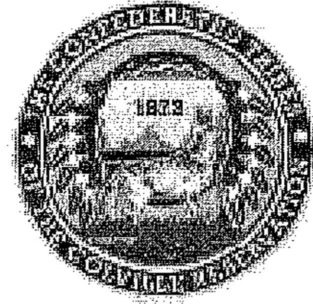


Policies and Procedures – Section #1

Steps in filing a claim

Employees are required to report any injury or illness to their supervisor or the Program Manager immediately, and in no event later than fourteen (14) working days from the date of occurrence. Failure to report such on-the-job injury shall result in the worker forfeiting benefits under this act, unless the claimant can demonstrate an extraordinary reason that prevented the reporting of the injury or occupational disease in a timely manner.

The supervisor must submit a supervisor's report to Risk Management within seven (7) days of receipt from the receipt of the claim by the injured worker. Once that report has been made, the employee has thirty (30) days from the date of the injury/illness to file a claim. Time Loss payments and medical bills associated with the injury will not be issued or paid until a claim has been filed.

If medical attention is necessary, the supervisor will supply the injured employee with the following forms:

- Employee Application for Compensation and Report of Injury or Occupational Disease
- Disability Claim Attending Physician Statement
- Supervisor's Accident Report of Injury

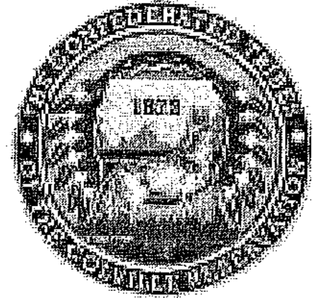
These forms can be obtained at the Risk Management/Benefits Office or downloaded from the Tribal website. (www.colvilletribes.com)

It is imperative that these forms are completed in a timely manner in order to submit and initiate a claim. This is especially important if the injured employee is missing work due to the injury/illness.

Completed forms must be forwarded to the Risk Management/Benefits Office. The injured employee will be assigned a Workers' Compensation Case Coordinator who will manage all forms and documents as well as assist the claimant through the process.

Upon receipt of the completed forms the case coordinator will create a claim file and initiate time loss if needed. The injured employee will not return to work until released to do so by their attending physician. The goal in each case is the restoration of the injured employee to maximum bodily function and gainful employment as soon as possible.

If you have questions, contact the Risk Management/Benefits Office at (509) 634-2028.



Policies and Procedures – Section #2

Accepting or denying a claim

The following issues will be examined to determine if a claim will be allowed or denied.

- Was the alleged injury a result of an incident, accident or occupational disease?
- Did the claim arise out of the covered person's employment?
- Did the claim arise while in the course and scope of employment and proximately out of covered employment?
- Did it arise while in the furtherance of the employer's interests?

Once a claim has been filed in a timely manner, it is then necessary to determine if the employee was acting in the course of employment at the time the injury is alleged to have occurred. For the claim to be accepted the employee must be acting at his/her employer's direction or in the furtherance of the employer's interests.

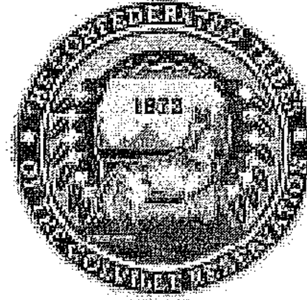
The circumstances surrounding the filed claim must involve one of the following:

Injury - Injury shall mean any physical impairment, including, without limitation, death and/or occupational disease. "Arising out of and in the course of employment" excludes any injury resulting primarily from the natural aging process, or normal daily activities, or an injury sustained during voluntary recreational or social activities. The injury must arise out of the course of employment, requiring medical services or resulting in disability or death; and further defined as a specific, traumatic incident at a definite time and place, while in the course of employment, that produces an immediate onset of pain and is established by medical evidence supported by objective findings.

Occupational Disease – Shall be only those diseases which arise out of and in the course and scope of the worker's employment. Such diseases shall have a direct casual connection with the employment and must have followed as a natural incident thereto from injurious exposure occasioned by the nature of employment. The disease must be incidental to the character of the business, occupation or process in which the worker was employed and not independent of the employment. The disease need not have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have resulted from the source as an incident and rational consequence. A disease which follows from a hazard to which a worker has or

would have been equally exposed outside of said occupation is not compensable as an occupational disease.

Mental Trauma Injuries- Mental traumas, disorders, and/or conditions, even if manifested in physical symptoms and/or related to stress, are not compensable injuries under this act, except that mental trauma is only recoverable if resulting from accidental physical injury traceable to a definite time, place, and cause rather than from repetitive mental trauma. **A mental trauma or emotional injury that arises principally from a personnel action, including, without limitation, a transfer, promotion, demotion, or termination is not a compensable injury under this act.**



Policies and Procedures – Section #3

Medical Services Provided

An injured employee is entitled to the following:

- Medical treatment that meets diagnosis-specific standards
- Help understanding the complexities of medical treatment
- A Treatment plan that includes return to work as part of a worker's recovery process
- Timely identification and access to healthcare providers who are qualified to treat the worker's illness or injury
- Encouragement to comply with treatment plans
- Accurate and timely descriptions of a worker's progressive functional capabilities
- Efficient and effective communication of necessary information with all appropriate parties

The attending physician will be notified at the beginning of a claim and informed of the accepted condition(s).

All medical treatment will be based on "objective findings". Any doubts about objective findings, will be clarified either with the attending physician or through an Independent Medical Examination (IME). The report of the IME shall be sent to the attending physician for comments. If the attending physician disagrees with the IME conclusion, they must provide the objective findings on which they base their disagreement.

If the Risk Management Department concludes there are no objective findings, they will advise the worker of the following in writing:

- They have been unable to obtain documentation of objective findings.
- Medical treatment on the claims will not be authorized.

The injured worker can discuss these concerns with their attending physician and, perhaps, obtain a more complete report. The Risk Management Department will consider any further reports provided by the attending physician.

The Risk Management Department will pay for "proper and necessary" health care services that are related to the diagnosis and treatment of an accepted condition. "Proper and necessary" refers to those health care services which are:

- Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;
- Curative or rehabilitative care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;
- Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and
- Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

The Risk Management Department will cover the following treatments without prior authorization:

- A maximum of twenty office calls for the treatment of the industrial condition, during the first sixty days, following injury. Subsequent office calls must be authorized. Reports of treatment rendered must be filed at sixty-day intervals to include number of office visits to date.
- Initial diagnostic x-rays necessary for evaluation and treatment of the industrial injury or condition.
- The first twelve physical therapy treatments, upon consultation by the attending doctor or under his direct supervision. Additional physical therapy treatment must be authorized and the request substantiated by evidence of improvement.
- Routine laboratory studies reasonably necessary for diagnosis and/or treatment of the industrial condition. Other special laboratory studies require authorization.
- Routine standard treatment measures rendered on an emergency basis or in connection with minor injuries not otherwise requiring authorization.
- Consultation with specialist when indicated.

The Risk Management Department **will not** cover the following treatments without prior authorization:

- Office calls in excess of the first twenty visits or sixty days whichever occurs first.
- X-ray and radium therapy.
- Diagnostic studies other than routine x-ray and blood or urinalysis laboratory studies.
- Physical therapy treatment beyond initial twelve treatments.
- Diagnostic or therapeutic injection.
- Home nursing, attendant services or convalescent center care.
- Provision of prosthetics, orthotics, surgical appliances, special equipment for home or transportation vehicle; custom made shoes for ankle/foot injuries

resulting in permanent deformity or malfunction of a foot; TNS units; masking devices; hearing aids; etc.

- Biofeedback program; pain clinic; weight loss program; psychotherapy; rehabilitation programs; and other programs designed to treat special problems.
- Prescription or injection of vitamins for specific therapeutic treatment of the industrial condition(s).
- Injections of anesthetic and/or anti-inflammatory agents into the vertebral facet joints.
- The long term prescription of medication.
- Diagnostic and surgical procedures which can be performed in other than a hospital inpatient setting.

The Risk Management Department **will not** pay for services performed by the following practitioners:

- Acupuncturists
- Herbalists
- Christian Science practitioners or theological healers
- Homoeopathists

The Risk Management Department **will not** allow nor pay for following treatment:

- Treatment to improve or maintain general health (i.e., prescriptions and/or injection of vitamins or referrals to special programs such as health spas, swim programs, exercise programs, athletic-fitness clubs, diet programs, social counseling).
- Continued treatment beyond stabilization of the industrial condition(s), i.e., maintenance care, except where necessary to monitor prescription of medication necessary to maintain stabilization i.e., anti-convulsive, anti-spasmodic, etc.
- Any treatment measure deemed to be dangerous or inappropriate for the injured worker in question.
- Treatment measures of an unusual, controversial, obsolete, or experimental nature.

The Risk Management Department will take any or all of the following steps when concerned about the amount or appropriateness of drugs the patient is receiving:

- Notify the attending physician of concerns regarding the medications such as drug interactions, adverse reactions, prescriptions by other providers;
- Require that the attending physician send a treatment plan addressing the drug concerns;
- Request a consultation from an appropriate specialist;
- Request that the attending physician consider reducing the prescription, and provide information on chemical dependency programs;
- Limit payment for drugs on a claim to one prescribing doctor.

If the attending physician or worker does not comply with these requests, or if the probability of imminent harm to the worker is high, the Risk Management Department

may discontinue payment for the drug after adequate prior notification has been given to the worker, pharmacy and physician.

Physician failure to reduce or terminate prescription of controlled substances, habit forming or addicting medications, or dependency inducing medications, after requested to do so for an injured worker may result in a transfer of the worker to another physician of the worker's choice.

Drugs are listed in the following categories:
Allowed - Drugs used routinely for treating accepted industrial injuries and occupational illnesses. Example: Nonscheduled drugs and other medications during the acute phase of treatment for the industrial injury or condition.
Prior authorization required - Drugs used routinely to treat conditions not normally accepted as work related injuries, drugs which are used to treat unrelated conditions retarding recovery from the accepted condition on the claim, and drugs for which less expensive alternatives exist. Example: All drugs to treat hypertension because hypertension is not normally an accepted industrial condition.
Denied - Drugs not normally used for treating industrial injuries or not normally dispensed by outpatient pharmacies. Example: Most hormones, most nutritional supplements.

In the event of complication, controversy, or dispute over the treatment aspects of any claim, the Risk Management Department will not authorize treatment until the attending doctor has arranged a consultation with a qualified doctor with experience and expertise on the subject. The Risk Management Department will make a decision once they receive notification of the findings and recommendations of the consultant.

Consultations may also be required in the following situations:

- All non-emergent major surgery on a patient with serious medical, emotional or social problems which are likely to complicate recovery.
- All procedures of a controversial nature or type not in common use for the specific condition.
- Surgical cases where there are complications or unfavorable circumstances such as age, preexisting conditions or interference with occupational requirements, etc.
- If the attending doctor, the Risk Management Department, or authorized department representative requests a consultation.
- Conservative care, (e.g., nonsurgical cases) extending past one hundred twenty days following initial visit.

Conditions preexisting the injury or occupational disease are not the responsibility of the Risk Management Department. When an unrelated condition is being treated concurrently with the industrial condition, the attending doctor must notify the department immediately and submit the following:

- Diagnosis and/or nature of unrelated condition.
- Treatment being rendered.

- The effect, if any, on industrial condition.

Temporary treatment of an unrelated condition may be allowed provided these conditions directly retard recovery of the accepted condition. The Risk Management Department will not approve or pay for treatment for a known preexisting unrelated condition for which the claimant was receiving treatment prior to his industrial injury or occupational disease, which is not retarding recovery of his industrial condition.

The Risk Management Department will not pay for treatment of an unrelated condition when it no longer exerts any influence upon the accepted industrial condition. When treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and the accepted industrial conditions.

All transfers from one doctor to another must be approved by the Risk Management Department. Normally transfers will be allowed only after the worker has been under the care of the attending doctor for sufficient time for the doctor to: Complete necessary diagnostic studies, establish an appropriate treatment regimen, and evaluate the efficacy of the therapeutic program. No reasonable request for transfer will be denied. The worker will be advised when and why a transfer is denied.

When a transfer is approved, the new attending doctor must be provided with a copy of the worker's treatment record by the previous attending doctor. X-rays in the possession of the previous attending doctor must be immediately forwarded to the new attending doctor for his or her retention as long as the worker remains under his or her care. Copies of x-rays and other records may be provided in lieu of originals.

The Risk Management Department reserves the right to require a worker to select another doctor or specialist for treatment, under the following conditions:

- When more conveniently located doctors, qualified to provide the necessary treatment, are available.
- When the attending doctor fails to cooperate in observance and compliance with the Risk Management Department rules.
- In time loss cases where reasonable progress towards return to work is not shown.
- Cases requiring specialized treatment, which the attending doctor is not qualified to render, or is outside the scope of the attending doctor's license to practice.
- Where the Risk Management Department finds a transfer of doctor to be appropriate and has requested the worker to transfer in accordance with this rule, the Risk Management Department may select a new attending doctor if the worker unreasonably refuses or delays in selecting another attending doctor.
- In cases where the attending doctor is not qualified to treat each of several accepted conditions.
- No transfer will be approved to a consultant or special examiner without the approval of the attending doctor and the worker.

Transfers will be authorized for the foregoing reasons or where the Risk Management Department in its discretion finds that a transfer is in the best interest of returning the worker to a productive role in society.

When a worker's care is transferred to another doctor each doctor must submit a separate bill to the Risk Management Department for their portion of the care.

In some cases, treatment by more than one practitioner may be allowed. The Risk Management Department will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system and/or require specialty or multidisciplinary care.

When requesting consideration for concurrent treatment, the attending doctor must provide the Risk Management Department with the following:

- The name, address, discipline, and specialty of all other practitioners assisting in the treatment of the injured worker and an outline of their responsibility in the case and an estimate of the length of the period of concurrent care.

When concurrent treatment is allowed, the Risk Management Department will recognize one primary attending doctor, who will be responsible for prescribing all medications; directing the over-all treatment program; providing copies of all reports and other data received from the involved practitioners and, in time loss cases, providing adequate certification evidence of the worker's inability to work.

The Risk Management Department will approve concurrent care on a case-by-case basis. Consideration will be given to all factors in the case including availability of providers in the worker's geographic location.

Elective surgery for an unrelated condition is not normally permitted during hospitalization for an industrial condition. Under some circumstances unrelated elective surgery may be permitted through prior agreement and approval by the Risk Management Department provided the unrelated surgery is not more extensive than the procedure for the industrial condition. The requesting doctor must submit a written request and identify which services are needed due to the industrial injury and which are needed due to unrelated conditions, along with an estimate of what effect, if any, the unrelated surgery will have on the accepted conditions and recovery time from surgery.

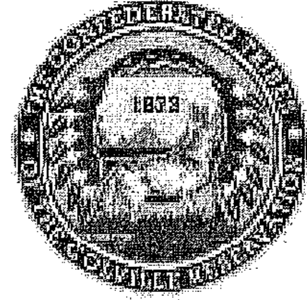
Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker's attending doctor.

A progress report must be submitted to the attending doctor and the Risk Management Department following six treatment visits or one month, whichever comes first. Massage therapy treatment beyond the initial six treatments will be authorized only upon substantiation of improvement in the worker's condition in terms of functional modalities, i.e., range of motion; sitting and standing tolerance; reduction in medication; etc. In addition, an outline of the proposed treatment program, the expected restoration goals,

and the expected length of treatment will be required.

Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the Risk Management Department.

Massage therapy treatments exceeding once per day must be justified by attending doctor.



Policies and Procedures – Section #4

Return to Work

The goal of the Risk Management Department is to return an injured worker to work with the employer-of-injury or current employer as soon as it is safe. Our return-to-work program shifts the focus from disability to return-to-work: judiciously, timely and cost-effectively. Our goal is to prevent the barriers that develop from prolonged disability and removal from the labor force. We will accomplish this by accommodating the temporary physical limitations that a worker has while still undergoing medical treatment and recovering from their industrial injury, or occupational disease.

Benefits to the worker include:

- Increased physical activities that when preformed within the limits set by the attending physician, help speed up the worker's medical recovery.
- Getting the injured worker out of his or her home and back to a work routine, ending the worker's isolation from co-workers, this will improve the worker's mental state.
- The worker's financial position will improve, because light duty work pays better than Time Loss.
- The worker health and welfare benefits will continue at the level provided at the time of injury (in accordance with benefit plans).

The Risk Management Department also benefits from this type of program as it reduces lost workdays while keeping the trained and skilled workers at work. This reduces claim costs and the possibility of loosing a valued employee.

Due to the physical restrictions imposed by the injury, an adjustment to the way a job is performed might be made to accommodate the worker's limitations during the recovery phase. These adjustments, which may be temporary or permanent, might be accomplished in one or more of the following ways:

Job restructuring:

- Altering or modifying the assignments, duties, tasks or hours of the job. Examples are part-time work, limited or modified duties, adding more rest breaks, trading jobs, etc.

Work-site adjustments:

- Altering or modifying the work site, including the environment. Examples are a change of position, altering repetitions of work, raising or lowering workbenches, desks, shelves etc.

Tools, equipment or appliances:

- The use of tools, equipment or appliances to enable the worker to perform the duties of the job while accommodating his or her medical limitations. Examples are ergonomic chairs, adjustable tables, wrist supports, arm rests, telephone headsets, modified hand tools, lifting devices, hoists, conveyors, rubber stress mats for standing etc

Key personnel involved in a return to work program:

- Department manager
- Department supervisors/leads
- Claims manager/administrator
- Vocational rehabilitation counselor

The steps in the program include:

- Identifying one or more temporary transition duty positions that could be offered to employees recovering from an industrial injury. The position will identify useful tasks that could be combined into a temporary position and clarify physical demands of the task(s).
- Developing written physical demand job analyses for as many positions as possible. These analyses will be easily accessible by the company claims coordinator.
- Furnishing the medical provider, with a copy to the injured worker, the job analysis for the job of injury and transitional work.
- Providing a cover letter requesting medical approval of transitional work.
- Requesting an estimate of when full duty may be resumed.

Once the medical provider has given authorization, the injured worker will be offered the position in writing. The offer will indicate the nature of the work and the shift hours, wages to be paid, who, when, and where to report to work. The injured worker will be required to sign the offer to verify acceptance or rejection of the job offer. A rejection of the offer may result in a loss of time loss benefits.

Before beginning work, both the worker and supervisor will review the employee's limitation and the job duties of the transitional work, to assure the recovering employee does not aggravate their condition.

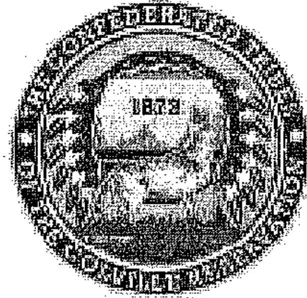
If in the medical provider's opinion, the injury will prevent the worker from returning to the job of injury, the Risk Management Department will request analysis of additional return to work options for the worker. The claims manager may assign a Vocational Rehabilitation Counselor or Vocational Services Specialist to the claim.

During the transitional work period the Risk Management Department will maintain communication with the worker, supervisor and medical provider to assure that recovery is progressing as expected.

When offering the return-to-work position the Risk Management Department will identify the terms of the position (such as the length of time the position will be available, or if it is a permanent position.).

The injured worker and his/her supervisor will assure that medical limitations contained in the employment agreement are adhered to. Under the medical provider's guidance, on-the-job physical conditioning efforts may be increased in order to return the employee to full duty.

The Risk Management Department may enlist the assistance of a Vocational rehabilitation counselor to help the injured worker achieve maximum medical and vocational outcomes in a timely and cost effective manner. The counselor may be hired for a complete assessment or just one or two task assignments to obtain the necessary information.



Time Loss Payments

The intent of the Time Loss Policy is to provide compensation to restore a portion of a worker's wage loss while temporarily unable to work in any capacity due to an industrial injury or occupational disease.

Documents used to determine if Time Loss Benefits are due include:

- Employee Application for Compensation and Report of Injury or Occupational Disease
- Disability Claim Attending Physician Statement
- Supervisor's Accident Report of Injury

The claim arrival date will be the date all the required documents are received by the Risk Management Department. A determination on claim acceptance or denial will be made once the claim arrival date has been established.

When Time Loss compensation is payable, the first payment thereof shall be made within fourteen (14) calendar days after acceptance of the claim and shall continue at regular semimonthly or biweekly intervals.

The Risk Management Department determines timeliness of first time loss payment by counting fourteen (14) calendar days from claims acceptance. Day one would be the day following claim acceptance.

- The day the time loss compensation is paid to the worker is included in the calculation. The first payment is late if paid after the fourteenth (14) calendar day, unless the fourteenth (14) calendar day falls on a holiday or Sunday, in which case the following day would constitute the fourteenth (14) calendar day.
- Sometimes a condition will not be disabling until surgery is performed. In these instances, time loss compensation becomes payable effective the date of surgery unless otherwise medically justified, and payment of time loss must be made within fourteen (14) calendar days of the last day worked.

Payments due to an injured worker under the age of eighteen (18) years "...shall be paid to his/her parent, guardian, or other person having legal custody". The parent or legal guardian can, upon written authorization, allow payment to be made directly to the minor worker.

Time loss benefits are never provided for the date of injury, and are not paid for the first three calendar days following the day of injury unless the injured worker's disability continues for a period of fourteen (14) consecutive calendar days from the date of injury.

The determining factor is the injured worker's disability on the fourteenth (14) calendar day. Payment would be made for the waiting period if the worker remains disabled on the fourteenth (14) calendar day, less the time actually worked. If a worker attempts to return-to-work and is able to work less than four hours, there should be no time loss deduction for that day.

Examples:
Ted was injured on June 2nd. He was unable to work June 3rd through June 14th. He returned to work on June 15th.

How many days of time loss is Ted eligible for?

Ted is eligible for 9 days of time loss. He is not eligible for the date of injury, June 2nd, nor is he eligible for the three days following as he returned to work on the 13th day.

Mary is injured on September 15th; she is certified to be off work through October 2nd, and returns to work on the 3rd.

How many days of time loss is Mary eligible for?

Mary is not eligible for September 15th as this is her date of injury. However, since Mary was off work for 17 consecutive days, the waiting period is waived and she is paid for all 17 days.

Time Loss compensation calculations are based on the wages the injured worker receives in his/her regular work schedule. These wages must include all employment.

Compensation includes:

- Gross cash wages from employer of injury
- Wages from second job

The following schedule is used to determine the number of days a worker works in a month:

Days worked Per Week	Multiply Daily Wages Times
7	30
6	26
5	22
4	18
3	13
2	9
1	5

Wages are determined by multiplying the daily wage by the number of days the worker is "normally employed"' e.g. If "normally employed" 5 days per week, multiply the daily wage by 22; if employed 3 days per week, multiply the daily wage by 13.

An injured worker will receive a percentage of wages based upon marital status and the number of dependents at the time of injury. The worker is entitled to:

Single with no dependents	60%	Married	65%
Each qualified dependent under age 18	2%	Each qualified dependent under 18	2%
Maximum of 5 dependents	70%	Maximum of 5 dependents	75%

Any child conceived prior to the date of injury but born after the date of injury entitles the injured worker to an additional 2% of gross monthly wage effective the date of the birth of the child.

If the dependent is 18 years old and is attending an accredited school, the dependents portion continues up to the age of 23. (School attendance must be documented). A dependent child, who is an invalid, continues to receive benefits beyond the age of 18 as long as he or she is a dependent.

If the worker necessarily incurs traveling expenses in attending an examination pursuant to the request of the Risk Management Department, such traveling expenses shall be repaid to him or her out of the accident fund upon proper voucher and audit.

The Risk Management Department may under certain circumstances suspend the compensation of an injured worker for unacceptable behavior. The use of this type of penalty should not be casually considered or implemented and is to be used as a last resort after proper warning has been given to the worker of the consequence of the following actions:

- Refusal to submit to or obstruction of medical examination requested by the Risk Management Department "at a place reasonably convenient for the worker."
- Persistence of the worker in "unsanitary or injurious practices, which tend to impede or retard his or her recovery."
- Refusal to submit to medical or surgical treatment "as is reasonably essential to his or her recovery."
- Refusal or obstruction of vocational evaluation or rehabilitation or failure to cooperate in "reasonable effort" at such rehabilitation.

Here are the items included in a suspension letter:

- What do you want them to do - This should be specific. Just telling them that they must cooperate is not specific. What exactly do they need to do to cooperate? Attend an exam or agree to attend an exam? Have the surgery or agree to have the surgery? You must be specific as to what you consider to be cooperating.
- Why you want them to do it - This should be supported by medical or vocational information. You can't make them agree to have a surgery if the doctor has offered it as only one of several treatment options. The doctor must say that surgery is the only treatment option.

- When you want them to do it - You must give a specific time frame for them to respond, as well as how you want them to respond. You should always get it in writing.
- What will happen if they don't - You must let them know what benefits are in jeopardy.

If an injured worker is paid more time loss compensation or permanent partial disability than he/she is entitled, an overpayment exists. To compute the amount of the overpayment, a determination of the correct benefits due is subtracted from the amount of benefits paid the worker. The difference is the overpayment. Overpayments can be deducted from future time loss or permanent partial disability benefits.

If an overpayment is made, the worker will be notified of the existence of the overpayment and informed of the Risk Management request for recovery of the overpayment.

When a large overpayment exists and disability benefits continue to be awarded, there is an option of deducting partial amounts of the overpayment for the ongoing benefits. In considering the amount to deduct from ongoing benefits several factors should be considered. Of primary concern is that the amount deducted from each payment should not be so large as to place a hardship upon the injured worker. Secondly, steps should be taken to ensure that the overpayment is recovered. An overpayment, which exists at the time of closure, can be deducted from a permanent partial disability award if such an award is paid. Each case will present its own circumstances.

Recovery of overpayments can be recovered from a second claim in which compensation is being paid.

If the Risk Management Department receives a "child support" lien, an initial determination is made as to the type of benefits for which the lien is intended (Time Loss Payments, PPD). Once the intent of the lien is properly recognized, the injured worker must be informed of the action to be taken.

Chapter 6-15 WORKERS COMPENSATION CLAIMS ACT

GENERAL PROVISIONS

6-15-1 **Purpose**

This act shall be known and cited as the "workers compensation claims act" (hereinafter "the act"). The purpose of the act is to establish the rights and benefits of employees of the Confederated Tribes of the Colville Reservation (hereinafter "tribe") for on-the-job bodily injuries due to accidents or occupational disease as set forth herein.

6-15-2 **No Waiver of Sovereign Immunity**

Nothing in the act shall be deemed or construed as waiver of sovereign immunity by the tribe and/or any of its affiliated entities. The State of Washington's statutory workers' compensation system shall not apply to employees of the tribe or any of its affiliated entities. The tribe does not consent to the jurisdiction of any state's workers' compensation appeals board or to the jurisdiction of any other court of law or equity.

6-15-3 **Insurance**

Every employer must provide for workers compensation benefits.

6-15-4 **Definitions**

Pronouns of the masculine gender used in the act shall apply to both sexes. Unless stated otherwise in a specific section of the act, time limits shall be calculated using calendar days.

Unless the context otherwise requires, the definitions which follow govern the construction and meaning of the terms used in the act:

(a) "Administrator" shall mean the workers' compensation program of the tribe, or its successor in duties.

(b) "Attending physician" shall mean the physician, or other approved medical care provider responsible for planning, provision, and oversight of medical treatment to a covered worker who sustains a covered injury.

(c) "Average weekly wage" shall be determined as follows:

(1) For a covered worker hired to a regular, full- or part-time position expected to last at least 13 weeks, the average weekly wage shall be calculated based on the preceding thirteen (13) weeks of the covered worker's actual wage earning from a covered employer. In the case of a worker who has not worked for a covered employer within the immediate preceding thirteen (13) weeks, the average weekly wage shall be calculated based on the salary level the worker was hired at or is currently receiving.

(2) For covered worker hired on a temporary, emergency or special projects basis who has continuously worked for a minimum of thirteen (13) weeks, the average weekly wage shall be calculated as provided in paragraph (1) above.

(3) For covered workers hired on a temporary, emergency, or special projects basis who have not continually worked for the preceding 13 weeks, the average weekly wage shall be calculated by taking the expected total gross wages and divide by the expected number of work weeks.

(4) For covered workers serving as volunteers, the average weekly wage shall be the salary of similarly paid positions for the covered employer performing similar work.

(5) For purposes of this definition, the work week shall be as defined by the personnel manual or policy applicable to the covered employee at the time of injury.

(d) "Benefits" shall mean the indemnity and medical payments provided by this act. "Indemnity" shall mean total disability and partial disability income benefits and impairment payments; and "medical" shall mean medical expense, mileage, and other expenses associated with medical treatment.

(e) "Child" includes dependent natural children, dependent stepchildren, adopted children; but does not include married children unless they are shown to be dependent.

(f) "Claimant" means the injured covered worker, or in the event of death of the covered worker, dependents of the deceased.

(g) "Consulting physician" shall mean the physician, other health care provider or other care expert that is retained by the administrator to assist the administrator in carrying out his duties and responsibilities under this act. Such activities may include, but are not limited to, determination of the validity of a claim; review of an attending physician's diagnosis and treatment plans; determination of MMI; determination of impairment rating. At the discretion and expense of the administrator, an injured worker may be required to be seen by the consulting physician to assist in making any required recommendations to the administrator.

(h) "Course and scope of employment" shall mean the employer's employment of the covered worker at the time the injury occurred. An injury must arise out of and be in the course and scope of employment, and the worker must be acting in the furtherance of the employer's interest at the time of the incident and/or accident, in order for a claim to be compensable.

(i) "Covered employer" and "employer" shall mean the tribe and its agencies, and any tribal corporations and enterprises.

(j) "Covered worker" and "worker" means every person who has entered into the employment of or performs work for an employer, works under contract of service, express or implied, or apprenticeship, for an employer, every executive offer elected or appointed and empowered under and in accordance with the charter and bylaws of a corporation, including a person holding an official position, or standing in a representative capacity of the employer, including officials (elders) elected or appointed by the tribe, compensated monetarily or otherwise, except as hereinafter specified. The terms covered worker and worker shall not include an independent contractor working under contract for an employer, whether that contract be express or implied. Covered workers shall include all persons employed by the employer regardless of where they work, whether it be on or off the Colville Reservation. Covered workers shall include volunteers or other persons providing work for an employer who do so without receiving compensation. Covered workers shall not include persons serving in the tribal police department reserve program or volunteer firefighters working for the tribal fire department or other volunteer positions covered by a tribal accident insurance policy.

(k) "Death" is any fatality of the covered worker proximately and directly caused by work injury or occupational disease.

(l) "Dependents" are the following persons, and they shall be deemed to be the only recognizable dependents under the provisions of this act:

(1) The widow or widower, if legally married and living with the deceased at the time of deceased's death and legally entitled to be supported by the deceased as a dependent defined by the most recent filed 1040 federal tax return. For purposes of this act, a covered worker may, in a written self-declaration to be provided by the employer, designate a person as their domestic partner, which person shall be treated as a dependent

widow(er) if the person was living with the deceased covered worker at the time of his/her death and listed on the most recently filed 1040 federal tax return.

(2) A child, natural or adopted, under 18 years of age, or incapable of self-support and unmarried; or a child under 25 years of age enrolled as a full-time student in an accredited education institute at the time of the covered worker's death.

(m) "Disability" means the inability of the covered worker to obtain and/or retain wages equivalent to the pre-injury wage rate as a result of a direct loss of functional capacity compromising that individual's ability to perform the necessary duties of the job. This functional loss must be directly and materially attributable to a compensable work-related injury and/or occupational disease and must be supported by the worker's attending physician and, if requested by the administrator, the consulting physician. "Partial disability" is distinguished as any incapacity less than 100% inability as defined above.

(n) "Impairment" means any anatomic or functional abnormality or loss existing after reaching maximum medical improvement (MMI) as defined herein that results from a compensable injury and/or occupational disease and is reasonably presumed to be permanent based on reasonable medical probability.

(o) "Injury" shall mean any physical impairment, including, without limitation, death and/or occupational disease as further herein defined. "Arising out of and in the course of employment" excludes an injury sustained while a covered worker is at home or preparing for work. "Injury" excludes any injury resulting primarily from the natural aging process, or normal daily activities, or an injury sustained during voluntary recreational or social activities. The injury must arise out of and in the course of employment, requiring medical services or resulting in disability or death; and is further defined as a specific, traumatic incident at a definite time and place, while in the course of employment, that produces an immediate onset of pain and is established by medical evidence supported by objective findings.

(p) "Intoxication" means blood alcohol content in excess of .02 percent or conviction of the offense of driving while intoxicated (or words to that effect) by any jurisdiction or, loss of the normal use of one's mental and/or physical faculties resulting from the voluntary introduction into the body of (1) an alcoholic beverage; (2) a controlled substance; (3) a mind-altering drug and/or hallucinogenic; (4) an abusable glue or aerosol pain; or (5) any other similar substance.

(q) "Maximum medical improvement" (MMI) means the earlier of:

(1) The point at which further material recovery from or last improvement to an injury can no longer reasonably be anticipated, based on the reasonable medical probability; or

(2) The expiration of 36 months from the date incapacity income benefits begin to accrue.

(r) "Occupational disease" shall be only those diseases which arise out of an in the course and scope of the worker's employment. Such diseases shall have a direct causal connection with the employment and must have followed as a natural incident thereto from injurious exposure occasioned by the nature of the employment. Such disease must be incidental to the character of the business, occupation, or process in which the worker was employed and not independent of the employment. Such disease need not have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have resulted from that source as an incident and rational consequence. A disease which follows from a hazard to which a worker has or would have been equally exposed outside of said occupation is not compensable as an occupational disease.

(s) "Settlement" shall mean the date the release of all claims is executed and the monetary terms of the agreement met.

(t) "Tribal Court" shall mean the Colville Tribal Court.

(u) "Tribal workers benefit system" shall mean this act, any and all rules and regulations promulgated hereunder.

(v) "Tribe" and "tribal" mean to refer to the Confederated Tribes of the Colville Reservation, a federally recognized Indian tribe, and its agencies, and any tribal corporation and enterprises.

6-15-5 **Acknowledgement of Act**

(a) All covered workers and persons asserting a claim shall be conclusively presumed to have elected to take workers benefits in accordance with the tenets, conditions, and provisions of this act by virtue of employment with the tribe or other employers as defined herein. The tribal workers benefits system is the exclusive remedy for any covered accidents and injuries. All covered workers and/or persons asserting a claim for workers benefits acknowledge that the tribe is a federally recognized American Indian tribe and is exercising its inherent sovereign authority in providing workers benefits under this code.

(b) The employer shall be responsible for and shall post in a conspicuous location a notice as follows:

NOTICE TO TRIBAL GOVERNMENT AND ENTERPRISE EMPLOYEES

AS EMPLOYEES OF THE CONFEDERATED TRIBES OF THE COLVILLE RESERVATION OR ITS ENTERPRISES, YOU ARE INSURED FOR ON-THE-JOB INJURIES UNDER THE TRIBAL WORKERS COMPENSATION CLAIMS ACT

If you are injured or sustain an occupational disease while at work, you may be entitled to benefits as provided by the Tribal Workers Compensation Claims Act, Chapter 6-15 of the Colville Tribal Code. NOTIFY YOUR EMPLOYER IMMEDIATELY OF ANY INJURIES, NO MATTER HOW SLIGHT. If you fail to do so, you may lose your benefits under the tribal workers benefits system. In no event shall benefits be paid to a worker who failed to notify his or her employer within fourteen (14) working days after sustaining such work-related injury, excepting cases where an extraordinary reason prevented the worker from reporting the injury or occupational disease to the employer in a timely manner.

It is your responsibility to file a claim for benefits under the act with the administrator of the system. You are required to file a claim for any injuries or occupational disease no more than thirty (30) days after you have knowledge thereof. It is your responsibility to obtain any necessary forms from the tribal workers benefits system claims administrator at:

Your exclusive remedy for any work connected injury or disease is through the tribal workers benefits system. The state's workers compensation system has no authority to accept a claim from you related to employment by the Confederated Tribes of the Colville Reservation, a sovereign Indian Nation employer, which is exclusively under the jurisdiction of the tribal workers benefits system.

6-15-6 **Notification to Employer of Injury by Worker**

(a) Any person claiming benefits under this act must notify his supervisor and the administrator of any and all injuries immediately, and in no event later than fourteen (14) working days from the date of occurrence. Failure to report such on-the-job injury shall result in the worker's forfeiture of benefits under this act, unless the claimant can demonstrate an extraordinary reason that prevented the reporting of the injury or occupational disease in a timely manner.

(b) The supervisor must submit a supervisor's report to the administrator within seven (7) days of receipt from the covered worker.

6-14-7 **Time Limit for Reporting of Incidents and Filing of Claims**

(a) Claims for injury shall be made by the covered worker to the administrator within thirty (30) days of the date of occurrence. For purposes of this act, a covered worker filing a claim for benefits under this act with the human resources office shall constitute filing a claim with the administrator.

(b) Claims for occupational disease shall be made by the covered worker to the administrator within thirty (30) days from the date of first notice to the claimant by a physician or from the date of manifestation of symptoms, whichever is earliest, but in no event longer than six (6) months from the date the worker terminates his employment with the tribe.

(c) Failure to give notice of injury to the employer as required by section 6-15-6 of the act or to file a claim with the administrator, within the time limit set forth in this section shall constitute a forfeiture by the covered worker, or his representatives in case of death, of all benefits available and payable under this act.

6-15-8 **Burden of Proof**

The burden of proof shall rest upon the covered person, or his dependents in the case of death, to prove:

(1) That the injury alleged was a result of an incident, accident or occupational disease;

(2) That it arose out of the covered person's employment;

(3) That it arose while in the course and scope of employment and arose proximately out of covered employment; and

(4) That it arose while in the furtherance of the employer's interests.

6-15-9 **Right to Waive Defenses**

The administrator shall have the right and power to waive any and all defenses affecting the compensability of a covered injury under this act.

6-15-10 **Guardian for Minor or Incompetent**

Any person who is mentally incompetent and/or under the age of 18 and is entitled to receive compensation under this act, shall be appointed a guardian or other representative by the tribe if a guardian has not been appointed in a prior action.

[6-15-20 to 6-15-39 RESERVED]

ADMINISTRATIVE DUTIES AND POWERS

6-15-40 **Custodian Duties**

The administrator or its designee shall be the payor of the workers benefits, and shall be the custodian of all claim files and related documents.

6-15-41 **Payment and Distribution of Benefits**

The administrator shall administer this act in accordance with the terms and conditions described herein and remit payment for all matters of benefit claims as provided for in this act. Further, the administrator shall have the authority to determine the distribution of benefit checks.

6-14-42 **Administrator Powers and Duties**

(a) The administrator shall be empowered to request medical reports, police reports, autopsy reports, and special investigations, engage the services of adjusters and consultants, and perform other activities as required to process any claim for benefits or to further this act.

(b) The administrator may retain a consulting physician for purposes of assisting the administrator to carry out the duties and powers of this act.

(c) The administrator shall maintain complete and accurate administrative records and claim files on all activities relating to the claims made under this act. All closed files shall be preserved for not less than seven (7) years.

6-15-43 Acceptance/Denial of Claim

Upon receiving a claim for benefits from an injured worker, the administrator shall promptly investigate the claim and begin payment of compensation within 21 days of a valid claim or the administrator shall send the claimant written notice, within 21 days, that further investigation is needed and the reasons for further investigation. The administrator shall complete its investigation within 45 days of receipt of the claim and shall commence the payment of benefits or notify the claimant in writing that the claim is denied.

COVERAGE AND COMPENSABILITY

6-15-50 Entitlement of Benefits

(a) Any claimant for benefits under this act shall be responsible for filing his claim with the administrator.

(b) Coverage exists under the act for a covered worker's injury without regard to fault or negligence if the injury arises out of and in the course and scope of employment and if the worker was acting in furtherance of the employer's interest at the time of the injury and/or incident, including, without limitation, any covered worker whose work at the time of injury was subject to the Longshore and Harbor Workers Compensation Act (33 U.S.C. §§ 901-950), the Jones Act (46 U.S.C. § 30104 or any other federal workers compensation acts. If an injury is an occupational disease as defined herein, the employer in whose employ the worker was last injuriously exposed to the hazards of the disease is considered to be the employer of the worker for purposes of obtaining benefits under this act.

6-15-51 Disclosure of Preexisting Disabilities/Conditions

(a) All workers shall disclose any preexisting physical or mental conditions, disorders, and disabilities that could potentially affect or impair the worker's ability to perform in a reasonable and safe manner the activities involved in the position in which he or she works. Disclosure shall be made in the employment application or interview before commencing employment or before commencing new job duties after job reclassification, reassignment, promotion, demotion, or other change in job duties. The content of such disclosure shall be made promptly by the covered worker after submitting a claim for benefits under this act.

(b) When a worker has a preexisting disability or condition which is aggravated, the tribal workers benefit system shall only be responsible for the portion of the injury attributable to the aggravation.

6-15-52 Mental Trauma Injuries

(a) Mental traumas, disorders, and/or conditions, even if manifested in physical symptoms and/or related to stress, are not compensable injuries under this act, except that mental trauma is only recoverable if resulting from accidental physical injury traceable to a definite time, place, and cause rather than from repetitive mental trauma.

(b) Regardless of subsection 6-15-52(a), a mental trauma or emotional injury that arises principally from a personnel action, including, without limitation, a transfer, promotion, demotion, or termination is not a compensable injury under this act.

6-15-53 **Going to and Returning from Work**

An accident and/or incident occurring to a worker while on the way to or from work, including lunch break, is not within the course and scope of employment except when such traveling is directly connected with the worker's work and in furtherance of the employer's interest. This exception will not apply if the worker deviates from a reasonably direct route of travel and/or is not acting in the interests of the employer.

6-15-54 **Benefits Precluded by Neglect and/or Refusal of Worker to Submit to Treatment**

(a) No benefits shall be payable for the death and/or disability of a worker if the worker's death and/or disability is caused by, or the worker's disability aggravated, caused or continued by, an unreasonable refusal and/or neglect to submit to and/or follow any competent or reasonable surgical or medical treatment, medical aid, or advice. A worker who has refused and/or neglected to submit to medical and/or therapeutic treatment, or to take medications prescribed, will be deemed to have reached maximum medical improvement as defined herein. Any such existence of a disability that could have been reasonably treated to success with reasonable medical probability will be discontinued in determining the appropriate incapacity rating as described herein.

(b) Any covered worker entitled to benefits under this act shall be presumed to have reached maximum medical improvement if such claimant has refused and/or neglected to seek appropriate medical treatment within three (3) months from the date of occurrence or from the last date of prior treatment.

6-15-55 **Injury or Death by Consumption and/or Application of Drugs and/or Chemicals**

No benefits of any nature shall be payable for injury and/or death caused or contributed to by any drug, including narcotics and hallucinogens, whether organic or chemical in nature, or any gas, vapors, and/or fumes taken and/or inhaled voluntarily, or by voluntarily poisoning, except those drugs prescribed by a physician or other practitioner licensed to prescribe such medication.

6-15-56 **Intoxication**

No benefits of any nature shall be payable for any covered worker injured or killed while intoxicated as defined in section 6-15-4(p), regardless of whether or not the intoxicated condition was the proximate cause of the injury or death. It is only necessary to prove that the covered worker was intoxicated at the time of the incident or accident to deny benefits under this act. All workers accepting employment with an employer and under this act, agree to submit to post-incident/post-accident drug and alcohol screening as authorized in the applicable tribal personnel policies, and agree to waive any privilege associated with the results of said tests.

6-15-57 **False Statement or Representation to Obtain Compensation; Penalty and Forfeiture**

If, in order to obtain any benefits under the provisions of this act, any person willfully makes a false statement or representation, they shall forfeit all rights to compensation, benefits, or payment upon proof that the offense was committed. Any claim resulting from an employment-related aggravation of a preexisting condition which was not disclosed as required under this act will be declined by the administrator pursuant to section 6-15-51.

6-15-58 **Injuries Resulting from Self-Inflicted Injuries, Willful Misconduct, "Horseplay", or Safety Violation**

No benefits of any nature shall be payable for any covered worker's injury or death caused by a covered worker's willful intention to injure himself or another. An injury sustained during "horseplay" is not incurred in the course and scope of employment, and thus such an injury under this act is not compensable. In addition, the willful disregard of a safety order from the employer to the worker to wear or use a safety device and/or to perform work in a certain manner may cause

such person to forfeit all rights to compensation, benefits, or payment upon proof that the offense was committed and that such disregard or performance was the direct and proximate cause of the injury, death, and/or occupational disease. A covered worker's willful disabling of safety devices on equipment constitutes a willful intention to injure himself thereby precluding eligibility for her benefits under this act.

6-15-59 **Injuries Resulting from Natural Causes**

No benefits of any nature shall be payable for any covered worker injured or killed when the injury or death results from natural causes, i.e., heart attack, stroke or other natural function failure, which does not arise out of the course and scope of employment while the worker was acting in furtherance of the employer's interest.

6-15-60 **Recreational, Social or Athletic Activities**

(a) No benefits shall be payable for any covered worker injured or killed if the injury or accident occurred as a result of the worker's voluntary participation in an off-duty, recreational, social, or athletic activity not constituting part of the worker's work-related duties, except where these activities are expressly required by the employment.

(b) No benefits under this act shall be payable to any covered worker if the injury, disease, or death arises from participation in voluntary physical fitness activities during the regular work day, regardless of whether the employee is or is not compensated for the time in which the physical fitness activities take place.

6-15-61 **Injuries Caused by Third Parties**

No benefits of any nature shall be payable for any covered worker injured or killed as the result of an act of a third party, including co-workers, who intended to injure the worker because of reasons personal to that worker and not directed at the worker for reasons related/relevant to his employment.

6-15-62 **Secondhand Smoke**

No benefits under this act shall be payable to or on behalf of any covered worker injured or killed as a result of exposure to or injury by secondhand smoke.

BENEFITS – GENERAL PROVISIONS

6-15-70 **Right to Compensation and Medical Treatment Benefits**

Every covered worker coming within the provisions of the act who is injured, and in the event of a worker's death, the dependents of every such covered worker, arising out of and in the course and scope of employment and while acting in furtherance of the employer's interest at the time of the incident and/or accident, unless the injury is otherwise limited or excluded by the terms and conditions of this act, shall be entitled to receive, and shall be paid, for loss sustained on account of the injury, death and/or occupational disease, such benefits as provided under the act.

6-15-71 **Workers Benefit as Exclusive Remedy**

The rights and remedies provided by the provisions of the act for a worker on account of injury or occupational disease for which benefits under the act are recoverable, shall be the exclusive and only rights and remedies of such worker, the worker's personal or legal representative, dependents, or next of kin, at common law or otherwise, on account of such injury and/or occupational disease against the employer, the employer's representatives, insurer, guarantor or surety, for any matter relating to the occurrence of or payment for an injury or death covered under this act. To that end, all civil causes of action against the covered employer and its employees, arising from said injuries or death, and the jurisdiction of all courts over such causes of action are hereby abolished and barred, except as specifically provided by this act.

6-15-72 **Effect of Compensation Paid in Other Jurisdictions or Third Party Recovery**

An injured worker who pursues and recovers compensation under laws of another jurisdiction or

from a third party shall notify the administrator. The injured worker forfeits compensation under this act in proportion to their recoveries from the other jurisdiction or third party.

6-15-73 Liability of Third Parties - Subrogation

(a) The employer and/or their representative, insurer, guarantor, or surety shall be subrogated to the common law rights of the worker to pursue any claims for compensation against any third party that is liable for the death of, or injuries to, said worker arising out of and in the course and scope of employment and while the worker was acting in the furtherance of the employer's interest to the extent of the benefits bestowed upon the said worker.

(b) In case of recovery, the administrator shall enter judgment for distribution of the proceeds thereof as follows:

(1) A sum sufficient to repay the employer and/or the administrator for the amount of the compensation actually paid to the worker under this act up to that time;

(2) A sum sufficient to pay the employer the present worth, computed at the current legal interest rate for court judgments and decrees, of the future payments of compensation for which the employer is liable, but the sum is not the final adjudication of the future payments which the worker is entitled to receive and if the sum received by the employer is in excess of the amount required to pay the compensation, the excess shall be paid to the worker.

(3) The balance, if any, shall be paid over to the worker.

(c) For subrogation purposes hereunder, any payment made to a covered worker, his guardian, parent, next of kin, or legal representative, by or on behalf of any third party, his or its principal or agent liable for, connected with, or involved in causing an injury to such worker shall be considered as having been so paid as damages resulting from and because said injury was under circumstances creating a legal liability against said third party, whether such payment be made under a covenant not to sue, compromise settlement, denial of liability, or otherwise.

6-15-74 Assignability of Benefits – Attachment of Liens

Benefits received under this act are not assignable, except that a legal beneficiary may, assign the right to death benefits. Income from death benefits are subject only to the following liens or claims, to the extent of any income or death benefits that are unpaid on the date the administrator receives written notice of the lien, judgment, or claim in the following order of priority:

(1) Court-ordered child support issued or recognized by the Courts of the Confederated Tribes of the Colville Reservation;

(2) A subrogation interest established under this act; and

(3) Debts owed to the tribe.

6-15-75. Aggravation of Preexisting Disease or Condition

If a covered worker is suffering from a preexisting disease and/or injury at the time an occupational incident, accident and/or disease occurs or arises in the course and scope of employment and the worker was acting in furtherance of the employer's interest at the time of the injury and/or incident, and the pre-existing disease and/or injury is aggravated thereby, the aggravation of the disease or injury is, subject to provisions herein, compensable under this act. The amount of the award for that disability as set forth in this act may be reduced or denied in its entirety by the administrator in consideration of the following:

(1) A prior settlement from any source for the same impairment;

(2) The difference between the degree of impairment of the worker before the covered accident and/or occupational disease and the degree of impairment after the covered accident or occupational disease; or

(3) The benefits to be paid for impairments and/or disabilities would be in excess of 100% of the whole person. For purposes of this subsection, benefits include those benefits or payments made under this act, benefits from the worker's compensation laws of any other jurisdiction or payments from third parties.

6-15-76 Termination of Benefits Upon Death

Where a worker is entitled to compensation under this act for an injury sustained, and death ensues from any cause not resulting from the injury for which he was entitled to the compensation, payments of the unpaid balance for such injury shall cease and all liability for such compensation thereafter shall terminate.

BENEFITS

6-15-80 Vocational Rehabilitation

(a) Vocational rehabilitation benefits or training are not mandatory under this act, but may at the discretion of the administrator, be ordered pursuant to his authority established herein, or as required under rules promulgated by the administrator.

(b) The administrator is authorized to consider and, if appropriate develop a "return to work" or similar program designed to allow injured employees to return to active employment as quickly as possible.

6-15-81 Waiting Period

An initial waiting period of three (3) consecutive calendar days is to accrue before the covered worker shall be entitled to benefits under this act. If the covered worker misses more than fourteen (14) consecutive calendar days, the first three (3) calendar days can be considered for benefits if the covered worker received no other compensation during this time including but not limited to, sick time, and vacation time.

6-15-82 Total Disability and Partial Disability Income Benefits

(a) When the worker is disabled from work duty as determined by the consulting physician, or in the administrator's discretion, the attending physician, by reason of a compensable injury or occupational disease, benefits shall be payable as follows:

(1) If the covered worker is 100% disabled, benefits are payable at 60% of the worker's pre-injury average weekly wage. However, this amount will be increased by 5% if the covered worker is married, and by 2% for each minor dependent living with the covered worker, up to a maximum of 75% of the worker's preinjury average weekly wage.

(2) If the covered worker is less than 100% disabled, benefits are payable at 60% of the difference between the worker's preinjury average weekly wage and the wage the covered worker is earning or capable of earning in his partially disabled condition.

(b) Except as provided herein, such benefits will continue to be paid in accordance with the terms of this act until which time the earliest of the following occur:

(1) The expiration of 12 months from the date of occurrence, or in the case of an occupational disease, 36 months from the earliest of the first manifestation of the symptoms or notification from a physician that the illness is inherent or related to the worker's occupation;

(2) The consulting physician, or in the discretion of the administrator, the attending physician, declares that the worker has reached maximum medical improvement;

(3) The claimant is incarcerated;

(4) A full, unrestricted release is provided by the consulting physician, or in the discretion of the administrator, the attending physician.

(5) A modified or light duty release is provided by the consulting physician, or in the discretion of the administrator, the attending physician, and a bona fide job offer of suitable work consistent with the worker's disability is rejected;

(6) A new or intervening incident is the proximate cause of disability;

(7) Benefits are refused by the worker;

(8) Presumption of MMI or abandonment of medical treatment as defined by section 10-4-54 of this act;

(9) The worker's earning capacity is reduced for reasons other than the disability from the work-related injury;

(10) The covered worker dies from any cause not resulting from the injury for which he was entitled to compensation under this section, and the covered worker's estate is not entitled to any further benefits as defined by this act.

6-15-83 **Impairment Benefits**

(a) At the expiration of 12 months from the date of the incident, accident and/or occupational disease, the worker is presumed to have reached MMI regardless of disability and/or current medical status. The consulting physician, or in the discretion of the administrator, the attending physician, is to provide an impairment rating in accordance with the most current edition of the American Medical Association (AMA) based on reasonable medical probability. In addition, at this time the consulting physician, or in the discretion of the administrator, the attending physician is required to provide a treatment plan for reasonable and necessary future medical needs. The attending physician's impairment rating and treatment may be subject to review and revision by the consulting physician at the discretion of the administrator.

(b) For purposes of converting the impairment rating into a monetary figure the administrator will issue, and periodically update as necessary, an award schedule for permanent partial disability.

(c) A rating may not be issued prior to the declaration of MMI. The administrator may reserve issuance of payment under the following conditions:

(1) Contribution of prior impairment ratings;

(2) Clarification by the administrator of this act as to the validity of the date for MMI;

(3) Similar rating or MMI issues to be resolved by the consulting physician or, if necessary, the arbitration panel established under this act.

(d) The rating recognized by the arbitration panel is binding. The rating will not be retroactively paid for weeks accrued in resolving the rating issue subsequent to the date of MMI. Such benefits will become effective the date of the ruling and commence at that time.

(e) Notwithstanding provisions herein, the administrator shall retain the right and discretion to order lump sum settlements by way of compromise and release.

6-15-84 Benefit Issuance Period

Except as provided herein:

(a) All benefits under this act are to be issued biweekly.

(b) There shall be no acceleration of benefits under this act.

(c) Any settlement issued on behalf of a covered worker shall be executed by signed memorandum only.

6-15-85 Not to Exceed Preinjury Average Weekly Wage

In no event may the worker's impairment benefits exceed 100% of the worker's preinjury average weekly wage except as may be increased by a tribally approved cost of living adjustment.

6-15-86 Benefit Offsets

The administrator is entitled to reduce benefits payable to covered workers under this act in an amount equal to employee payments paid for by the employer for any pecuniary wages paid in the form of social security, long-term and short-term disability, employer elected salary contribution, vacation or sick leave, or any other entitlement of a similar nature paid in whole or in part by the employer. Further, if any overpayment is made under this chapter to the covered worker of any disability income benefits as set forth in section 6-15-82 of this act, such shall be deducted from any benefits payable under functional impairment benefits as set forth in section 6-15-83 of this act; or in the case where no functional impairment benefits are payable, then such overpayment of benefits may be deducted through payroll deductions.

DEATH BENEFITS

6-15-90 Distribution of Death Benefits

(a) When death ensues to the covered worker by reason of a compensable injury or occupational disease, benefits shall be payable to the dependents who were dependent as defined in section 10-4-4 on the earnings of the worker for support at the time of his injury, compensation upon the basis of 65% of the worker's average weekly wage, commencing from the date of death as follows:

(1)If there are no children entitled to benefits, then all to the surviving spouse for the projected probable life span of the decedent based on established mortality tables. To be an eligible "surviving spouse" under this act, the surviving spouse must have been married and living with the decedent at the time of the compensable injury, proof of eligibility may be required. If there are surviving eligible dependents, the surviving spouse shall be entitled to one-half of death benefits. If there is a surviving spouse, one-half of death benefits paid to each surviving eligible dependent in equal shares.

(2) If there is no surviving spouse, equal share of all to dependents as defined in section 6-15-4.

(3) Notwithstanding any other provisions of the act, the maximum amount payable as a death benefit under section 90 is $100,000.

(b) Where a worker is entitled to compensation under this act for an injury sustained, and death ensues from any cause not resulting from the injury for which he was entitled to the compensation, payments of the unpaid balance for such injury shall cease and all liability thereafter shall terminate.

6-15-91 Redistribution of Death Benefits

(a) If a legal beneficiary as defined in section 10-4-90 dies or otherwise becomes ineligible for death benefits, benefits shall be redistributed to the remaining legal beneficiaries in accordance with section 6-15-90.

(b) If all legal beneficiaries cease to be eligible, any duty to pay the remaining death benefits payable under section 6-15-90 shall cease immediately.

6-15-92 Verification of Eligibility of Death Benefits
Upon request from the administrator, all persons claiming to be eligible for death benefits shall furnish all necessary documentation to support their claim of eligibility.

6-15-93 Burial Benefits
If death results from a compensable injury, the person and/or entity who incurred the liability for the costs of the burial shall be reimbursed for either the actual costs incurred for such reasonable burial expenses, or $5,000, whichever is less.

MEDICAL BENEFITS

6-15-100 Entitlement to Medical Benefits
All covered workers are entitled to reasonable health care, supplies and reasonably necessary transportation incurred for such services. Medical benefits are payable from the date the compensable injury or accident occurred and will cease effective the date the claim closes.

6-15-101 Right to Select Physician; Employer Selection
(a) Except in an emergency, all health care must be approved or recommended by the employer or administrator. Health care treatment must be offered promptly and be reasonably suited to treat the injury. If the worker has reason to be dissatisfied with the care offered, he should communicate the basis of such dissatisfaction to the administrator, in writing, following which the administrator may agree to alternate care reasonably suited to treat the injury. If the administrator and the worker cannot agree on alternate care, the worker may request review by an administrative law judge, who may, upon application and the reasonable proofs of the necessity thereof, allow and order other such care. Any nonauthorized treatment of the covered worker is not payable under this section and shall be at the worker's sole expense.

(b) Chiropractic, osteopathic, naturopathic, acupuncture, or other nontraditional forms of treatment must be preapproved by the administrator and approved by the attending physician. Duration of treatment and/or number of visits to such medical providers shall be subject to administrator's approval, who may rely upon the advice of the consulting or attending physician.

6-15-102 Release of Medical-Related Information
Any worker, employer or insurance carrier or its agents making or defending a claim for benefits agrees to release all information to which the worker, employer, carrier, or its agents have access concerning the worker's physical or mental condition relative to the claim and further waives any privilege for the release of such information. The information shall be made available to any party or the party's representative upon request, and includes any third-party health care providers. Any institution or person releasing the information to a party or the party's representative shall not be liable for criminal or civil damages by reason of the release of the information.

6-15-103 Medical Expenses
Expenses shall be limited to those usual and customarily charged in the community, or like community, for similar services. Charges believed to be excessive or unnecessary may be denied by the administrator. Any institution or person rendering treatment to a worker under this act agrees to be bound by such charges as allowed by the administrator and shall not recover in law or equity any amount in excess of that set by the administrator.

6-15-104 Settlement of Future Medical

The worker may negotiate settlement of future medical expenses. For purposes of settling the future medical expenses, the basis for settlement will be the value of the current and future medical plan.

ADJUDICATION OF DISPUTES

6-15-120 Appeals from Decisions of the Administrator

(a) The administrator shall administer this act in accordance with the terms and conditions set forth in this act. Any appeals from final decisions of the administrator shall follow the procedures as set forth in this act and in accordance with any and all applicable rules and regulations.

(b) First Level – Any claimant may appeal a decision of the administrator by filing a contested claim in writing to the administrator within 30 calendar days of the administrator's final decision. The administrator will forward the appeal to an administrative law judge who will receive all the pertinent documents concerning the case, and may hold hearings to obtain more information as necessary. The claimant appealing the final decision of the administrator shall bear the burden of proof that the administrator's decision was not in accordance with, or was in violation of, this act. The decision of the administrative law judge shall be final and binding on all parties except for an appeal to the Tribal Court as provided herein.

(c) Second Level – Tribal Court. Any and all appeals from a decision of the administrative law judge shall be heard by the Tribal Court under the laws of the tribe. The administrative decision shall be upheld unless the Tribal Court finds the decision was:

(1) Unsupported by evidence;

(2) Arbitrary and capricious;

(3) An abuse of discretion by the administrator; or

(4) Contrary to the act or other applicable law.

6-15-121 Hearings

(a) A claimant and the administrator shall have the right to be represented by an attorney or spokesperson in all matters presented before the administrative law judge and/or Tribal Court, if applicable, to cross-examine all witnesses and to review all evidence of any nature, as may be related to the matter under consideration. All hearings will be conducted in a manner that does not violate due process.

(b) Administrative appeals under this act shall not be bound by formal rules of evidence or by technical or formal rules of procedure.

6-15-122 Claimant Attorney's Fees and Other Related Costs

(a) No attorney fees will be available or awarded to any claimant under this act.

(b) The claimant or administrator may engage the services of physicians or experts for hearing purposes at the respective parties' costs which are not reimbursable regardless of the ultimate outcome of the dispute. The opinions of such consultants may be considered in a contested case, notwithstanding the provisions of this act limiting the outside or unauthorized treatment.

(Enacted 3/10/11, Resolution 2011-138)

Claims Administration-Risk Management-Consulting
1802 Terminal Drive
Richland, WA 99354

Activity Prescription Form (APF)

Billing Code: 1073M

General info

Worker's Name:	Patient ID:	Visit Date:	Claim Number:
Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:

Required: Work status

☐ Worker is released to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ____/____/____
(If selected, skip to "Plans" section below)

☐ Worker may perform modified duty, if available, from (date): ____/____/____ to* ____/____/____ (*estimated date)
☐ If released to modified duty, may work more than normal schedule
☐ Worker may work limited hours: ______ hours/day from (date): ____/____/____ to* ____/____/____ (*estimated date)
☐ Worker is working modified duty or limited hours

☐ Worker not released to any work from (date): ___/___/___ to* ___/___/___ (*estimated date)
☐ Poor prognosis for return to work at the job of injury at any date

Required: Measurable Objective Finding(s) (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?
☐ 1-10 days ☐ 11-20 days ☐ 21-30 days ☐ 30+ days ☐ permanent
Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	50 lbs	20 lbs	10 lbs	0 lbs	0 lbs
Lift L, R, B	lbs	lbs	lbs	lbs	lbs
Carry L, R, B	lbs	lbs	lbs	lbs	lbs
Push / Pull L, R, B	lbs	lbs	lbs	lbs	lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐ Yes ☐ No
Modified duty available? ☐ Yes ☐ No
Date of contact: ____/____/____
Name of contact: ______________
Notes:

Note to Claim Manager:

☐ May need assistance returning to work
New diagnosis: ______________
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected ☐ Slower than expected (*address in chart notes*)
Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other (e.g., Activity Coaching) ______________
Surgery: ☐ Not Indicated ☐ Possible ☐ Planned Date: ___/___/___ ☐ Completed Date: ___/___/___

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/___
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐ Yes ☐ No ☐ Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: ______________
☐ Consultation needed with: ______________
☐ Study pending: ______________

Req: Sign

☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient

Signature: ______________ ☐ Doctor ☐ ARNP ☐ PA-C ____/____/____ Date ( ) ______ Phone