurer's **experience factor** by adding the second injury fund usage share to the claim cost usage share and dividing by 2, then dividing this total by the claims cost usage share.

Self-insurer's experience factor (E) = [((A/B) + (C/D))/2] / (C/D)

(d) The department calculates the **weighted average factor** to determine what adjustments to the preliminary base and adjusted rates may be necessary because of prior over or under collection for the fund. The weighted average factor is the sum for all self-insurer's of each self-insurer's **experience factor** multiplied by their self-insured claim cost for the previous fiscal year, divided by the total self-insured claim costs for the previous fiscal year.

Weighted average factor = [(E x F) sum all self-insurers] / G

(e) The department determines the **final base rate** and the **final adjusted rate** for the fiscal year by dividing the preliminary base rate and the preliminary adjusted rate ((a) and (b) of this subsection) by the weighted average factor.

(f) The department determines the second injury fund assessment rate for each self-insurer by multiplying the self-insurer's experience factor by either the final base rate or the final adjusted rate.

(g) The total assessment due each quarter is calculated by multiplying the self-insurer's second injury fund assessment rate by the self-insurer's total claims costs during that quarter.

[Statutory Authority: RCW 51.44.040. WSR 10-20-132, § 296-15-225, filed 10/5/10, effective 11/5/10. Statutory Authority: RCW 51.14.077, 51.14.150, 51.14.160, 51.44.040, 51.44.070, and 51.44.150. WSR 09-13-018, § 296-15-225, filed 6/5/09, effective 7/6/09.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 296-15-227 Self-insurance insolvency trust fund assessment. (1) The insolvency trust fund assessment is paid by all insolvency trust members to cover claim payments made by the department on behalf of insolvent self-insurers. The assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(a) Self-insured school districts, cities, and counties are exempt from and are not covered by this insolvency trust. These self-insurers are not liable for the insolvency trust fund assessment.

(b) Any interest earned on insolvency trust fund assessments paid by self-insurers will be added to the balance of the insolvency trust fund.

(c) Failure to pay an insolvency trust fund assessment is grounds for withdrawal of self-insurance certification.

(2) The insolvency trust fund assessment rate is determined annually for each fiscal year.

(3) Insolvency trust members who voluntarily surrender their self-insurance certification must continue to pay this assessment for three years after the date of surrender.

(4) The total insolvency trust fund assessment due each quarter is calculated by multiplying the insolvency trust fund assessment rate

by an insolvency trust member's total claims costs during that quarter.

[Statutory Authority: RCW 51.14.077, 51.14.150, 51.14.160, 51.44.040, 51.44.070, and 51.44.150. WSR 09-13-018, § 296-15-227, filed 6/5/09, effective 7/6/09.]

WAC 296-15-229 Self-insurance supplemental pension fund (SPF) and asbestosis fund assessments. (1) The SPF relieves employers from cost-of-living increases on benefits paid to workers. The SPF assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(a) The SPF rate is determined annually for each calendar year.

(b) The total SPF assessment due each quarter is calculated by multiplying the SPF assessment rate by a self-insurer's worker hours during that quarter.

(c) One-half of the SPF assessment may be withheld from employee wages or salaries.

(d) Self-insurers may request reimbursement from the SPF quarterly, as authorized under Title 51 RCW, or they may deduct eligible SPF reimbursement amounts directly from their quarterly SPF assessment. If requesting reimbursement from the SPF quarterly, the self-insurer must use a form substantially similar to L&I form F207-011-000 or, if there is Social Security offset, L&I form F207-011-222.

(2) The asbestosis fund provides benefits to workers who have been diagnosed with an industrially related asbestosis condition during the often lengthy process of determining the liable employer. The asbestosis fund assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(a) The asbestosis fund assessment rate is determined annually for each calendar year.

(b) The total asbestosis fund assessment due each quarter is calculated by multiplying the asbestosis fund assessment rate by a self-insurer's worker hours during that quarter.

(c) One-half of the asbestosis fund assessment may be withheld from employee wages or salaries.

[Statutory Authority: RCW 51.14.077, 51.14.150, 51.14.160, 51.44.040, 51.44.070, and 51.44.150. WSR 09-13-018, § 296-15-229, filed 6/5/09, effective 7/6/09.]

WAC 296-15-231 Self-insurance electronic data reporting system (SIEDRS). (1) **What is SIEDRS?** SIEDRS is a computer system that collects claim data electronically from self-insurers. Effective July 1, 2008, all self-insurers must send timely and accurate claim data to SIEDRS in the required format.

(2) **How often must a self-insurer report claim data to SIEDRS?** All claims opened during a calendar month, as well as any updates made during that month to claims opened after the self-insurer's enrollment date (postenrollment claims), must be reported to SIEDRS by the tenth calendar day of the following month. Data can be submitted more often, but not more than once per day.

Newly certified self-insurers must begin submitting data by the tenth calendar day of the month following their date of certification.

For example, if an employer is certified to self-insure effective January 1st, data must be submitted to SIEDRS by February 10th.

(3) **What is the required format?** Data submitted to SIEDRS must comply with all requirements outlined in the SIEDRS Enrollment Package (Publication F207-194-000).

(4) **When must a self-insurer correct errors?** Error corrections must be submitted to SIEDRS within ten calendar days of notification of the error. Notification occurs on the date SIEDRS provides the error report to the self-insurer.

(5) **What happens if a self-insurer doesn't comply with SIEDRS requirements?**

(a) The department may assess penalties for failure to comply with SIEDRS requirements. The department will consider penalties when a self-insurer:

(i) Refuses or fails to send data files to SIEDRS.

(ii) Repeatedly reports late.

(iii) Repeatedly fails to correct errors on time.

(iv) Demonstrates repeated and uncorrected inaccuracies in reporting format.

(b) Repeated failure to comply with SIEDRS requirements may result in increased sanctions, up to and including withdrawal of self-insurance certification.

(6) **How will penalties be assessed?**

(a) Penalties are assessed for any occurrences within a twelve-month period, and need not be consecutive. An occurrence is defined as a failure to comply with any part of this section, and is attributed to an individual file regardless of the number of claims it contains. For example, a failure to submit a data file (of any size) for one particular month results in one occurrence.

(b) Penalties are cumulative. For example, failure to send data files for twelve occurrences results in twelve penalties with a cumulative total of seventy-one thousand dollars.

(c) The department has the discretion to consider withdrawal of certification at any time, based on the self-insurer's compliance record.

(d) Penalty table:

Occurrence	Failure to Send Data Files	Late Reporting	Failure to Correct Errors on Time	Uncorrected Reporting Format Inaccuracies
1st	$500	$250	$250	$500
2nd	$500	$250	$250	$500
3rd	$1,000	$500	$500	$1,000
4th	$2,000	$1,000	$1,000	$2,000
5th	$4,000	$1,500	$1,500	$4,000
6th	$6,000	$2,000	$2,000	$6,000
7th	$7,000	$3,000	$3,000	$7,000
8th	$8,000	$4,000	$4,000	$8,000
9th	$9,000	$5,000	$5,000	$9,000
10th	$10,000	$6,500	$6,500	$10,000
11th	$11,000	$8,000	$8,000	$11,000
12th	$12,000	$10,000	$10,000	$12,000

(i) 1st and 2nd occurrences may be waived at the department's discretion for good cause.

(ii) For any waived occurrence, a notification is sent to the employer indicating noncompliance subject to penalty on repeat violation.

(iii) Any occurrence waived counts against the employer's overall SIEDRS compliance record.

(iv) If the department waives two occurrences then the 3rd occurrence results in a penalty equal in amount to the 3rd occurrence.

[Statutory Authority: RCW 51.14.110. WSR 09-01-177, § 296-15-231, filed 12/23/08, effective 1/23/09.]

WAC 296-15-232 Self-insurance medical bill electronic data interchange. (1) Self-insurers are required to report medical bills incurred from their workers' compensation claims according to department guidelines.

(a) All bills associated with qualifying claims must be reported, and the department will establish a minimum threshold percentage for reporting of bill to claims to monitor compliance.

(b) Qualifying claims include claims for which:

(i) The date of injury (DOI) was on or after January 1, 2020.

(ii) The claim was initiated during a time that the employer was self-insured, and the liability for that claim remains with the employer.

(2) Self-insurers must submit complete and accurate reports based on standards set forth by the International Association of Industrial Accident Boards and Commissions (IAIABC).

(a) The department will systematically monitor report data for quality and timeliness, and establish objective performance standards based on the overall reporting of data.

(b) The department will establish a maximum threshold percentage for errors or untimely submittals.

(c) The department will provide notification to submitters if performance measures are below the standard set by the department.

(d) Submitters will have thirty days from the date of notification to make corrections to errors and resubmit, or request an extension in writing to the department.

(e) The department will review errors that remain uncorrected after thirty days. Uncorrected errors may result in training, audit, rule violation penalties, and/or a corrective action process.

(3) New self-insurers may apply for an exemption to reporting medical bills with their application for certification as a self-insured employer.

(a) To qualify for the exemption, the employer must have had one or fewer claims filed in the state of Washington in the last three years, and the employer must have fewer than five employees in the state.

(b) The department may deny any request for exemption.

(c) Authority to grant or deny exemptions belongs to the supervisor of industrial insurance, or designee.

(d) If granted, the exemption expires after three years. The employer may apply for another exemption at that time.

[Statutory Authority: RCW 51.04.020 and 51.14.110(3). WSR 19-17-067, § 296-15-232, filed 8/20/19, effective 1/1/20.]

WAC 296-15-255 Hearings for corrective action or withdrawal of certification. (1) This section applies only to proceedings to withdraw certification or for corrective action instituted by the director in response to a petition filed with the department pursuant to RCW 51.14.090. This section shall not apply to actions instituted by the director to withdraw certification pursuant to RCW 51.14.080 nor to corrective action instituted by the director pursuant to RCW 51.14.095.

(2) When there is a petition for such action by any employee or union or association having a substantial number of employees in the employ of the self-insured, the director or the director's designee may, in the director's or designee's sole discretion, hold a hearing to determine whether or not there are grounds for action. In reviewing such a petition, the director or the designee may require additional information from a petitioner before deciding whether to hold a hearing under this section.

(3) Any such hearing shall be conducted in accordance with the department's rules governing administrative hearings. The director will notify all parties at least twenty days prior to the date of the hearing. The notice shall include the following:

(a) Nature of proceedings;

(b) Legal authority for holding the hearing;

(c) Reference to the section of statutes and rules involved;

(d) A description of matters asserted;

(e) The date, time, and place of the hearing.

All parties will be allowed to respond and present evidence and arguments on the issues involved.

Within thirty days of the hearing date, the department will provide written notification of the proceedings, findings, and conclusions to all hearing participants.

(4) If, following the hearing, the decision is to withdraw certification or take corrective action, such action shall comply with the provisions of RCW 51.14.090 and/or 51.14.095.

[Statutory Authority: RCW 51.32.190 and 51.14.090. WSR 96-21-145, § 296-15-255, filed 10/23/96, effective 11/25/96. Statutory Authority: RCW 51.04.020. WSR 86-18-037 (Order 86-35), § 296-15-255, filed 8/28/86.]

(Effective July 1, 2024)

WAC 296-15-257 When a self-insured employer is subject to corrective action or withdrawal of certification as instituted by the director. (1) This section applies to withdrawal of certification or corrective action instituted by the director pursuant to RCW 51.14.080 and/or 51.14.095.

(2) The director or the director's designee shall take corrective action against a self-insured employer if the director determines that:

(a) The self-insured employer is not following proper industrial insurance claims procedures;

(b) The self-insured employer's accident prevention program is inadequate;

(c) The employer no longer meets the requirements of a self-insurer;

(d) The self-insurer's deposit is insufficient;

(e) The self-insurer intentionally or repeatedly induces employees to fail to report injuries, induces workers to treat injuries in the course of employment as off-the-job injuries, persuades workers to accept less than the compensation due, or unreasonably makes it necessary for workers to resort to proceedings against the employer to obtain compensation;

(f) The self-insurer habitually fails to comply with rules and regulations of the director regarding reports or other requirements necessary to carry out the purposes of this title;

(g) The self-insurer habitually engages in a practice of arbitrarily or unreasonably refusing employment to applicants for employment or discharging employees because of nondisabling bodily conditions;

(h) The self-insurer fails to pay an insolvency assessment under the procedures established pursuant to RCW 51.14.077; or

(i) A self-insured employer violated the duty of good faith and fair dealing two times within a three-year period.

(3) Corrective action taken shall follow WAC 296-15-260.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-257, filed 5/21/24, effective 7/1/24.]

(Effective until July 1, 2024)

WAC 296-15-260 Corrective action or withdrawal of certification. (1) Corrective action against a self-insured employer shall be by order and notice. A notice of corrective action shall include the nature and specifics of the findings and may include the following:

(a) Probationary certification status for the self-insured employer for a period not to exceed one year;

(b) Mandatory training to correct areas of program deficiency to be approved by the department.

The subject matter to be covered shall be specified in the notice of corrective action. Personnel required to attend and the time period within which the training is to be conducted will also be identified.

(c) Monitoring activities of the self-insured employer for a specified period of time to determine progress regarding correction of program deficiencies may be required. The department may require submission of complete and accurate records and/or conduct an audit to verify program compliance.

(d) If there is a contract between the self-insured employer and a service organization which has been filed with the department (WAC 296-15-110), the corrective action order may specify and require that the service organization be subject to mandatory training and monitoring of activity provisions of the order.

(e) The corrective action order shall specify a time frame for submission of progress reports to the department's self-insurance section.

(f) During the first thirty days following the corrective action order, the self-insured employer shall submit a plan for the implementation of corrective action which shall include specific completion dates. If the plan is determined to be incomplete or inadequate, the department's self-insurance administrator shall notify the self-insurer of the necessary requirements or changes needed, and shall specify the date by which an amended plan shall be submitted.

(2) If sufficient grounds for decertification exist, an order and notice will be issued. The order and notice will include the following:

(a) The grounds upon which the determination is based.

(b) The period of time within which the grounds existed or arose.

(c) The date, not less than ninety days after the self-insured employer's receipt of the order and notice, when certification will be withdrawn.

(d) Provisions as stipulated by RCW 51.14.090.

(3) Upon conclusion of the probationary certification period in the case of corrective action, the program deficiencies requiring corrective action by the self-insured employer shall be evaluated by the department and a written report sent to affected parties. Program activities may be reaudited beyond the stated time period in order to assess continuing compliance with the objectives of the corrective action directives.

(4) If, at the conclusion of the probationary period, program deficiencies continue to exist, the department shall decide whether to extend the period of probation, require additional corrective action or proceed with decertification of the self-insured employer. An order and notice stating the decision shall be issued.

[Statutory Authority: RCW 51.32.190 and 51.14.090. WSR 96-21-145, § 296-15-260, filed 10/23/96, effective 11/25/96. Statutory Authority: RCW 51.04.020. WSR 86-18-037 (Order 86-35), § 296-15-260, filed 8/28/86. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-260, filed 12/1/83, effective 1/1/84.]

(Effective July 1, 2024)

WAC 296-15-260 Corrective action or withdrawal of certification. (1) Corrective action against a self-insured employer shall be by order and notice. A notice of corrective action shall include the nature and specifics of the findings and may include the following:

(a) Probationary certification status for the self-insured employer for a period not to exceed one year;

(b) Mandatory training to correct areas of program deficiency to be approved by the department.

The subject matter to be covered shall be specified in the notice of corrective action. Personnel required to attend and the time period within which the training is to be conducted will also be identified.

(c) Monitoring activities of the self-insured employer for a specified period of time to determine progress regarding correction of program deficiencies may be required. The department may require submission of complete and accurate records and/or conduct an audit to verify program compliance.

(d) If there is a contract between the self-insured employer and a service organization which has been filed with the department (WAC 296-15-110), the corrective action order may specify and require that the service organization be subject to mandatory training and monitoring of activity provisions of the order.

(e) The corrective action order shall specify a time frame for submission of progress reports to the department's self-insurance section.

(f) During the first 30 days following the corrective action order, the self-insured employer shall submit a plan for the implementa-

tion of corrective action which shall include specific completion dates. If the plan is determined to be incomplete or inadequate, the department's self-insurance administrator shall notify the self-insurer of the necessary requirements or changes needed, and shall specify the date by which an amended plan shall be submitted.

(2) Upon conclusion of the probationary certification period in the case of corrective action, the program deficiencies requiring corrective action by the self-insured employer shall be evaluated by the department and a written report sent to affected parties. Program activities may be reaudited beyond the stated time period in order to assess continuing compliance with the objectives of the corrective action directives.

(3) If, at the conclusion of the probationary period, program deficiencies continue to exist, the department shall decide whether to extend the period of probation, require additional corrective action or proceed with decertification of the self-insured employer. An order and notice stating the decision shall be issued.

(4) If sufficient grounds for decertification exist, an order and notice will be issued. The order and notice will include the following:

(a) The grounds upon which the determination is based.

(b) The period of time within which the grounds existed or arose.

(c) The date, not less than 30 days after the self-insured employer's receipt of the order and notice, when certification will be withdrawn.

(d) Provisions as stipulated by RCW 51.14.090.

(5) The director may delay withdrawing the certification of the self-insured employer while the employer has an enforceable contract with a licensed third-party administrator that may not be legally terminated. However, the self-insured employer may not renew or extend the contract.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-260, filed 5/21/24, effective 7/1/24. Statutory Authority: RCW 51.32.190 and 51.14.090. WSR 96-21-145, § 296-15-260, filed 10/23/96, effective 11/25/96. Statutory Authority: RCW 51.04.020. WSR 86-18-037 (Order 86-35), § 296-15-260, filed 8/28/86. Statutory Authority: RCW 51.04.020(1). WSR 83-24-027 (Order 83-22), § 296-15-260, filed 12/1/83, effective 1/1/84.]

(Effective until July 1, 2024)

WAC 296-15-266 Penalties. (1) **Under what circumstances will the department consider assessing a penalty for an unreasonable delay of benefits, when requested by a worker?** Upon a worker's request, the department will consider assessment of an unreasonable delay of benefits penalty for:

(a) Time-loss compensation benefits: The department will issue an unreasonable delay order, and assess associated penalties based on the unreasonably delayed time-loss as determined by the department, if a self-insurer:

(i) Has written medical certification based on objective findings from the attending medical provider authorized to treat that the claimant is unable to work because of conditions proximately caused by the industrial injury or occupational disease, or the claimant is participating in a department-approved vocational plan; and

(ii) Fails to make the first time-loss payment to the claimant within fourteen calendar days of notice that there is a claim*, or fails to continue time-loss payments on regular intervals as required by RCW 51.32.190(3); and

(iii) Fails to take action per WAC 296-15-425.

* Notice of claim is provided to the self-insured employer when all the elements of a claim are met. The elements of a claim are:
- Description of incident. Examples: Self-Insurance Form 2 (SIF-2), physician's initial report (PIR), employer incident report.
- Diagnosis of the medical condition. Examples: PIR, on-site medical facility records if supervised by provider qualified to diagnose.
- Treatment provided or treatment recommendations. Examples: PIR, on-site medical facility records if supervised by provider qualified to treat.
- Application for benefits. Examples: SIF-2, PIR, or other signed written communication that evinces intent to apply.

(b) Unreasonable delays of loss of earning power compensation payments or permanent partial disability award payments will also be subject to penalty.

(c) Unreasonable delays of payment of medical treatment benefits will also be subject to penalty.

(d) Unreasonable delays of authorization of medical treatment benefits will also be subject to penalty.

(e) Failure to pay benefits without cause: The department will issue an order determining an unreasonable refusal to pay benefits, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer fails to pay a benefit such as time-loss compensation, loss of earning power compensation, permanent partial disability award payments, or medical treatment when there is no medical, vocational, or legal doubt about whether the self-insurer should pay the benefit. Accrued principal and interest will apply to nonpayment of medical benefits.

(f) Paying benefits during an appeal to the board of industrial insurance appeals: The department will issue an unreasonable delay order, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer appeals a department order to the board of industrial insurance appeals, and fails to provide the benefits required by the order on appeal within fourteen calendar days of the date of the order, and thereafter at regular fourteen day or semi-monthly intervals, as applicable, until or unless the board of industrial insurance appeals grants a stay of the department order, or until and unless the department reassumes jurisdiction and places the order on appeal in abeyance, or until the claimant returns to work, or the department issues a subsequent order terminating the benefits under appeal.

(g) Benefits will not be considered unreasonably delayed if paid within three calendar days of the statutory due date. In addition, if benefits are delayed due to an underpayment from the monthly wage calculation for time-loss compensation under RCW 51.08.178, then the department shall presume the benefits are not unreasonably delayed if:

(i) The self-insurer sent a written copy of the wage calculation to the injured worker on a department-developed template; and

(ii) The self-insurer informed the worker, in writing, on a department-developed template that the worker should contact the self-insurer with any questions; and

(iii) The self-insurer notified the worker, in writing, on a department-developed template to write to the department within sixty days if the worker disputed the calculation.

This presumption may be rebutted by a showing of action without foundation or unsupported by evidence demonstrating an unreasonable delay of benefits despite the notification to the worker and the worker's failure to dispute.

Provided, (g)(i) through (iii) of this subsection will not apply to payments for statutory cost-of-living adjustments, payments that do

not use the amount stated in the department-developed template, or a refusal to make payments ordered by the department.

(2) **How is a penalty request created and processed?**

(a) An injured worker may request a penalty against his or her self-insured employer by:

(i) Completing the appropriate self-insurance form or sending a written request providing the reasons for requesting the penalty;

(ii) Attaching supporting documents (optional).

(b) Within ten working days of receipt of a certified request, the self-insured employer must send its claim file to the department. Failure to timely respond may subject the self-insured employer to a rule violation penalty under RCW 51.48.080. The employer may attach supporting documents, or indicate, in writing, if the employer will be providing further supporting documents, which must be received by the department within five additional working days. If the employer fails to timely respond to the penalty request, the department will issue an order in response to the injured worker's request based on the available information.

(c) The department will issue an order within thirty days after receiving a complete written request for penalty per (a) of this subsection. The department's review during the thirty-day period for responding to the injured worker's request will include only the claim file records and supporting documents provided by the worker and the employer per (a) and (b) of this subsection.

(d) In deciding whether to assess a penalty, the department will consider only the underlying record and supporting documents at the time of the request which will include documents listed in (a) and (b) of this subsection, if timely available, to determine if the alleged untimely benefit was appropriately requested and if the employer timely responded.

(e) The department order issued under (c) of this subsection is subject to request for reconsideration or appeal under the provisions of RCW 51.52.050 and 51.52.060.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-266, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.04.020 and 51.48.017. WSR 15-01-162, § 296-15-266, filed 12/23/14, effective 1/23/15. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-266, filed 2/28/06, effective 4/1/06.]

(Effective July 1, 2024)

WAC 296-15-266 Penalties. (1) **Under what circumstances will the department consider assessing a penalty for an unreasonable delay of benefits?** Upon a worker's or beneficiary's request or based upon its own motion, the department will consider assessment of an unreasonable delay of benefits penalty for:

(a) Time-loss compensation benefits if:

(i) The self-insurer has written medical certification based on objective findings from the attending provider authorized to treat that the worker is unable to work because of conditions proximately caused by the industrial injury or occupational disease;

(ii) The worker is participating in a department-approved vocational plan;

(iii) The self-insurer fails to make the first time-loss payment to the worker within 14 calendar days of notice that there is a claim;

(iv) The self-insurer fails to continue time-loss payments on regular intervals as required by RCW 51.32.190(3); or

(v) The self-insurer fails to take action per WAC 296-15-425.

(b) Unreasonable delays of loss of earning power compensation payments or permanent partial disability award payments will also be subject to penalty.

(c) Unreasonable delays of payment of medical treatment benefits will also be subject to penalty.

(d) Unreasonable delays of authorization of medical treatment benefits will also be subject to penalty.

(e) Failure to pay benefits without cause: The department will issue an order determining an unreasonable refusal to pay benefits, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer fails to pay a benefit such as time-loss compensation, loss of earning power compensation, permanent partial disability award payments, or medical treatment when there is no medical, vocational, or legal doubt about whether the self-insurer should pay the benefit. Accrued principal and interest will apply to nonpayment of medical benefits.

(f) Paying benefits during an appeal to the board of industrial insurance appeals: The department will issue an unreasonable delay order, and assess associated penalties, based on the department's calculation of benefits or fee schedule, if a self-insurer appeals a department order to the board of industrial insurance appeals, and fails to provide the benefits required by the order on appeal within 14 calendar days of the date of the order, and thereafter at regular 14-day or semi-monthly intervals, as applicable, until or unless the board of industrial insurance appeals grants a stay of the department order, or until and unless the department reassumes jurisdiction and places the order on appeal in abeyance, or until the worker returns to work, or the department issues a subsequent order terminating the benefits under appeal.

(g) Benefits will not be considered unreasonably delayed if paid within three calendar days of the statutory due date. In addition, if benefits are delayed due to an underpayment from the monthly wage calculation for time-loss compensation under RCW 51.08.178, then the department shall presume the benefits are not unreasonably delayed if:

(i) The self-insurer sent a written copy of the wage calculation to the injured worker on a department-developed template; and

(ii) The self-insurer informed the worker, in writing, on a department-developed template that the worker should contact the self-insurer with any questions; and

(iii) The self-insurer notified the worker, in writing, on a department-developed template to write to the department within 60 days if the worker disputed the calculation.

This presumption may be rebutted by a showing of action without foundation or unsupported by evidence demonstrating an unreasonable delay of benefits despite the notification to the worker and the worker's failure to dispute.

Provided, (g)(i) through (iii) of this subsection will not apply to payments for statutory cost-of-living adjustments, payments that do not use the amount stated in the department-developed template, or a refusal to make payments ordered by the department.

(2) **Under what circumstances will the department consider assessing a penalty for violation of rules?** Upon a worker's or beneficiary's

request, or based upon its own motion, the department will consider assessment of a rule violation penalty if the self-insurer or third-party administrator fails to meet the requirements of Titles 51 RCW and 296 WAC.

(3) **How is a penalty request created and processed?**

(a) An injured worker may request a penalty against their self-insured employer by completing the appropriate self-insurance form or sending a written request providing the reasons for requesting the penalty. The request may include supporting documents.

(b) Within 10 working days of notification of the penalty request from a worker or department review, the self-insurer or third-party administrator may file a response. The response may include supporting documents.

(c) The department will issue an order in accordance with RCW 51.52.050 and 51.52.060 within 30 days after receiving a complete written request for penalty per (a) of this subsection. The department's review during the 30-day period for responding to the injured worker's request will include only the records in the department claim file at the time of the request and supporting documents provided by the worker and the employer per (a) and (b) of this subsection.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-266, filed 5/21/24, effective 7/1/24. Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-266, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.04.020 and 51.48.017. WSR 15-01-162, § 296-15-266, filed 12/23/14, effective 1/23/15. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-266, filed 2/28/06, effective 4/1/06.]

(Effective July 1, 2024)

WAC 296-15-268 Self-insurance penalty calculations. (1) For all penalties assessed per WAC 296-15-266, RCW 51.48.017, 51.48.080, or 51.14.180, the penalty amount shall be determined by weighing the following factors:

(a) Amount of delayed payment.

(b) Length of time of the delay.

(c) History or past practice.

(d) Whether the department has issued an order directing the payment.

(e) Required adjustments to the amount of the payment.

(f) Number of unaddressed requests for action to be taken by the employer or third-party administrator made by the department, worker/beneficiary, or provider.

(g) Efforts by the employer or third-party administrator to communicate with the worker, including communication of the basis for or calculation of a payment.

(2) For all penalties assessed subject to a multiplier of up to three times the amount of the penalty, the amount of the multiplier will be determined by weighing the following factors:

(a) Number of prior violations in the past year of the same nature.

(b) Harm or financial impact done due to the denial or delay of benefits.

(c) Whether the employer or third-party administrator paid the undisputed amount of benefits.
(d) The employer's or third-party administrator's timeliness or delay in responses to request from the department, worker/beneficiary, or provider.
(3) For all penalties assessed based on a violation of good faith and fair dealing, subject to a penalty of up to 52 times the average weekly wage, the amount of the multiplier will be determined by weighing the following factors:
(a) Prior violations of good faith and fair dealing.
(b) Harm or financial impact done due to the denial or delay of benefits.
(c) Amount or number of other penalties assessed simultaneously.
(d) Employer's or third-party administrator's participation in the investigation.
(e) Whether the violation was based on WAC 296-15-270 or 296-15-272.
(4) The following mitigating factors may be a basis for reduction of the penalty calculation in subsections (1), (2), and (3) of this section, including a multiplier:
(a) Efforts by the employer or third-party administrator to correct the actions.
(b) Efforts by the employer or third-party administrator to communicate and educate employees and adjudicators of relevant policies and procedures.
(c) Worker's failure to provide the employer or third-party administrator necessary documentation to complete a review or investigation.
(d) Investigation attempts made by the employer or third-party administrator before it denied benefits.
(e) Employer's or third-party administrator's participation in the department's investigation and timeliness of responses.
(f) Any other factors deemed appropriate by the department.
(5) Penalties assessed based on a violation of the duty of good faith and fair dealing, within a five-year period, will be calculated as follows:
(a) First time results in a minimum penalty of one times the average weekly wage.
(b) Second time results in a minimum penalty of 15 times the average weekly wage.
(c) Third time results in a minimum penalty of 25 times the average weekly wage.
(d) Four or more times results in a minimum penalty of 40 times the average weekly wage.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-268, filed 5/21/24, effective 7/1/24.]

(Effective July 1, 2024)

WAC 296-15-270 Violation of the duty of good faith and fair dealing. (1) If a self-insured employer (SIE) or third-party administrator (TPA) subject to the good faith and fair dealing duty manages the workers' compensation claim in a manner which demonstrates a greater concern for the self-insured employer's interest than the worker's interest, the SIE/TPA will be in violation of its duty to en-

gage in good faith and fair dealing. Additionally, violation of the SIE/TPA duty to engage in good faith and fair dealing includes repeatedly engaging in any of the following actions with such frequency as to indicate a general business practice:

(a) When requesting an interlocutory order pursuant to WAC 296-15-420(2): Fails to provide a reasonable explanation for an interlocutory order, fails to exercise due diligence while investigating claim determination, and/or fails to provide provisional benefits as entitled during the interlocutory period.

(b) Unreasonably delays or refuses to pay wage replacement benefits without a factual, legal, vocational, or medical basis.

(c) Fails to ensure appropriate handling of claims pursuant to WAC 296-15-350.

(d) Fails to request claim denial or interlocutory order pursuant to WAC 296-15-420 within 60 days.

(e) Fails to authorize medical care pursuant to WAC 296-15-330 or without factual, legal, or medical basis.

(f) Fails to pay compensation pursuant to WAC 296-15-340.

(g) Fails to adhere to duties and performance requirements pursuant to WAC 296-15-550.

(h) Fails to provide a copy of the claim file in a timely manner pursuant to RCW 51.14.120.

(i) Fails to communicate with injured workers using department-developed templates pursuant to WAC 296-15-425, including use of the templates in the workers preferred language.

(j) Fails to notify the worker or beneficiary of their rights and obligations pursuant to WAC 296-15-400, RCW 51.28.010 or 51.28.030.

(k) Requests the department issue an order denying the claim without a factual, legal, or medical basis.

(l) Fails to provide a worker or beneficiary a SIF-2 or ability to file a claim pursuant to WAC 296-15-320 and 296-15-405.

(m) Fails to have claims managed by a certified claims administrator or trainee in accordance with WAC 296-15-350(2).

(n) Fails to forward an application to reopen a claim within five working days of receipt pursuant to WAC 296-15-470.

(o) Fails to forward a protest or appeal to the department within five working days of receipt pursuant to RCW 51.14.120(2) and WAC 296-15-480.

(2) Errors or delays that are inadvertent or minor are not a violation of the duty of good faith and fair dealing.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-270, filed 5/21/24, effective 7/1/24.]

(Effective July 1, 2024)

WAC 296-15-272 When intentional behavior is deemed a violation of the duty of good faith and fair dealing. (1) If a self-insured employer (SIE) or third-party administrator (TPA) subject to the duty of good faith and fair dealing intentionally engages in any of the following actions, the SIE/TPA is in violation of its duty to engage in good faith and fair dealing if it fails to:

(a) Provide a worker or beneficiary a SIF-2 or ability to file a claim pursuant to WAC 296-15-320 and 296-15-405, with the intent to interfere with the worker's ability to pursue benefits under Title 51 RCW.

(b) Forward an application to reopen a claim within five working days of receipt pursuant to WAC 296-15-470, with the intent to interfere with the worker's ability to reopen a claim or pursuing further benefits.

(c) Forward a protest or appeal to the department within five working days of receipt pursuant to RCW 51.14.120(2) and WAC 296-15-480, with the intent to interfere with the worker's ability to pursue a request for reconsideration, appeal, or further benefits.

(2) It is a violation of the duty to engage in good faith and fair dealing to coerce a worker to accept less than the compensation due under Title 51 RCW.

(3) Errors or delays that are inadvertent or minor are not a violation of the duty of good faith and fair dealing.

[Statutory Authority: RCW 51.14.090, 51.14.095, and 51.14.180. WSR 24-11-121, § 296-15-272, filed 5/21/24, effective 7/1/24.]

WAC 296-15-310 Administrative organization to manage a self-insurance program. Every employer certified to self-insure is obligated to comply with the provisions of Title 51 RCW and the rules and regulations of the department, and to have the necessary administrative processes in place to manage its self-insurance program. Each self-insurer is ultimately responsible for the sure and certain delivery of Title 51 RCW benefits to its injured workers and is accountable for all aspects of its workers' compensation program.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-310, filed 2/28/06, effective 4/1/06.]

WAC 296-15-320 Reporting of injuries. What elements must a self-insurer have in place to ensure the reporting of injuries? Every self-insurer must:

(1) Establish procedures to assist injured workers in reporting and filing claims.

(a) Immediately provide a Self-Insurer Accident Report (SIF-2) form F207-002-000 to every worker who makes a request, or upon the self-insurer's first knowledge of the existence of an industrial injury or occupational disease, whichever occurs first.

(b) Establish procedures for ensuring the timely delivery of completed SIF-2s to the claims management entity.

(2) Designate individuals as resources to address employee questions. These resources must:

(a) Have sufficient knowledge to answer routine questions; and

(b) Have responsibility for seeking answers to more complex problems; and

(c) Have detailed knowledge of the self-insurer's claim filing process; and

(d) Be reasonably accessible to employees.

(3) Upon request, produce a report of all workers' compensation claims filed in a format required by the department.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-320, 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, § 296-15-320, filed 2/28/06, effective 4/1/06.]

WAC 296-15-330 Authorization of medical care. What are the requirements for authorization of medical care? Every self-insurer must:

(1) Authorize treatment and pay bills in accordance with Title 51 RCW and the medical aid rules and fee schedules of the state of Washington.

(2) Provide a written explanation of benefits (EOB) to the provider, with a copy to the worker if requested, for each bill adjustment. A written explanation is not required if the adjustment was made solely to conform to the maximum allowable fees as set by the department.

(3) Provide a written explanation to the worker and provider(s) regarding any denied bill. Bills returned to the provider because a proper bill was not submitted under WAC 296-20-125 do not require a written explanation.

(4) Establish procedures to ensure prompt responses to inquiries regarding authorization decisions and bill adjustments.

(5) Comply with the requirements of the health care provider network. This includes:

(a) Utilizing only those providers approved for the provider network, except when the provider specialty or geographic location is not yet covered by the network;

(b) Providing information to workers about the requirement for providers to be enrolled in the network in order to treat injured workers and information on how a worker can find network providers. This information must be included in publications used by self-insurers to comply with WAC 296-15-400 (2)(a);

(c) Ensuring, when applicable, that only network providers are paid for care after the initial office or emergency room visit; and

(d) Promptly assisting workers who are being treated by a nonnetwork provider to transfer their care to a network provider of their choice; including, at a minimum, notification to the worker within forty-five days of receipt of the first bill from a nonnetwork provider that the provider will not be paid for treatment beyond the initial visit on the claim and information about how to find network providers.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-330, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.36.010, 51.04.020 and 51.04.030. WSR 13-09-023, § 296-15-330, filed 4/9/13, effective 5/10/13. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-330, filed 2/28/06, effective 4/1/06.]

WAC 296-15-340 Payment of compensation. What are the requirements for payment of compensation? Every self-insurer must:

(1) Pay time-loss compensation in accordance with Title 51 RCW and the rules and regulations of the department.

(2) Provide to workers a statement of benefits with each time-loss payment, to include the type of benefit paid and the period paid with from and to dates. If authorized by the worker, an electronic statement may be provided. In addition, provide to workers a statement of benefits with payments for reimbursements to workers.

(3) When payable, time-loss must continue at regular semi-monthly or bi-weekly intervals. When making an initial payment, an employer may adjust the date for payment of time-loss to align with a worker's normal date for payment of wages; however, the payment must be made within ten days of the entitlement period.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-340, 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, § 296-15-340, filed 2/28/06, effective 4/1/06.]

WAC 296-15-350 Handling of claims. What elements must a self-insurer or third-party administrator (TPA) have in place to ensure appropriate handling of claims? Every self-insurer or TPA must:

(1) Establish procedures for securing the confidentiality of claim information.

(2) Have sufficient numbers of certified claims administrators to ensure uninterrupted administration of claims. In this regard:

(a) Effective July 1, 2021, every person making claim decisions must be a certified claims administrator or in the process of getting their certification. For the purposes of this section, every person making claim decisions includes:

(i) Those persons who manage claims directly; and

(ii) Who request to allow or deny claims under WAC 296-15-420;

(iii) Take action on claims under WAC 296-15-425; or

(iv) Close claims under WAC 296-15-450.

(b) Excluded from the requirement of (a) of this subsection are those persons who manage operations indirectly in support of claims administrators, such as, human resources, accounting, or executive management.

(c) When a new person is hired by the employer or TPA to make claims decisions, if the new person is not already a certified claims administrator, then the new person, within six months of hire, must begin working toward achievement of certification through a comprehensive goal-oriented curriculum approved by the department to achieve certification within two years. While in process of meeting educational needs, the employer must ensure mentoring is provided by a Washington certified claims administrator. Providers of the comprehensive goal-oriented curriculum will conduct regular training courses to allow for a new person in the process of completing the training to successfully manage Washington claims and achieve Washington certification within two years. This will include considering online alternatives, when feasible.

(d) When a certified claims administrator leaves the hire of an employer or TPA, and this results in an employer or TPA temporarily not meeting the qualifications for a certified claims administrator, the employer may apply for a temporary waiver for up to six months pending hiring of a replacement.

(3) Designate one certified claims administrator as the department's primary contact person for claim issues.

(4) Designate one address for the mailing of all claims-related correspondence. The self-insurer is responsible for forwarding documents to the appropriate location if an employer's claims are managed by more than one organization.

(5) Establish procedures to answer questions and address concerns raised by workers, providers, or the department.

(6) Ensure claims management personnel are informed of new developments in workers' compensation due to changes in statute, case law, rule, or department policy.

(7) Include the department's claim number in all claim-related communications with workers, providers, and the department.

(8) Legibly date stamp or produce an imprint on incoming correspondence, identifying both the date received and the location or entity that received it.

(9) Ensure a means of communicating with all injured workers.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-350, filed 5/18/21, effective 7/1/21. Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-350, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.04.020, 51.14.030. WSR 14-02-121, § 296-15-350, filed 1/2/14, effective 2/2/14. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-350, filed 2/28/06, effective 4/1/06.]

WAC 296-15-360 Qualifications of personnel—Certified claims administrators. (1) **What is a certified claims administrator?** An experienced adjudicator who has been certified by the department to meet the requirements of WAC 296-15-350(2).

(2) **How do I become a certified claims administrator for self-insured claims?**

(a) Under the mentorship of a certified claims administrator, have a minimum of one year of experience in the administration or oversight of claims under Title 51 RCW. The experience must have occurred within the five years immediately prior to your filing of the application to take the "self-insurance claims administrator" test.

(b) Have completed:

(i) A comprehensive goal-oriented curriculum approved by the department and resulting in a worker's compensation professional designation; or

(ii) An approved training program within the department.

(c) Take and pass the department's "self-insurance claims administrator" test. The department will provide annual reports to stakeholders. The department will report the results, identify and consider feasible alternative methods of test delivery, make any recommendations for improvements if appropriate and seek comments from stakeholders.

(i) If you have the requisite experience under (a) of this subsection, you may take the test without completing the training required under (b)(i) or (ii) of this subsection. The provision to take the test for certification without completing the requisite training will expire January 1, 2022.

(ii) If you have already passed the test and are a certified claims administrator, you will maintain your certified claims administrator designation without completing the training required under (b)(i) or (ii) of this subsection, and you will need to fulfill the continuing education credits under subsection (6) of this section.

After passing the test, you are designated a certified claims administrator. This is a lifetime certification, provided that continuing education requirements are met.

(3) **How do I receive approval to take the test?** To be approved to take the "self-insurance claims administrator" test, you must apply using the department's online database.

The department will review your application and determine if you meet the minimum requirements to take the test. The department will respond to your application no less than fourteen days prior to the next scheduled test date.

(4) **What happens if I fail the test?** You may retest after the failed test.

If you are a certified claims administrator and you fail the test, your certification will be terminated until you retest and pass.

(5) **What must a department-approved comprehensive goal-oriented curriculum for a worker's compensation professional designation include?** The curriculum must include:

(a) All phases of basic, intermediate, and advanced claim validity issues, including injury during the course of employment, occupational exposure and illness or disease, causal relationship of injury or illness, prima facie consideration, and submittal of claims to department;

(b) All phases of basic, intermediate, and advanced medical benefit management, including treatment authorization, surgery approval, aggravation of conditions, segregation of conditions, use of consultations and independent medical examinations (IMEs), and department medical guidelines;

(c) All phases of basic, intermediate, and advanced compensation management, including determining the wage as the basis of compensation, payment of temporary total disability payments, permanent partial disability payments, and loss of earning power compensation; and

(d) All phases of basic, intermediate, and advanced work disability prevention, including worker-centric return to work practices, modified or light duty jobs, other vocational recovery interventions, and medical provider collaboration on return to work, activity prescription forms, and job analyses.

(e) Training must include at least seventy-two credit hours as provided in subsection (6)(b) of this section.

(f) Curriculum submitters must provide their written core curriculum plan to the department with a table of contents listing the courses in the curriculum, and a detailed description of the content for each course. The curriculum advisory committee will review the submitters' proposed curriculum content and advise of any recommended adjustments, and the department will determine and provide notice of approval or denial within ninety days, or extend the time for approval or denial of the plan for another ninety days. The department may request additional materials, and require adjustments in the core curriculum plan prior to approval, as it deems necessary.

A department-approved curriculum must be reapproved every three years.

(6) **How does a certified claims administrator maintain their certified status?** A certified claims administrator may maintain certified status by earning the required continuing education credits as outlined in this subsection.

(a) You must earn forty-five credits every three years.

Credits earned within five years prior to the effective date of this rule may be carried forward and applied toward meeting the required continuing education credits for three years following the effective date of this rule up to a maximum of forty-five credits.

Credits may be earned in the following areas:

(i) Instruction on relevant workers' compensation subjects that help injured workers heal and return to work, and focus on areas of recovery such as, but not limited to, medical benefit management, payment of compensation, and vocational services;

(ii) Instruction on existing or historical workers' compensation statutes, case law, rule, or departmental policy, which may assist with managing claims, answering questions, and addressing concerns in accordance with WAC 296-15-350(5);

(iii) Instruction on new developments in workers' compensation such as, but not limited to, changes in statute, case law, rule, or departmental policy, which may assist claims management personnel in remaining current in accordance with WAC 296-15-350 (5); or

(iv) Credits may also be earned in injury prevention and safety, in addition to credits for injury recovery and claims administration, but not to exceed five of the forty-five credits in three years.

The forty-five credits must include any training designated as mandatory by the department. All training must be specific to Washington law, or describe in detail how the training is relevant to administering Washington law. If you fail to earn sufficient continuing education credits, you will be required to retake the written test to maintain your certified status.

(b) Continuing education providers must submit a training plan with a detailed outline of each area of training to the department when courses are offered. The curriculum advisory committee will review the submitters' proposed training plan and advise of any recommended adjustments, and assignment of course credit will be determined by the department as follows: A maximum of one credit per hour of training will be awarded. Credit will be assigned based on 0.5 increments; no credit will be awarded for increments less than 0.5.

(c) Department-approved continuing education courses must be reapproved biannually (every two years).

(d) You must track and report earned credits at the department's online database. You must obtain and retain signed verification of courses attended. Verification of earned credits must be received by the department by the date the certified claims administrator's certification expires. Extensions will not be granted. If your certification lapses, you will not need to complete the comprehensive goal-oriented curriculum if you apply for reinstatement within two years of the lapse, and then take and pass the department's "self-insurance claims administrator" test.

(e) The department may audit the reported credits of any certified claims administrator at random, or "for cause." Falsification of reported credits will result in revocation of the individual's certified claims administrator status, and may result in the department's refusal of future applications to take the self-insurance claims administrator test.

(7) **How often must certified claims administrators notify the department of changes to their contact information?** Certified claims administrators must notify the department within thirty calendar days of the effective date of a change in mailing address, work location, or name. Changes must be reported using the department's online database.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-360, filed 5/18/21, effective 7/1/21. Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-360, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.04.020, 51.14.030. WSR 14-02-121, § 296-15-360, filed 1/2/14, effective 2/2/14; WSR

12-03-088, § 296-15-360, filed 1/17/12, effective 2/17/12. Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 07-17-162, § 296-15-360, filed 8/22/07, effective 10/1/07; WSR 06-06-066, § 296-15-360, filed 2/28/06, effective 4/1/06.]

WAC 296-15-370 Notification to the department. When must a self-insurer notify the department about changes in its administrative organization? Any changes to the self-insurer's established administrative organization must be reported to the department in writing, within ten days of the effective date of the change.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-370, filed 2/28/06, effective 4/1/06.]

WAC 296-15-400 Self-insured workers' rights and obligations. How must a self-insurer notify its workers of their rights and obligations under the industrial insurance laws?

Self-insurers must notify workers of their industrial insurance rights and obligations at the following times:

(1) Within thirty days of hire, provide a form substantially similar to the one page Workers' Compensation Filing Information L&I form F207-155-000, or if authorized by the worker provide a link to the form giving electronic access online in lieu of a paper form.

(2) When a worker files a claim, provide the following information in writing:

(a) The current edition of the department's pamphlet P207-085-000, *A Guide to Workers' Compensation Benefits for Employees of Self-Insured Businesses*, or if authorized by the worker provide a link to the pamphlet giving electronic access online in lieu of a paper pamphlet; and

(b) The name, address, and phone number of the person or organization handling the worker's claim.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-400, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a). WSR 98-24-121, § 296-15-400, filed 12/2/98, effective 1/2/99.]

WAC 296-15-405 Filing a self-insured claim. (1) **What form is used to report a self-insured worker's industrial injury or occupational illness?**

The reporting form for a self-insured worker's industrial injury or occupational illness is the Self-Insurer Accident Report (SIF-2) L&I form F207-002-000. Self-insurers must obtain these forms from the department and must report their workers' industrial injuries and illnesses to the department with SIF-2s. The department tracks the claim numbers assigned to self-insurers.

When notified of injury or illness, the self-insurer must provide the worker with this prenumbered form and assistance in filing a claim. The self-insurer must provide the worker the designated copy of the completed SIF-2 (which includes an explanation of the worker's rights and responsibilities) within five working days of completion.

(2) **What form does a health care provider use to report a self-insured worker's industrial accident or occupational illness?**

Physicians should report a self-insured claim with a Provider's Initial Report (PIR) L&I form F207-028-000 when a self-insured worker has an industrial injury or is notified of an occupational illness. Replacements are acceptable.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-405, filed 12/18/18, effective 7/1/19. Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a). WSR 98-24-121, § 296-15-405, filed 12/2/98, effective 1/2/99.]

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.]

WAC 296-15-425 Communicating to injured workers during the course of the claim. (1) **How does a self-insurer communicate claims administration actions to workers?**

The self-insurer must communicate in writing using a department-developed template to inform workers of actions involving delivery of benefits.

(2) **What is the purpose of the department-developed template?**

To provide timely and accurate delivery of benefits and prompt resolution of disputes during the course of a claim (between the allowance and closure of a claim); to promote efficient claims processing that is protective of workers and effective for employers by improving communications to workers, clarifying requirements and providing certainty of claims administration for self-insurers, and streamlining regulatory oversight by the department.

(3) **When must a department-developed template be completed and sent to the worker?**

Within five days of a claims administrator taking action on a claim involving:

(a) Calculation of the worker's monthly wage that forms the basis for time-loss compensation at time of payment;[1]

(b) Starting*, stopping, or denying time-loss or loss of earning power compensation;

(c) Acceptance or denial of a condition contended under the claim;

(d) Authorization or denial of treatment requested by a medical provider with specified diagnosis and procedure codes for treatment requiring authorization under WAC 296-20-03001; or

(e) Assessment of an underpayment or overpayment of benefits (from date of knowledge).

*When starting time-loss compensation the self-insurer must send a copy of the department-developed template and SIF-2 to the department.

(4) **What is a department-developed template?**

A department-developed template is used by the self-insurer to inform a worker of administrative actions on the claim involving delivery of benefits. The template:

(a) Informs the worker of the action being taken, and that if the worker disputes the action the worker should within sixty days write and ask the department to intervene to adjudicate the dispute.

(b) Upon receipt of a dispute, the department will intervene to adjudicate the matter and issue an order in accordance with RCW 51.52.050.

(c) If no dispute is received, then the department will not issue an order, and when the condition of the injured worker has become fixed, the self-insurer may close the claim in accordance with RCW 51.32.055 and WAC 296-15-450. If an overpayment remains unpaid at the time of closure, then upon request, the department will issue an overpayment order in accordance with RCW 51.32.240.

[1]When communicating the worker's monthly wage, the department-developed template will serve as a cover letter to the SIF-5A, the time-loss calculation rate notice under WAC 296-15-420.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-425, filed 12/18/18, effective 7/1/19.]

WAC 296-15-4302 What is the Self-Insurance Vocational Reporting Form? The Self-Insurance Vocational Reporting Form replaces the Employability Assessment Report (EAR) and is used as a cover sheet for all vocational reports submitted to the department by the self-insured employer.

Note: A Self-Insurance Vocational Reporting Form is not required if the worker is not eligible for vocational services because they returned or were released to work at the job at the time of injury or on the date of disease manifestation.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4302, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4304 What must the self-insurer do when an assessment report is received? (1) A self-insurer must submit a Self-Insurance Vocational Reporting Form and the assessment report to the department within ten working days after receiving the completed report. A completed report is one that, in the opinion of the department, meets the requirements in WAC 296-19A-070.

(2) When time-loss is terminated, based on the vocational rehabilitation provider's recommendations, the self-insurer must notify the worker or the worker's representative as required in WAC 296-15-420(9).

(3) The self-insurer can terminate time-loss on the date they receive the recommendation but, if the department determines the assessment report failed to demonstrate the worker is able to work, the self-insurer must request additional information from the vocational rehabilitation provider before resubmitting the report and an updated Vocational Services Reporting Form to the department.

(4) If the self-insurer terminated time-loss based on the assessment report's recommendation but the department concludes the assessment report failed to demonstrate the worker is able to work, the self-insurer must reinstate time-loss effective the day after the last date paid.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4304, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4306 When must a self-insurer submit a vocational rehabilitation plan to the department? No later than ninety calendar days after the date the department determined the worker was eligible for vocational plan development services, the employer must submit a Self-Insurance Vocational Reporting Form and a completed vocational plan for the worker.

If the plan cannot be completed and submitted to the department within that time period, the self-insurer must, prior to the ninetieth day, submit a Self-Insurance Vocational Reporting Form and the vocational rehabilitation provider's request for an extension as required in WAC 296-19A-094.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4306, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4308 What must the vocational rehabilitation plan include? The vocational rehabilitation plan must meet the requirements in WAC 296-19A-100.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4308, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4310 What must the self-insurer do when the department denies the vocational rehabilitation plan? The vocational rehabilitation plan may be denied if the plan does not meet the requirements in WAC 296-19A-100 and the department cannot make a determination based on the information provided.

If the plan does not meet the requirements or is denied as incomplete, the self-insurer must correct the plan and/or obtain the information requested by the department, and resubmit the completed plan and an updated Vocational Services Reporting Form.

If the plan cannot be corrected and/or completed and submitted to the department within ninety calendar days after the date the department determined the worker was eligible for vocational plan development services, the self-insurer must, prior to the ninetieth day, submit a Self-Insurance Vocational Reporting Form and the vocational rehabilitation provider's request for an extension as required in WAC 296-19A-094.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4310, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4312 What must the self-insurer do when the vocational rehabilitation plan is successfully completed? The self-insurer must:

(1) Notify the worker or the worker's representative of the time-loss termination as required in WAC 296-15-420(9).

(2) Submit a Self-Insurance Vocational Reporting Form to the department within ten working days of the date time-loss benefits ended. The Self-Insurance Vocational Reporting Form must include:

(a) The total cost and time expended for the approved plan;

(b) The total time-loss compensation benefits paid during the plan implementation; and

(c) The total vocational services costs and time-loss days paid since the date the worker was found eligible for services; and

(d) A closing report with a copy to the worker or the worker's representative. The closing report must meet the requirements in WAC 296-19A-120.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4312, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4314 What must the self-insurer do if the vocational rehabilitation plan is not successfully completed? When a vocational rehabilitation plan ends before successful completion, the vocational

rehabilitation provider will submit a closing report to the self-insurer.

(1) **Plan not completed due to causes outside the worker's control.** Within ten working days of receiving the vocational closing report, the self-insurer must:

(a) Continue time-loss benefits; and

(b) Submit a Self-Insurance Vocational Reporting Form to the department. The form must include:

(i) The total cost and time expended for the approved plan;

(ii) The total time-loss compensation benefits paid during the plan implementation;

(iii) The total vocational services costs and time-loss days paid since the date the worker was found eligible for services; and

(iv) A closing report with a copy to the worker or the worker's representative. The closing report must meet the requirements in WAC 296-19A-120(2).

(2) **Plan not completed due to worker's actions.** Within ten working days of receiving the vocational closing report, the self-insurer must:

(a) Submit a request for suspension of benefits with supporting documentation.

(b) Submit a Self-Insurance Vocational Reporting Form to the department. The form must include:

(i) The total cost and time expended for the approved plan;

(ii) The total time-loss compensation benefits paid during the plan implementation;

(iii) The total vocational services costs and time-loss days paid since the date the worker was found eligible for services; and

(iv) A closing report with a copy to the worker or the worker's representative. The closing report must meet the requirements in WAC 296-19A-120(2).

(3) **Worker is employable.** When the worker is employable based on an assessment of the training completed to date, the self-insurer must:

(a) Notify the worker or the worker's representative of the time-loss termination as required in WAC 296-15-420(9).

(b) Submit a Self-Insurance Vocational Reporting Form to the department within five working days of the date time-loss benefits ended.

(c) The Self-Insurance Vocational Reporting Form must include:

(i) The total cost and time expended for the approved plan;

(ii) The total time-loss compensation benefits paid during the plan implementation;

(iii) The total vocational services costs and time-loss days paid since the date the worker was found eligible for services; and

(iv) A closing report with a copy to the worker or the worker's representative. The closing report must meet the requirements in WAC 296-19A-120(2).

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4314, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4316 What must the self-insurer do when the worker declines further vocational rehabilitation services and elects option 2 benefits? When the department approves a rehabilitation plan, the

department will notify the worker in writing of their right to decline further vocational rehabilitation services and elect option 2 benefits. The worker must make an election within the time frame required in WAC 296-19A-600. When the worker elects option 2 benefits, the self-insurer must take the following action within five working days of receiving the worker's request:

(1) Submit a Self-Insurance Vocational Reporting Form to the department. The Self-Insurance Vocational Reporting Form must include:

(a) The total vocational services costs paid since the date the worker was found eligible for services; and

(b) The option 2 election form signed by the worker.

(2) Upon issuance of a department order confirming the option 2 election, terminate time-loss benefits effective the date of the department order with proper notification to the worker as required in WAC 296-15-425, and commence payment of option 2 benefits to the worker according to the established payment schedule. The first payment must be made no later than fifteen days after the date time-loss is terminated. Option 2 benefits may be paid before the department issues an order.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-4316, filed 12/18/18, effective 7/1/19; WSR 16-21-074, § 296-15-4316, filed 10/18/16, effective 11/18/16. Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4316, filed 2/29/08, effective 3/31/08.]

WAC 296-15-4318 What must the self-insurer do when the worker elects option 2 benefits and the claim is closed? The self-insurer must submit a quarterly report to the department on a form stipulated by the department listing the total retraining costs paid to date for each worker since the option 2 benefit was granted. These quarterly reports must document all funds expended and funds that remain available for all workers of the employer until each worker has expended the total vocational costs available to him or her, or until five years have passed since the benefit was granted.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.32.095, 51.32.099 and 51.32.0991 (2007 c 72). WSR 08-06-058, § 296-15-4318, filed 2/29/08, effective 3/31/08.]

WAC 296-15-440 Use of independent medical examinations. What will the department consider when resolving a dispute to a scheduled independent medical exam (IME) in a self-insured claim?

(1) **The department will consider whether:**

(a) The notification letter included the self-insured employer's need for the IME consistent with RCW 51.36.070 and how this may be disputed by the worker.

(b) Notice of the IME was mailed to the injured worker and the worker's representative no later than 28 calendar days prior to the IME. Except for an IME scheduled to make a decision regarding claim allowance.

(c) The worker agreed to waive the 28-day notice for initial IME scheduling or reschedules.

(2) **When a written dispute is filed:**

(a) A worker or their attending provider may file a dispute at any time during the IME process. Disputes received by the self-insurer or third-party administrator must be submitted to the department within five working days of receipt.

(b) The department will only consider postponing an IME if the dispute is received by the department at least 15 calendar days prior to the IME.

(c) The dispute should include the specific reason(s) why the IME is out of compliance with RCW 51.36.070 and a copy of the notification letter from the self-insured employer.

(3) **The department will take action as follows:**

(a) Where the dispute presents a factual case that the examination was scheduled in violation of RCW 51.36.070 or these rules, pending a further investigation, the department may order the self-insurer to cancel the IME, and to notify the examiner, worker, and attending provider. The facts the employer provides in the IME notification letter, and the facts supplied by the worker or their attending provider will be used in this determination.

(b) The department will issue an order to resolve the dispute in accordance with RCW 51.52.050.

(c) Should a worker attend a disputed IME and, after a report is rendered, the department determines the IME was scheduled in violation of RCW 51.36.070, the report may not be considered in the administration of the claim.

[Statutory Authority: RCW 51.04.020, 51.04.030, and 51.36.070. WSR 22-07-110, § 296-15-440, filed 3/23/22, effective 4/23/22.]

WAC 296-15-450 Closure of self-insured claims. (1) **Who closes self-insured claims?**

The department has the authority to close all self-insured claims. Self-insurers have the authority to close certain claims.

Within two years of claim closure on a claim the self-insurer closed, the department may require a self-insurer to pay additional benefits if the self-insurer:

(a) Made a clerical error in benefits paid;

(b) Paid benefits due to mistake of identity or innocent misrepresentation; or

(c) Violated the conditions of claim closure.

(2) **What claims may a self-insurer close?**

A self-insurer may close	If the	With time-loss?	Other requirements?	With PPD?
Medical only (MO) claims	Claim was filed on or after 07/01/90 and before 08/01/97	Without	None.	Without[1]
Time-loss (TL) claims	Claim was filed on or after 07/01/86 and before 08/01/97	With	1. Not if the department issued an order resolving a dispute; AND 2. Only if the worker returned to work with the employer of record at the same job or at a job with comparable wages and benefits.[2]	Without[1]

A self-insurer may close	If the	With time-loss?	Other requirements?	With PPD?
All claims: Medical only (MO) claims Time-loss (TL) claims Permanent partial disability (PPD) claims	Claim was filed on or after 08/01/97	With or without	1. Not if the department issued an order resolving a dispute; AND 2. Only if the worker returned to work with the employer of record at the same job or at a job with comparable wages and benefits;[2] AND 3. Only if the closing medical report was sent to the attending or treating doctor and 14[3] days allowed for response.	With or without

[1] A self-insurer may not close a claim with PPD if the injury or illness occurred before 08/01/97.
[2] Comparable means the wages and benefits are at least ninety-five percent of the wages and benefits received by the worker at the time of injury.
[3] When not specified, time is in calendar days.

(3) **When a self-insurer is closing a PPD claim, what must it do with the closing medical report?**

When a self-insurer is closing a PPD claim, it must send the closing medical report to the attending or treating doctor, and the doctor must be allowed fourteen days to respond. When the attending or treating doctor responds:

Within 14 days	And the doctor AGREES with	And the doctor DISAGREES with	Then the self-insurer	
Within	Fixed and stable and PPD rating		MAY	Close the claim.
Does not respond			MAY	Close the claim
Within or before the order is issued		Fixed and stable	MUST	1. Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list; OR 2. Forward the claim to department for closure. The department may require additional medical examinations.
Within or before the order is issued	Fixed and stable	PPD rating	MUST	1. Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list; OR 2. Forward the claim to department for closure. The department may require additional medical examinations.
Not within, after the order is issued, but before the order is final		Fixed and stable and/or PPD rating	MUST	Forward the claim including the doctor's response to the department as a protest within five working days of receipt.

(4) **What must a self-insurer do with a closing medical report, regardless of who is closing the claim?**

A self-insurer must send the closing medical report to the attending or treating doctor. If the doctor responds that he/she does not concur with the results, the self-insurer must:

(a) Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list in order to do the closing action itself; OR

(b) Forward the claim to department for closure. The department may require additional medical examinations.

(5) **When a self-insurer is closing a claim, what written notice must it provide to the worker and attending or treating doctor?**

At claim closure, a self-insurer must send the closing order to the worker and attending or treating doctor.

(a) For a MO claim, use a Self-Insurer's Claim Closure Order and Notice substantially similar to F207-020-111.

(b) For a TL claim, use a Self-Insured Employers' Time-Loss Claim Closure Order and a department-developed form[1]. Include a complete and accurate department-developed form with the worker's copy.

(c) For a PPD claim:

(i) When no TL or loss of earning power (LOEP) was paid, use a form substantially similar to L&I form F207-165-000 (MO with PPD). Include a complete and accurate department-developed form with the worker's copy.

(ii) When TL or LOEP was paid, use a form substantially similar to L&I form F207-164-000 (TL with PPD). Include a complete and accurate department-developed form with the worker's copy.

[1]The department-developed form (formerly SIF-5) is the form used to request claim closure.

(6) **When a self-insurer is closing a claim, what information must it submit to the department?**

A self-insurer must submit to the department:

(a) MO claim closures by the end of the month following closure. These may be transferred electronically or reported by paper.

(i) Closures transferred electronically must be in the department's format.

(ii) Closures submitted in paper must include the SIF-2 L&I form F207-002-000 showing the date of closure and any vocational services provided.

(b) TL and PPD claim closures at the time of closure. Include copies of each of the following:

(i) SIF-2 if not previously submitted.

(ii) Closure order.

Note: If no one protests the self-insurer's closure order, it will become final and binding in sixty days, just like a department order.

(iii) A PPD Payment Schedule, if necessary, substantially similar to L&I form F207-162-000.

(A) A payment schedule is required when the amount of the award is more than three times the state's average monthly wage at the date of injury. At initial/down payment, send copies to the worker and the department.

(B) The first payment of the PPD award must be paid within five working days of claim closure. Continuing payments must be paid according to the established payment schedule.

(iv) A complete and accurate department-developed form showing all requirements for closure have been met, any TL or LOEP paid, period of payment, and total amount paid.

(7) **What must the self-insurer do to request closure of a claim by the department?**

When a self-insurer is asking the department to close the claim, it must submit:

(a) A complete and accurate department-developed form requesting closure;

(b) A transaction record of all time-loss payments made; and

(c) All records not previously submitted to the department excluding bills.

(8) **When the department has closed a PPD claim, when must the self-insurer create a payment schedule?**

When the department has closed a PPD claim, the self-insurer must create a PPD Payment Schedule substantially similar to L&I form

F207-162-000 when the amount of the award is more than three times the state's average monthly wage at the date of injury. At initial/down payment, send copies to the worker and the department.

(9) **When the department has closed a PPD claim, when must the self-insurer make the first payment of the award?**

When the department has closed a PPD claim, the self-insurer must make the first payment of the award without delay. Continuing payments must be paid according to the established payment schedule.

[Statutory Authority: RCW 51.04.020. WSR 19-01-095, § 296-15-450, 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, § 296-15-450, 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, § 296-15-450, filed 12/2/98, effective 1/2/99.]

WAC 296-15-470 When a worker files for reopening. When must a self-insurer forward an application to reopen a claim to the department? A self-insurer must forward an application to reopen a claim to the department within five working days of receipt.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-470, filed 2/28/06, effective 4/1/06.]

WAC 296-15-480 When a self-insured claim is protested. When must a self-insurer submit a worker's written protest or appeal to the department?

A self-insurer must submit a written protest by a worker to the department within five working days of receipt. The date the protest is received by the self-insurer is considered the date the protest is received by the department.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-480, 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, § 296-15-480, filed 12/2/98, effective 1/2/99.]

WAC 296-15-490 When a self-insured claim is on appeal. (1) **When must a self-insurer submit a worker's written appeal to the department?** A self-insurer must submit to the department a written appeal by a worker within five working days of receipt. The date the appeal is received by the self-insurer is considered the date the appeal is received by the department.

(2) **How may department orders be defended in self-insured appeals?**

The department may ask the office of the attorney general to represent the department at the board of industrial insurance appeals.

(3) **What must a self-insurer send to the department when any party appeals a claim to superior or appellate court?**

When any party appeals a claim to superior or appellate court, the self-insurer must promptly send to the department copies of the notice of appeal, judgment, and all other relevant information.

[Statutory Authority: RCW 51.04.020, 51.14.020, 51.32.190, 51.14.090, and 51.14.095. WSR 06-06-066, § 296-15-490, 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, § 296-15-490, filed 12/2/98, effective 1/2/99.]

WAC 296-15-495 Third-party action on a self-insured claim. What must a self-insurer send to the department when there is a third-party action?

When there is a third-party action, in addition to fulfilling the statutory requirements, the self-insurer must send the department copies of:

When	What
Upon notification	Written indication of the worker's election.
After recovery of damages	1. Signed settlement agreement or court order; and 2. Total amount of attorney fees and costs; and 3. Total amount of benefits paid, including TL, PPD, and medical, excluding payments for IMEs.

[Statutory Authority: RCW 51.32.190(6), 51.32.055 (8)(a) and (9)(a). WSR 98-24-121, § 296-15-495, filed 12/2/98, effective 1/2/99.]

WAC 296-15-520 Self-insured third-party administrator (TPA) licensing requirements. To be licensed as a TPA, a business entity must:

(1) Be licensed to do business in the state of Washington, as evidenced by holding a business license from the department of revenue;

(2) Demonstrate to the department's satisfaction that it can meet the requirements for handling claims under WAC 296-15-350 for the self-insured employers it contracts with; and

(3) Comply with the reporting requirements of these rules in accordance with Title 51 RCW.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-520, filed 5/18/21, effective 7/1/21.]

WAC 296-15-530 Self-insured third-party administrator (TPA) licensing application requirements. (1) To apply for a TPA license, a business entity must:

(a) Submit to the department a department-developed application;

(b) Provide a list of the self-insured employers in Washington the TPA is under contract to handle claims for;

(c) Provide a list of their certified claims administrators; and

(d) Provide a list of their claims administrators in the process of obtaining their certification in accordance with WAC 296-15-360.

(2) Upon receipt of the required information above, the department will respond within thirty calendar days with the status of the TPA's license request.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-530, filed 5/18/21, effective 7/1/21.]

WAC 296-15-540 Self-insured third-party administrator (TPA) licensing renewal application requirements. (1) A TPA must apply annually to renew its license. To apply, the TPA must:

(a) Submit a department-developed renewal application to the department;

(b) Provide an updated list of the self-insured employers in the state of Washington the TPA handles claims for;

(c) Provide an updated list of their certified claims administrators; and

(d) Provide an updated list of their claims administrators in the process of obtaining their certification in accordance with WAC 296-15-360.

(2) The department will review the TPA's license to ensure the submitted materials together with other evidence demonstrates the TPA continues to meet the requirements of WAC 296-15-520 and 296-15-550.

(3) Provisional status may be added to a TPA's license who fails to renew license as required in accordance with WAC 296-15-570.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-540, filed 5/18/21, effective 7/1/21.]

WAC 296-15-550 Self-insured third-party administrator (TPA) duties and performance requirements. Every TPA must:

(1) Agree to be responsible for ensuring that claims are managed in accordance with Title 51 RCW, Washington Administrative Codes, L&I policies, L&I medical treatment guidelines, and medical aid fee schedule.

(2) Follow recognized claim processing practices to include:

(a) Promptly respond to inquiries from workers, L&I, ombuds office, and medical providers:

(i) Telephone inquiries within three business days; and

(ii) Written correspondence within fifteen business days, unless otherwise specified.

(b) Provide workers with a current contact name and phone number to address their questions and concerns.

(c) Provide the reason(s) for the examination in the worker's independent medical examination (IME) appointment letter.

(d) Keep and preserve the claim records of the contracting self-insured employer and make available to the department upon request.

(i) If the TPA discontinues managing claims, then the TPA must either transfer all claim records to the employer or a new TPA, whichever applies.

(ii) If the employer defaults, the TPA must ensure preservation of the claim records, and transfer of all open claims to the department within five business days and all closed claims to the department within thirty calendar days of the date of default.

(e) Demonstrate competent claims handling in all areas of the comprehensive core curriculum under WAC 296-15-360(5) as verified by standard department performance-based audits.

(i) Audits may include, but are not limited to, review of timeliness, accuracy, entitlement to benefits, complaint-based audits or issue-based audits.

(ii) Workers or their representatives, providers, or the ombuds, may submit a complaint in writing or electronically.

(f) Promptly remediate any repeat audit deficiencies in accordance with WAC 296-15-560.

(g) May provide automatic deposit of benefit checks to workers or their representatives. The TPA may not electronically reverse the benefit payment deposited in an account, but must instead pursue any payment adjustments as provided in RCW 51.32.240.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-550, filed 5/18/21, effective 7/1/21.]

WAC 296-15-560 Self-insured third-party administrator (TPA) penalties. (1) A TPA may be penalized under RCW 51.48.080 for deficiencies involving, but not limited to:

(a) Failure to maintain the requirements under WAC 296-15-425, 296-15-520, or 296-15-550. Beginning July 1, 2023, as authorized by RCW 51.48.095, this penalty will be adjusted for inflation every three years based on the consumer price index (Seattle, Washington area for urban wage earners and clerical workers, all items compiled by the Bureau of Labor Statistics of the United States Department of Labor) and posted to the L&I website.

(b) The department will not assess additional penalties under RCW 51.48.017 when a TPA:

(i) Promptly self-assesses;

(ii) Correctly calculates the amount of the penalty;

(iii) Reports to the department; and

(iv) Pays to the worker a penalty not to exceed the greater of $1,000 or 25 percent upon discovery of the delayed payment, unless the department determines there is a reoccurring issue or establishes additional benefits have been delayed.

(2) A TPA may be directed to obtain training when reoccurring problems are identified. A TPA who refuses to obtain the training for their staff may be penalized when their failure to obtain training results in subsequent rule or statutory violations.

[Statutory Authority: RCW 51.04.020 and 51.16.035. WSR 22-21-117, § 296-15-560, filed 10/18/22, effective 1/1/23. Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-560, filed 5/18/21, effective 7/1/21.]

WAC 296-15-570 Self-insured third-party administrator (TPA) license suspension and revocation. A TPA's license may become provisional, suspended, or revoked if:

(1) Demonstrates a continuing practice of failure to maintain requirements or correct deficiencies. The department may consider issuing a directive listing the specific areas of noncompliance and requiring correction within time frames established by the department; and

(2) If the corrections are not made timely, then the department may issue an order of suspension or revocation in accordance with RCW 51.52.050.

[Statutory Authority: RCW 51.04.020, 51.32.190 and 2020 c 277. WSR 21-11-083, § 296-15-570, filed 5/18/21, effective 7/1/21.]