

Solving The Puzzle Of Workers' Compensation

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About the Author



Christine A. Foster's practice is devoted to representing workers who have been injured in the workplace. Prior to beginning her own private practice in 1992, she worked with Justice Robert Utter of the Washington Supreme Court on special research projects and with the Office of the Washington State Attorney General representing the Department of Labor & Industries in appeals before the Board of Industrial Insurance Appeal, superior courts and courts of appeal in Washington State.

In addition to representing workers before the Board of Industrial Insurance Appeals, Ms. Foster has also successfully represented injured workers in the appellate courts relative to significant Industrial Insurance issues, which include *Brand v. Department of Labor & Industries*, 91 Wn.App.280, 959 P.2d 133 (1998) rev'd. 139 Wn.2nd 659,989 P.2d 1111 (1999) and *Somsak v. Crition Industries*, 75 Wn.Spp. 657, 879 P.2d 326 (1994) (regarding jurisdictional limitations on appeals from Department orders.)

Ms. Foster graduated, *cum laude*, from the University of Puget Sound, now Seattle University School of Law, in 1988. She is admitted to the Washington State Bar Association and United States District Court (Western District, Washington); she is a member of the Western Trial Lawyers Association, King County Bar Association, Washington State Association for Justice and is listed in Who's Who in American Law. Ms. Foster has spoken before both peer and community groups on topics related to workers' compensation and employment discrimination.

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1.0 WHAT IS WORKERS' COMPENSATION?

From a historical perspective, the workers' compensation system is the result of a highly industrialized society that saw an increase in the number of people working for others, an increase in the number of injuries to those workers and a concomitant number of lawsuits against employers. To avoid a slow down and/or possible demise of industrialization and economic growth, the workers' compensation system was born. The concept of workers' compensation was first introduced in Germany in the latter part of the 19th century.

Workers' compensation law is premised upon the concept that injured workers shall be compensated regardless of fault in exchange for benefit amounts which are strictly limited and foregoing the right of private action against the employer – except in certain limited circumstances. Every state has a workers' compensation law in effect. While systems may differ in operation and/or the benefits provided, the foundation of all systems is the same.

The Washington State Industrial Insurance Act, described as the "Great Compromise", was enacted in 1911. It required workers to forego

their right of legal action in court in exchange for a swift and certain no-fault remedy for industrial injuries and occupational diseases. Our Industrial Insurance Act is codified at Title 51 of the Revised Code of Washington; its regulations are found in the Washington Administrative Code, Chapter 296. While the law has been through many changes since 1911, the foundation upon which it was built remains solid. RCW 51.04.010 reads, in pertinent part:

The State of Washington, therefore exercising herein its police and sovereign power, declares that all phases of the premises are withdrawn from private controversy and sure and certain relief for workers, injured in their work, and their families and dependents is hereby provided regardless of questions of fault and to the exclusion of every other remedy, proceeding or compensation, except as otherwise provided in this title; and to that end all civil actions and civil causes of action for such personal injuries and all jurisdiction of the courts of the State over such causes are hereby abolished, except as in this title provided.

One of the exceptions to the exclusive remedy provision above is found at RCW 51.24.020 which provides that a worker shall have the privilege of workers' compensation benefits and a private cause of action against the employer if the injury results from the deliberate intention of his or her employer to produce such injury. Many courts have construed the meaning of "deliberate intention".

The trend of the courts is best described by the words of Justice Talmadge who wrote, "[a]lthough the court . . . may have been correct in stating that in 1916 everyone 'agreed that the blood of the workman was a cost of production', that statement no longer reflects the public policy or the laws of Washington."

The Industrial Insurance Act is not, nor is it intended to be, a comprehensive health and/or disability plan of insurance. It is only intended as a "safety net" – although in its application, this safety net too often is a net with gaping holes. All benefits to which an injured worker may be entitled are determined solely by legislative prerogative as expressed in statute. The specific amount of benefits to which a worker may be entitled are specifically set forth by the Act. Every body part is assigned a certain monetary value. Therefore, the actual physical, mental and/or economic impact of injury or disease to an injured worker is not considered in determining the amount of a worker's permanent partial disability as it is statutorily determined.

2.0 WHO IS COVERED BY WORKERS' COMPENSATION?

As the Workers' Compensation Act is a statutory creature, benefits under the Act are payable only when the law says to do so. In Washington a worker is entitled to coverage when he/she suffers an "injury" or "occupational disease". These are terms of art and if the worker's situation fails to fit into one of these definitions, no benefits are payable.

In a nutshell, any "worker" who sustains an "injury" while "acting in the course of employment" or suffers an "occupational disease", making timely application to the Department of Labor & Industries is entitled to workers' compensation benefits unless he/she is subject to a statutory exclusion.

An injury is defined as "sudden and tangible happening of a traumatic nature, producing an immediate result, and occurring from without, and such physical conditions as result therefrom". It should be noted that injuries that cause psychiatric residuals are also covered.

To be compensable, an injury must occur while the worker is "in the course of employment". Subject to many statutory and case law exceptions, generally one who is acting at the direction and/or in furtherance of the employer's business at the time of the injury is in the course of employment. Intentional injury to oneself or injury while in the commission of a felony excludes a worker and his/her beneficiaries from benefits under the Act.

A heart attack or stroke may be considered an injury but such events are subject to a special legal test. Generally, to be compensable, the heart attack or stroke must be proximately caused by an "unusual exertion" that occurred in the course of employment.

An "occupational disease" is defined as "such disease or infection as arises naturally and proximately out of employment". Some occupational diseases are readily recognizable. An example would be black lung disease among coal miners. However, the less clear-cut occupational diseases are compensable if they meet the criteria set forth by the Supreme Court. An occupational disease is a condition that arises naturally and proximately out of distinctive conditions of the worker's particular employment. It should be noted that stress related conditions without physical injury are not recognized as compensable occupational diseases.

3.0 WHEN IS AN APPLICATION TIMELY?

Assuming the existence of an injury or an occupational disease, the worker must make timely application to the Department of Labor & Industries to be covered. An injury claim must be filed within one year after the date of injury to be valid. This is a strict statute of limitations, and the onus is on the worker to make application. Reporting the injury to a doctor or to the employer pursuant to a "company policy" is not adequate. It is the responsibility of the injured worker to file the application with the Department of Labor & Industries.

Failure to meet this limitation is usually fatal to a claim for benefits. A trial court may provide equitable relief to a party who has failed to follow a statutory requirement for filing a claim for industrial insurance benefits if the party did not exhibit a lack of diligence and the party's competence to understand orders, procedures, and time limits affected the communication process.

An occupational disease claim must be filed within two years following the date the worker is given written notice from a physician. The written notice must notify the worker of the existence of his/her occupational disease, that a claim for disability may be filed and that he/she has two

years to file a claim. The statute of limitations does not begin to run until all the elements of an occupational disease are present and a compensable disability results from the exposure. Consequently, where a condition is diagnosed as an occupational disease but no treatment is indicated and/or no disabling effects have occurred, the statute does not begin to run.

In the event of a death due to an injury or occupational disease, the beneficiary must make timely application for benefits within one year of the date of death due to injury or within two years from the date of death due to occupational disease. Beneficiaries are entitled to benefits in their own right and are not in all cases bound by the actions of the worker him/herself.

4.0 WHAT ARE THE BENEFITS?

Assuming the worker is subject to coverage under the Act, he/she suffers an industrial injury or occupational disease and makes timely application for benefits, the following are potential benefits to which the worker may be entitled:

4.1 Treatment. The law provides that an injured worker shall receive proper and necessary medical, surgical, hospital care and other services at the hands of a physician of his/her choice subject to some limitations. The rules and regulations that govern what treatment may be provided and what the health care providers will be paid are found in the Medical Aid Rules under Washington Administration Code 296-20-010 through 296-20-17003.

Generally, treatment is authorized and permitted until such time as the condition becomes medically stable and has reached a fixed state or in other words, when the condition has reached maximum medical rehabilitation. The Department tends to limit treatment to that which is "curative" only. Treatment that is considered "palliative", or supportive in nature without expectations of improvement, will likely not be authorized.

Health care providers who treat injured workers are bound by the medical aid rules relating to what services are permitted (at the Department level anyway) and the fee paid for such services. Equally, health care providers may not seek payment directly from the worker for services rendered or for the difference between the fee allowed and the usual charge. In the event the claim is rejected by the Department of Labor and Industries, or treatment is for an unrelated condition, they may seek direct payment from the injured worker.

4.2 Time Loss Benefits: If an injured worker is temporarily unable to return to any type of suitable employment with a reasonable degree of success and continuity as a result of the injury, he/she may be entitled to time loss benefits. In making that determination, the Department is to take into consideration the worker's age, education, prior work history and the restrictions due to the injury.

As a practical matter, if the worker is unable to return to his/her usual work, time loss benefits will continue so long as the attending physician continues to certify the workers' inability to perform such work.

The amount of time loss benefits is determined by statute. The statute sets forth the benefit amount based on a percentage of the worker's "wages"

depending on the worker's marital status and number of children (subject to a maximum and a minimum). "Wages", also a term of art, is defined as the monthly wages the worker was receiving from all employment but not including overtime pay. However, the amount of time loss shall be limited to the maximum amount of 105% of the average state wage. While time loss does not include overtime pay at the rate of time and one-half, overtime hours at the regular hourly rate can be considered in the calculation if such hours represent hours the worker is normally employed. Recently, our Supreme Court held that the time loss calculation shall include reasonable value of medical insurance benefits and other "consideration of like nature received from the employer as part of the contract of hire".

In the event the injury only causes a partial loss of earning capacity, then the worker may be entitled to loss of earning power benefits so long as the claim remains open and the loss of earning power is greater than 5%. Paid as a percentage of time loss, these benefits are paid in the proportion which the new earning power bears to the old.

For injuries after July 1, 1993, loss of earning power benefits are paid as 80% of the actual difference between present and past wages subject to some limitations. Benefits cannot exceed 150% of the average monthly

wage, be greater than 100% of the time loss rate or less than they would have been under the law for claims before July 1, 1993.

Such benefits provide an incentive for workers to return to work as the combination of wages and loss of earning power benefits exceeds time loss benefits alone.

4.3 Vocational Rehabilitation: The decision whether or not to provide vocational rehabilitation to an injured worker is purely at the discretion of the Department of Labor and Industries. The decision to provide vocational services normally follows an evaluation process that is conducted through a vocational counselor who meets with the injured worker and obtains information regarding the worker's age, education and prior work history. Based on the information gathered, a determination is made as to eligibility for vocational services.

The vocational determination is based on whether or not the injured worker, taking into consideration the above listed factors, is "employable". "Employable" is defined as being capable of performing and obtaining a suitable gainful occupation with a reasonable degree of success and continuity.

A determination of eligibility may be disputed to the Director of the Department in writing within 15 days of the receipt of the adverse determination or the decision stands. This 15 day limitation is applicable to the injured worker and employer. The decision rendered by the Director in response to a dispute is considered final. However, an appeal of the Director's decision may be made to the Board of Industrial Insurance Appeals but, unlike other appeals, the burden of proof is that the Director's decision was arbitrary and capricious.

A determination that the injured worker is "employable" or "not eligible" for vocational services will result in an immediate termination of time loss benefits although the claim may be left open for medical treatment. No time loss benefits are paid pending a dispute regardless of doctor certification of disability. This may be true even if new medical information is submitted, as it would be considered a part of the "dispute" to the determination. However, if, after the Director decides vocational services are not necessary and such determination becomes final, a worker may again request vocational services if the worker's condition has worsened such that a new vocational determination is warranted.

An injured worker determined to be eligible for vocational services in order to be "employable" is provided with vocational services. The extent of

such services varies depending on the case as determined by a priority system. When retraining is necessary after 1/1/2008, such retraining cannot exceed 2 years in duration or exceed \$12,000 in costs although the Director has discretion to grant an additional vocational benefit.

Time loss or loss of earning power benefits are generally paid through the completion of the approved vocational program. Upon completion of the program, however, such benefits are generally terminated regardless of the worker's actual employment status.

4.4 Permanent Partial Disability: Commonly referred to as the "settlement", permanent partial disability is defined as "loss of either one foot, one leg, one hand, one arm, one eye, one or more fingers, one or more toes, any dislocation where ligaments were severed where repair is not complete, or any other injury known in surgery to be permanent partial disability" (RCW 51.08.150).

Judicially, the concept presumes that the condition is medically fixed and stable and the worker is capable of performing and obtaining gainful employment. Permanent partial disability refers to the degree of loss of bodily function only. The extent of permanent partial disability is a medical determination and must be supported by objective medical findings. The law

recognizes and pays for permanent partial disabilities that are “specified” and “unspecified”.

“Specified disabilities” are those relating to parts of the body subject to amputation, namely, the extremities. Injuries to these parts of the body are rated in terms of a percentage as compared to the amputation of the particular extremity or part thereof. That percentage in turn translates to a sum of money set forth in the statute and depending on the area affected. The AMA Guides to Evaluation of Permanent Impairment is the authority used by most physicians to determine percentages of impairment.

“Unspecified disabilities” are those parts of the body not subject to amputation. Injuries or diseases affecting the back, neck, lungs, internal organs and psychiatric disorders are a few examples of such impairments. The impairments are expressed in terms of the percentage of loss as compared to total bodily impairment (TBI). The Department promulgated “Categories of Impairment” for rating many of the unspecified disabilities.

Permanent partial disability awards are based upon the schedule of benefits in effect on the date of the injury. All ratings of impairment must be made by medical doctors and the opinions of the worker’s attending

physician are to be given special consideration in comparison to the opinions of a one-time examiner.

If the worker's injury or occupational disease causes a pre-existing condition, that was previously asymptomatic and not disabling, to become symptomatic and disabling, the entire disability is to be attributed to the industrial injury or occupational disease. However, if the pre-existing condition was symptomatic and/or there was an established disability, then that disability must be segregated from the disability caused by the injury.

Payment of permanent partial disability, the last act of the Department, is accompanied by an Order and Notice closing the claim. Without timely protest or appeal to such order, no further benefits are payable and the order becomes forever final with respect to the extent of the worker's disability at that time.

After the claim is closed and the injured worker's industrial injury or occupational disease becomes aggravated and causes increased disability, the worker may file an application to reopen the claim. Such application may be filed at any time for payment of treatment benefits. However, to be eligible for other benefits (i.e. time loss or loss of earning power, permanent partial disability or total permanent disability),

the application to reopen must be made within seven years of the first closure of the claim pursuant to "medical recommendation, advice or examination". Note that the period is ten years for injuries involving the loss of vision or function of the eyes.

A claim may be reopened as many times as is necessary within the seven-year period. To reopen a claim, the injured worker must file a reopening application with the Department and provide proof, based in part on one or more objective medical findings, that there has been a worsening of the industrially related condition between the date the claim was last closed and the time of the application to reopen. For psychiatric conditions, it is not necessary to establish objective evidence of worsening.

4.5 Total and Permanent Disability: Permanent total disability is the "loss of both legs, or arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful occupation". Meeting the statutory definition of total permanent disability results in entitlement to benefits regardless of actual ability to work.

However, a worker can be found totally and permanently disabled if, given his/her age, education, prior work history and the physical restriction,

he/she is unable to perform or obtain any form of gainful employment with a reasonable degree of success and continuity. While loss of physical function must be supported by medical testimony, the testimony of a vocational expert considering the medical information is also relevant evidence to establish the injured worker's inability to perform or obtain gainful employment.

The benefits a totally and permanently disabled worker receives are generally the same monthly benefits as those paid for time loss benefits. The only difference in total temporary disability (time loss benefits) and total permanent disability pension is its duration, not its character. In addition, medical treatment is not payable after the determination of total permanent disability. However, the statute does provide that, in the sole discretion of the Director of the Department, medical treatment necessary to sustain life or other treatment deemed appropriate may be payable even after claim closure.

4.6 Widow and Children Benefits: Spouses and children of an injured worker may be entitled to benefits in their own right given the existence of certain facts. In the event a worker's death is the direct result of the injury or occupational disease, the spouse/children are entitled to benefits. In the event the worker, already determined to be totally and

permanently disabled, dies due to any cause, benefits to the surviving spouse and children also may be payable.

If benefits will be paid, the amount will depend upon the option chosen by the worker at the time he/she was deemed totally disabled. In either case, remarriage will "suspend" the surviving spouse's benefits until that marriage terminates.

It is important to note that the type and amount of benefits a worker may be entitled to may change with each legislative session. However, the schedule of benefits applicable to any particular worker is determined by those in effect on the date of injury.

In the case of an occupational disease claim, benefits are established as of the date the condition requires medical treatment or becomes disabling, whichever occurs first, regardless of the date of the contraction of the disease or the date of filing the claim.

5.0 WHAT RIGHTS DO WORKERS HAVE TO PROTEST OR APPEAL DEPARTMENT ACTION?

Any time the Department of Labor and Industries makes a determination of benefits, it is done in the form of an "Order and Notice". Any person aggrieved by such an order must file a protest or appeal, in writing, within sixty days of the date of receipt of the Order. An "aggrieved person" may include the worker, the employer and even a doctor or other health care provider.

While the language of the statute indicates that "whenever the department has taken any action or made any decision relating to any phase of the administration of this title the worker....or other person aggrieved thereby may request reconsideration of the department or may appeal", it is clear that to be appealable, the action must be in the form of an Order and not casual correspondence.

In lieu of an appeal, a written "protest" may be filed with the Department within sixty days. By doing so, the Department must either issue another order or the Department may treat the protest as an appeal and forward it to the Board of Industrial Insurance Appeals for action.

The procedure before the Board of Industrial Insurance Appeals is too involved for the scope of this paper. Suffice it to say that in the event a case

gets to that point, the worker must be familiar with all applicable laws, procedural deadlines, statutes of limitations, and other potential traps that loom therein. We strongly recommend a worker have legal representation in proceedings before the Board of Industrial Insurance Appeals.

6.0 WHAT IF A THIRD PARTY IS RESPONSIBLE FOR THE INJURY OR OCCUPATIONAL DISEASE?

While the Workers' Compensation Act removes all phases of on-the-job injuries from private controversy, if the injury to the worker is due to the negligence of a third person not in the worker's same employ, the injured worker may elect to pursue the third party for tort damages.

By electing to pursue the third party, the worker is not precluded from receiving workers' compensation benefits but the Department has a lien against any recovery to the extent that benefits were paid and/or are payable to the worker. The lien is perfected by operation of law and the worker is required to notify the Department of the recovery. Distribution of the third party recovery is controlled by statute.

The worker is required to notify the Department of the election. If the recovery is by settlement and it is deficient in repaying the Department lien, the Department's approval is required or the settlement will be considered null and void.

In the event of Department approval, the worker's benefits would continue without interruption. Where the recovery is in excess of the Department lien, further workers' compensation benefits would be suspended until such time as benefits the worker would have received, and

are otherwise payable by the Department, equal the excess recovery. At that point, benefits would resume as if never stopped. In such "excess" cases, the claim must be open and treated as any other case for the worker to receive credit against the excess recovery.

Caution is advised in determining whether the settlement is deficient or not. A settlement is "deficient" if the recovery, after deduction for attorney fees, costs and the worker's 25% is less than the Department's "entitlement". "Entitlement" is defined as benefits "paid or payable". Many erroneously assume that the determination is made merely by deducting the amount the Department paid to date from the gross recovery rather than also factoring in future payable benefits as well.

Electing not to pursue the third party, or failure to make an election, results in an assignment of the cause of action to the Department of Labor and Industries. The Department, in theory, is to pursue the matter in the worker's name. The worker could benefit from the Departments' efforts if successful.

7.0 CONCLUSION

In summary, under the Industrial Insurance Act, there are limited benefits, limited avenues of recovery and limited time periods in which action must be taken. It is important to understand that it is the attending doctor who holds the key to what benefits an injured worker may receive. The information the worker's attending doctor provides will normally determine the course the claim will take. The Department wants that information in the form of opinions based on objective medical findings rather than conclusions without medical support. Often times, attending physicians are not familiar with the applicable law entitling workers to workers' compensation benefits. Therefore, when requesting medical opinions from attending physicians it is important to make sure they have a proper understanding of the applicable law and its liberal construction in favor of injured workers.

8.0 DISCLAIMER

The information above is not, nor is it intended to be, a complete digest of the Washington workers' compensation law. Rather, it is an overview of the law intended to help those unfamiliar with workers' compensation to recognize some of the key issues and concepts. With that warning, I hope the information is helpful to you.