

January 2014

# Nurse Practitioners' Guide to Oregon On-the-Job Injuries



community  
Workers' Compensation

# Nurse Practitioners' Guide to Oregon On-the-Job Injuries

# Contents

## Quick Reference for Chart Notes

Chart notes should be used to supplement the information provided on Form 827.

Your chart notes should be legible and include the following:

- Worker information — worker's name and insurer claim number.
- History — if part of a closing examination.
- Examination — date, subjective and objective findings, current diagnosis (ICD-10-CM codes for dates of service on or after Oct. 1, 2015), and physical limitations.
- Other findings — laboratory and imaging results.
- Type of treatment.
- Medically stationary status — estimated length of further treatment, if known.
- Permanent disability — findings of permanent impairment, if known.
- Other — information regarding such things as surgery or hospitalization, palliative care plan, or aggravation.
- Next appointment date.
- Referrals to other health care providers.
- Work status — any limits, including dates, on the worker's ability to perform work activities.

The insurer may request progress reports periodically. Chart notes may be submitted instead of Form 827 if the notes provide the information requested. You must respond within 14 days of receipt of such a request.

Health care providers' roles and limits .....	2
Specifics for authorized nurse practitioner status .....	3
Claim status.....	6
Release of medical records.....	7
Change of attending physician/authorized nurse practitioner .....	7
Surgery .....	8
Closing evaluations .....	8
Medical care after medically stationary.....	9
Timeline summary for elective surgery.....	9
Billing.....	10
Payment .....	10
Interim medical benefits .....	11
Claim settlement .....	12
Disputes .....	12
Summary of extent of treatment by authorized nurse practitioner.....	13
Summary of terms.....	14
Self-test.....	19
Appendix .....	22

## Workers' Compensation Division

Employer Compliance Unit  
350 Winter St. NE  
P.O. Box 14480  
Salem, OR 97309-0405

# Nurse Practitioners' Guide to Oregon On-the-Job Injuries

This guide covers the basics for most of the workers' compensation cases you'll encounter. For more specifics, refer to Oregon Workers' Compensation Statutes, ORS 656.245, 248, 260, 262, 327, and the Oregon Administrative Rules, Chapter 436, Divisions 009, 010, and 015. You may check the Workers' Compensation Division's Web site for updates, [www.cbs.state.or.us/wcd/policy/rules/oarors.html](http://www.cbs.state.or.us/wcd/policy/rules/oarors.html).

Health care providers need to know the requirements and limitations of providing medical care and promptly supply the information needed by insurers to help the process run smoothly.



---

## Authorization

You must maintain an Oregon nurse practitioner licensure to receive the nurse practitioner authorization. You must review this guide and enclosed materials, which are available by contacting the Workers' Compensation Division's publications specialist at 503-947-7627, or from the Workers' Compensation Division's website, [www.wcd.oregon.gov](http://www.wcd.oregon.gov).

You have to be authorized to provide medical services to Oregon injured workers. You must sign and submit Form 2882 (Nurse Practitioner's Statement) found in the back of this guide to become authorized. Once the director receives the form, you become authorized to provide medical services to Oregon workers, and WCD will send you an authorized nurse practitioner (ANP) number.

# Health care providers' roles and limits

## Attending physician (AP)

An attending physician is primarily responsible for the treatment of a worker unless the worker chooses to treat with an authorized nurse practitioner. Generally, a medical doctor, doctor of osteopathy, or oral surgeon qualifies as an attending physician (type A attending physician). A chiropractic physician, naturopathic physician, and physician assistant also may qualify for a limited period (type B attending physician). Only a medical doctor, doctor of osteopathy, oral surgeon, or chiropractic physician is allowed to make impairment findings. Emergency room physicians may not assume the role of attending physician and may only authorize time loss for a maximum of 14 days when they refer the worker to another primary care provider for care.

The Oregon workers' compensation system places considerable responsibility on the attending physician in reporting claims, directing and managing treatment of workers' compensation patients, authorizing time-loss benefits, commenting on the physical suitability of jobs for workers, and evaluating workers' conditions when they are medically stationary.

Type B attending physicians are allowed to be attending physicians on the initial claim for up to 60 consecutive days or 18 visits, whichever occurs first, and to authorize time loss for up to 30 days from the first visit to any of these type B attending physicians.

## Authorized nurse practitioner

An authorized nurse practitioner may provide compensable medical services to a worker for a period of **180 consecutive calendar days** from the date of the first authorized nurse practitioner visit on the initial claim. An authorized nurse practitioner also may authorize the payment of temporary disability (time-loss benefits) for a maximum of **180 calendar days**

from the date of the first authorized nurse practitioner visit on the initial claim. Like podiatric physicians, naturopathic physicians, and physician assistants, authorized nurse practitioners are not allowed to make impairment findings.

When a worker becomes medically stationary and may have permanent impairment, the authorized nurse practitioner must refer the worker to a type A attending physician to make any impairment findings.



**Note:** Nurse practitioners who are not authorized, may **not** authorize time-loss benefits.

## Specialist physician

A specialist physician qualifies to be an attending physician but does not assume that role. A specialist physician provides services upon referral of the attending physician or authorized nurse practitioner. During that time the attending physician or authorized nurse practitioner continues to monitor the worker and authorize any time-loss benefits.

A **consulting physician** advises the attending physician or authorized nurse practitioner regarding the treatment of a worker's injury.

## Ancillary care provider

Ancillary care providers are health care providers who do not qualify as attending physicians. An ancillary care provider provides services, such as physical therapy or acupuncture, which are prescribed by an attending physician, specialist physician, or authorized nurse practitioner and carried out under a treatment plan.

## Managed care organization (MCO)

Insurers may enroll workers into a managed care organization (MCO), and you should ask the worker if he or she is enrolled in an MCO. An MCO is a health care provider group that contracts with insurers or self-insured employers to provide a wide variety of medical services to enrolled workers through participating providers. Generally, only MCO panel providers are allowed to treat MCO-enrolled

workers. However, if you have a documented history of treatment with the worker, maintain the worker's medical records, and agree to comply with the MCO's terms and conditions (such as refer the worker to the MCO for specialized care, including physical therapy), you may continue to treat an MCO-enrolled worker. Contact the MCO for details. Your rights and duties as an MCO panel provider may differ from those described in this guide. However, at a minimum, you may provide up to **180 consecutive calendar days** of treatment and authorize up to **180 consecutive calendar days** of time loss on the initial claim. Therefore, if you treat an MCO-enrolled worker, you should refer to the MCO provider-participation agreements or contracts for specific requirements in addition to this guide.

### Compensable injury or disease

Oregon workers' compensation requires that all treatment for a work injury be related to the accepted condition. When the insurer accepts the claim, the insurer determines what conditions to accept based on information you provide in your chart notes; therefore, it is important that your chart notes are comprehensive and clear.

**Compensable injury** is an accidental injury to a person or prosthetic appliance, arising out of and in the course of employment that requires medical services or results in disability or death.

**Occupational disease** is a disease or infection arising out of and occurring in the course and scope of employment. It is caused by substances or activities to which an employee is not ordinarily subjected or exposed to other than during employment and requires medical services or results in disability or death. A mental disorder or physical disorder caused or worsened by job-related mental stress also may be an occupational disease.

If an occupational disease claim is based on a worsening of a pre-existing disease or condition, the employment conditions must be the major contributing cause of the combined condition and pathological worsening of the disease.

## Specifics for authorized nurse practitioner

### First visit

The worker initiates a workers' compensation claim by filing a **Form 801**, "Report of Job Injury or Illness," or **Form 827**, "Worker's and Health Care Provider's Report for Workers' Compensation Claims."

As an authorized nurse practitioner, you can treat the worker without authorization from an attending physician for up to **180 consecutive calendar days** and authorize time-loss benefits for up to **180 calendar days** from the first day the worker sees you or any other authorized nurse practitioner on the initial claim.

On the first visit, you must notify the worker, preferably in writing, that he or she may personally be liable for non-compensable medical services. This may include:

- If the worker seeks treatment for conditions that are not related to the accepted compensable injury or illness.
- If the worker has been enrolled in an MCO and seeks treatment from you and you are not a panel provider for that MCO.
- If the worker seeks treatment after having been notified that the treatment is experimental, outmoded, unscientific, or unproven.
- If the worker seeks treatment from an authorized nurse practitioner after the 180 consecutive days without authorization from a qualified attending physician or specialist physician.

**See Appendix for a sample worker notification.**

### Form 827

**Have the worker complete this form only if:**

- You are the very first health care provider the worker sees for his or her injury.
  - In this case, send Form 827 to the insurer within **three days**.

- You assume responsibility for the worker's care from an attending physician or other authorized nurse practitioner.
  - In this case, send Form 827 to the insurer within **five days**.

Remember to sign Form 827 and give the worker a copy.

**See Appendix for additional information on Form 827.**

## Progress reports

Generally, an authorized nurse practitioner must respond within **14 days** to a request from the insurer or the director for any records and reports needed to review the frequency, necessity, and efficacy of treatment. Ongoing progress reports regarding the worker's condition are essential for the insurer to provide accurate and timely benefits to the worker. Using **Form 827** is optional for progress reports and closing reports.

## Chart notes

You must include chart notes with all your billings. The chart notes must be legible and include pertinent worker information such as:

- Worker information — worker's name and insurer claim number.
- History — if part of the closing examination.
- Examination — date, subjective and objective findings, current diagnosis (ICD-10-CM codes for dates of service on or after Oct. 1, 2015), and physical limitations.
- Other findings — laboratory and imaging results.
- Type of treatment.
- Work status — any limits, including dates, on the worker's ability to perform work activities.
- Medically stationary status — estimated length of further treatment.
- Other — information regarding such things as surgery or hospitalization.
- Next appointment date.
- Referrals to other health care providers.
- Objective findings should include comments on what is reproducible, measurable, or

observable.

- Impairment findings, including whether impairment is temporary or permanent. When reporting impairment findings, authorized nurse practitioners must observe the following restrictions:
  1. An authorized nurse practitioner treating a non-MCO-enrolled worker cannot make impairment findings. If the claim is a disabling claim, and there is evidence or reasonable expectation of permanent impairment, the authorized nurse practitioner must refer the worker to a physician qualified to evaluate the worker's impairment.
  2. An MCO panel-authorized nurse practitioner treating the worker must check with the MCO to ascertain responsibility.
  3. If the authorized nurse practitioner is treating an MCO-enrolled worker because there is a documented pre-injury relationship and if the worker meets other requirements in ORS 656.245(5), the authorized nurse practitioner may make impairment findings, if authorized by the MCO.

If you are treating a worker who requires infrequent follow-up care, discuss the situation with the insurer so the worker's benefits will continue uninterrupted. Time-loss benefits cannot be authorized retroactively for more than **14 days**.

The insurer may request an authorized nurse practitioner to complete a **physical-capacity or work-capacity evaluation**. If this occurs, the authorized nurse practitioner must complete the evaluation within **20 consecutive calendar days** or refer the worker for such an evaluation within **seven consecutive calendar days**. If the worker is incapable of participating in this type of evaluation, the authorized nurse practitioner must notify the insurer in writing.

Original *diagnostic studies*, if requested by the director or the insurer, must be forwarded within **14 days** of receipt of the written request.

## Return to work

An authorized nurse practitioner or attending physician has a primary responsibility to determine whether the worker is able to continue regular employment or whether there are any limits on the worker's ability to perform work activities. All parties benefit when the worker returns to work as quickly as possible after an on-the-job injury. Therefore, if you determine that the worker is unable to continue regular employment, the Workers' Compensation Division strongly encourages you, the authorized nurse practitioner, to contact the employer and discuss potential modified work duties the worker is able to perform.



As an authorized nurse practitioner, you may authorize time-loss benefits for up to **180 calendar days** from the first day the worker sees you or any authorized nurse practitioner on an initial claim. Within an MCO, there may be exceptions.

Workers who are not physically capable of returning to any employment for a period of time are entitled to time-loss benefits. Workers who can return to modified work (light duty) may be entitled to time-loss benefits. If you place, modify, or lift any work modifications, you must inform the worker immediately and notify the insurer in writing within **five consecutive calendar days**. Prompt notification to the insurer will reduce insurer inquiries and promote timely payment of benefits to the worker.

When you release a worker to return to work, you must specify any work restrictions. You may use Form 3245, "Return-to-Work Status," to document the worker's restrictions. However, you are not required to use Form 3245 unless the insurer requests it.

**See Appendix for Form 3245.**

The employer also may ask an authorized nurse practitioner to respond to a specific job description. Response within the requested time assists in the worker's timely return to work.

If the worker refuses a job offer for modified work approved by the authorized nurse practitioner, the worker's time-loss benefits may be reduced or stopped.

## Workers' compensation insurer

The worker's employer should be able to provide the name and address of its workers' compensation insurer.

If you are unable to contact the employer, you may call the WCD Employer Index at 503-947-7814 or visit the WCD Employer Proof of Coverage search page at [www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm](http://www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm).

## Ancillary services

If you refer the worker to an ancillary care provider (e.g., physical therapy), the ancillary care provider must send you a treatment plan for your signature within seven days. As the referring authorized nurse practitioner you are required to sign a copy of the treatment plan and send it to the insurer within **30 days** of the beginning of the ancillary treatment.

## Claim status

### Deferred claims

A deferred claim is a claim not yet accepted or denied. While the claim is deferred, medical services should be billed to the insurer but are not payable until the claim is accepted. The insurer has **60 days** from the employer's knowledge to accept or deny the claim.

### Accepted conditions

An accepted condition is a medical condition for which an insurer accepts responsibility for the payment of benefits on a claim filed by a worker. The insurer provides written notice of the accepted conditions. The insurer generally will accept specific conditions based on the diagnosis by the attending physician or authorized nurse practitioner.



**Note:** It is important that the health care provider report a diagnosis rather than a symptom.

### Denied claims

A claim denial is a written refusal by an insurer to accept compensability or responsibility for a worker's claim of injury or illness. On accepted claims, the insurer may deny certain conditions only; this is known as a partial denial. If the insurer is aware that you are treating a worker at the time the insurer issues a denial, the insurer must notify you that it has issued a denial. Only a worker can appeal a denial of a claim. When the insurer does not issue a Notice of Acceptance or denial within **60 days** of employer notice, the worker may file an appeal with the Oregon Workers' Compensation Board for a de facto denial.

### New and omitted conditions

A worker may request, in writing, acceptance of a new condition at any time. The insurer has **60 days** to accept or deny new conditions. Medical services for new conditions are not compensable unless conditions are accepted.

**Example:** An initial diagnosis of low back sprain/strain results in the acceptance of that condition. After further diagnostic studies, a herniated disk is diagnosed and the worker makes a new condition claim in writing for that herniated disk.

A worker may request, in writing, acceptance of an **omitted condition** that the worker believes was incorrectly omitted from the **Notice of Acceptance**. The insurer has **60 days** to accept or deny an omitted condition. Medical services for omitted conditions are not compensable unless conditions are accepted.

**Example:** Following a traumatic injury, the attending physician documents a cervical spine fracture and low back pain. The immediate focus of medical treatment is on the cervical fracture, and the low back condition (a sprain/strain) is inadvertently omitted from the Notice of Acceptance. The low back pain persists and the worker later files an omitted condition claim for low back sprain/strain.



An authorized nurse practitioner is allowed to provide medical services for accepted new or omitted medical conditions up to **180 consecutive calendar days** from the initial authorized nurse practitioner visit on the initial claim, unless the claim has been closed or the worker has reached medically stationary status. You may be able to treat a worker who is enrolled in an MCO beyond 180 consecutive calendar days regardless of claim closure.

### Consequential condition

Workers may claim new conditions (injury or disease) arising as compensable consequences of their accepted conditions. These are not “new claims” or “aggravations.” The compensable injury must be the major contributing cause of the **consequential condition**. Acceptance of the consequential condition results in the reopening of the claim for medical care and other benefits.

**Example:** A worker could develop a consequential condition when, in the course of recovering from accepted knee conditions, he or she develops a shoulder condition from using crutches. In order for the shoulder condition to be compensable, the knee injury must contribute more than 50 percent to the worker’s need for treatment or disability.

### Combined condition

A **combined condition** is when a pre-existing condition combines with a compensable condition to cause disability or prolong treatment.

**Example:** A worker has arthritis of the knee and then sustains a job-related injury to the same knee. The acute condition is diagnosed as a sprain. Both conditions contribute to the worker’s disability. The combined condition is compensable only if the compensable injury (the sprain) contributes more than 50 percent to the worker’s disability or need for treatment.

## Release of medical records

When a worker files a workers’ compensation claim the worker authorizes health care providers to release relevant medical records to the insurer, self-insured employer, or the Department of Consumer and Business Services. The privacy rule of HIPAA allows health care providers to disclose protected health information to regulatory agencies, insurers, and employers as authorized and necessary to comply with the laws relating to workers’ compensation. However, this authorization does not authorize the release of information regarding the following:

- Federally funded alcohol and drug abuse treatment programs.
- HIV-related information, which should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition.



**Note:** Any disclosures to employers are limited to specific purposes, such as return to work or modified work.

## Change of attending physician/authorized nurse practitioner

If you assume responsibility from an attending physician for treating a workers’ compensation worker, the worker must complete **Form 827** to clearly indicate that the worker has transferred ongoing treatment for the on-the-job injury to you. The worker must sign the form to acknowledge the new selection, and you must send Form 827 within **five consecutive calendar days** after the date of change or first treatment. If the insurer objects to the change, the insurer must advise the worker of the reasons and provide Form 2332 “Request to Change Attending Physician or Authorized Nurse

Practitioner.” The worker may complete Form 2332 and submit it to the director to request the change.

Under Oregon law, the worker may choose the first attending physician or authorized nurse practitioner and may change attending physician or authorized nurse practitioner two times by choice. Additional changes require pre-approval from the insurer or the Workers' Compensation Division. Generally, changes outside the worker's control do not count toward the three choices. If the worker is enrolled in an MCO, the MCO contract governs any change of physician.

The following situations are not changes of attending physician:

- Emergency or “on call” treatment.
- Examinations at the request of the insurer.
- Referrals for specialized treatment or consultations.
- Referrals to radiologists or pathologists for diagnostic studies.
- Closing examination upon referral by an authorized nurse practitioner

## Surgery

### Elective surgery

Elective surgery is surgery that may be required as part of the recovery from an injury or illness, but that doesn't need to be done on an emergency basis to preserve life, function, or health. If you recommend elective surgery, you must notify the insurer at least **seven consecutive calendar days** before the surgery.

The notice must include:

- Medical information substantiating the need for surgery.
- Date and place of surgery, if known.

#### The following timeline applies to elective surgery:

You or the surgeon give notice to the insurer that you recommend surgery. Within **seven days\*** the insurer must approve the surgery or

send Form 3228, “Elective Surgery Notification,” to you or the surgeon and state whether they want to request a consultation. The consultation must be completed within **28 days**. The insurer must send the consultation report to you or the surgeon within **seven days**.

If you or the surgeon disagree with the consultation report, you should try to resolve the issues with the insurer. If you determine no agreement can be reached, you or the surgeon must notify the insurer by signing Form 3228 or provide other written notification to the insurer. If the insurer believes surgery is excessive, inappropriate, or ineffectual, the insurer must request Administrative Review within **21 days\***.



**\*Note:** If the insurer does not respond to your surgery notification within seven days or does not request administrative review within 21 days after you sign Form 3228, the insurer will be barred from challenging the appropriateness of the proposed surgery. However, failure to respond timely does not bar the insurer from contending that the proposed surgery is not related to the compensable condition/injury.

### Emergency surgery

Emergency surgery is surgery that must be performed promptly (i.e., before seven consecutive calendar days), because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention. In such cases, the surgeon should notify the insurer of the need for emergency surgery.

## Closing evaluations

A closing evaluation is a medical examination to measure impairment, which occurs when the worker is medically stationary. Once a worker reaches maximum recovery, he or she becomes medically stationary, meaning no further material improvement would reasonably be expected from medical treatment or the passage of time.

Closing reports must be submitted to the insurer within **14 days** of the date the worker is declared medically stationary. An authorized nurse practitioner may perform a closing examination if the worker is enrolled in an MCO and the MCO authorizes the authorized nurse practitioner to make impairment findings, or if the worker has no permanent impairment. If the worker is not enrolled in an MCO, and the worker may have permanent impairment, an authorized nurse practitioner must refer the worker to a type A attending physician when the worker becomes medically stationary.



**Note:** Bulletin 239 outlines the requirements for performing a closing evaluation.

## Medical care after medically stationary

After the worker’s condition becomes medically stationary, you are only allowed to continue to treat an Oregon injured worker as directed by the attending physician.

## Aggravation

Aggravation claims are not considered “initial claims” and you are not allowed to treat workers with aggravation claims without being directed by an attending physician. If a worker returns to an authorized nurse practitioner because of a worsening of his or her condition after the initial claim closure, the authorized nurse practitioner will be paid for that visit but must refer the worker to an attending physician for continued care. If the worker is enrolled in an MCO, check with the MCO regarding treatment of the aggravation.

To qualify as an aggravation, an accepted condition must have pathologically worsened. The worker may file a claim for aggravation by filing Form 827 anytime within five years after first closure on a disabling claim or the date of injury on a non-disabling claim. Temporary waxing and waning of symptoms is not considered an aggravation; however, the worker may qualify for additional curative treatment.

## Timeline summary for elective surgery

Elective surgery timeline	Within
You give notice of surgery to insurer	7 days prior to surgery
Insurer approves surgery or sends Form 3228 and may request a consultation	7 days*
Complete consultation	28 days
Insurer sends you completed consultation report	7 days
If you disagree with consultation and you can't resolve the disagreement with the insurer, notify them in writing or sign Form 3228	N/A
Insurer requests administrative review	21 days*



**\*Note:** If the insurer does not respond to your surgery notification within seven days or does not request administrative review within 21 days after you sign Form 3228, the insurer will be barred from challenging the appropriateness of the proposed surgery. However, failure to respond timely does not bar the insurer from contending that the proposed surgery is not related to the compensable condition/injury.

## Billing

Here is some useful information for a smoother billing process:

- Send your billings to the insurer on a current CMS 1500 form no later than **60 days** after the date of service – even if the worker's claim has not yet been accepted.
- Charge the usual fees that you charge to the public.
- Use CPT® and Oregon Specific codes.
  - If there is no specific code, use the appropriate unlisted code at the end of each CPT® section or the appropriate HCPCS code.
- Use modifier 81 only when you assist with surgery.
- You must include legible chart notes with all your billings.
  - Chart notes may be only in a coded or semi-coded manner if you provide a legend with each set of records.
  - You cannot charge a fee for providing the chart notes with your billings.
- If you are asked to prepare a report or review records other than your own, use CPT® code 99080 and indicate the actual time spent.
  - If the request comes from the insurer, the insurer must pay you, even if the claim is denied.
- If the claim is denied, you may be able to bill for interim medical benefits. (See the interim medical benefits section on page 11 to help determine if the services qualify.)

## Payment

Once the claim is accepted, the insurer must issue payment within **45 days** of receiving your billings and chart notes. If the insurer fails to pay promptly, you may charge a reasonable monthly service charge for the period that the

payment was delayed, but only if you levy such a charge to the general public.

Authorized nurse practitioner fees are paid at the rate of 85 percent of a physician's allowable fee for a comparable service. Workers cannot be billed for the reduction in fees allowed by the fee schedule or OAR 436-009.

Oregon law allows an employer to pay up to a certain amount for medical services for a nondisabling workers' compensation claim. See Bulletin 345 for the current maximum amount. Go to [www.wcd.orgon.gov](http://www.wcd.orgon.gov) and click on "Bulletins" on the right-hand side. However, the employer must make the payments to its insurer and not directly to you. Therefore, you must always bill the workers' compensation insurer and not the employer. This limitation does not apply to a certified self-insured employer.

Unless you contracted otherwise, you should get paid either the amount that you charged or the amount of the Oregon Workers' Compensation fee schedule, whichever is lower. For the fee schedule rules see <http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html>.

Dietary supplements are generally not reimbursable, and no fee is payable for a missed appointment.

If an insurer reduces a fee stating that the service is included in another service billed, you may want to verify that the CPT®, published by the AMA, or the Division 009 rules specify that. Specifically, WCD has not adopted the National Correct Coding Initiative (NCCI) edits, and the insurer should not apply any NCCI edits.

If you do not receive payment within **45 days** or you are not satisfied with the payment amount, contact the insurer.

If you are unable to resolve the disagreement with the insurer, you may request director review.

If you disagree with the decision of the insurer, you must request review within **90 days** of the mailing date of the most recent explanation of benefits or a similar notification.

To request review, use a copy of Form 2842, "Request for Dispute Resolution of Medical Issues and Medical Fees," found in the back

of this guide. For fee disputes, use worksheet 2842a, "Medical Fee Dispute Resolution Request and Worksheet," in addition to Form 2842.



**Note:** Be aware that the insurer does not have to pay you if the following applies:

- The claim has not been accepted.
- You do not include chart notes with your billings.
- You treat for conditions that are not accepted by the insurer.
- The worker is enrolled in an MCO and you or the referring physician/authorized nurse practitioner are not panel providers for that MCO. However, upon enrollment in an MCO, a worker is allowed to continue to treat with a non-qualified health care provider for at least seven days after the mailing date of the notice of enrollment.

## Interim medical benefits

If the claim is denied and the worker has a health benefit plan (private health insurance), you can bill for interim medical benefits, unless the insurer denied the claim within **14 days** of the date the employer first learned the worker filed a claim.



**Note:** The Oregon Health Plan is not considered a health benefit plan.

Interim medical benefits are limited to the following:

- Diagnostic services required to identify appropriate treatment or to prevent disability.
- Medication required to alleviate pain.
- Services required to stabilize the worker's claimed condition and to prevent further disability. Examples include, but are not limited to:

- Antibiotic or anti-inflammatory medication.
- Physical therapy and other conservative therapies.
- Necessary surgical procedures.

Send your bills with a copy of the denial to the worker's health benefit plan, to bill for interim medical benefits.



**Note:** The health benefit plan does not have to issue any payments before the denial is final. If the health benefit plan has a time limit to bill for services, submit your bill simultaneously to the workers' compensation carrier and the health benefit plan.

Once you receive payment from the health benefit plan, resubmit your bills to the workers' compensation insurer with a copy of the explanation of benefits (EOB) from the benefit plan.

The workers' compensation insurer will pay any amount not reimbursed by the health benefit plan in accordance with the Oregon fee schedule rules. This may include any deductibles or co-payments.

**There will be revised rules affecting interim medical benefits as of Jan. 1, 2015.**



## Claim settlement

### Disputed claim settlements (DCS)

If a worker and the insurer disagree about whether the worker has a valid workers' compensation claim or condition, the worker and the insurer may resolve the disagreement by a disputed claim settlement. **If they reach such a settlement, the claim will remain denied, and for a sum of money, the worker will give up all rights to future benefits for the denied medical conditions of the claim.**

Oregon law requires that, under a disputed claim settlement, health care providers be reimbursed for medical services at half the amount allowed by the fee schedule; however, total reimbursement to health care providers cannot exceed 40 percent of the total settlement. Generally, only those bills that have been received by the insurer are included in the DCS.

When a worker's claim is settled by a DCS, you can submit the unpaid portion of your bills to the worker's health insurer. If there is no health insurer, you may bill the worker directly.

### Claims disposition agreements (CDA)

A claims disposition agreement is a compromise and release of all benefits, except medical benefits, on an accepted claim for a cash amount, and will not affect medical

reimbursement.

## Disputes

Use Form 2842, "Request for Dispute Resolution of Medical Issues and Medical Fees," to initiate disputes (See the Appendix). Workers, insurers, or self-insured employers can request administrative review if they believe treatment is excessive, inappropriate, unnecessary, or in violation of a medical-services rule.

### MCO-enrolled claims

For disputes about medical treatment, parties or a party must request dispute resolution from the MCO, in writing, within **30 consecutive calendar days** of the disputed action. The MCO's final decision can be appealed to WCD, in writing, within **60 consecutive calendar days** of the MCO's final decision.

All other disputes may be resolved either through the MCO or WCD, at the discretion of the MCO. Contact the MCO to find out about its resolution process for disputes other than treatment disputes.

### Non-MCO enrolled claims

For all billing or treatment disputes, the disputing party must request WCD administrative review within **90 consecutive calendar days** of the date the party received written



## Summary of extent of treatment by an authorized nurse practitioner (ANP)

	ANP treating a worker not enrolled in MCO	ANP treating as MCO panel provider	Worker has pre-injury relationship with ANP and “brings” ANP into the MCO*
<b>Duration of treatment by ANP</b>	180 days from first visit on new claim.	At least 180 days from first visit on new claim, but possibly more, depending on MCO.	At least 180 days from first visit on new claim, but possibly more depending on MCO.*
<b>Duration of temporary disability authorization by ANP</b>	60 days from first visit on new claim.	At least 60 days from first visit on new claim, but possibly more, depending on MCO.	At least 180 days from first visit on new claim, but possibly more, depending on MCO.*
<b>ANP determines medically stationary date</b>	Only if the medically stationary date falls within 180 days of first ANP visit on a new claim.	If the medically stationary date falls within 180 days of first visit on a new claim, and as otherwise authorized by MCO.	If the medically stationary date falls within 180 days of first visit on a new claim, and as otherwise authorized by MCO.*
<b>ANP writes final report with impairment findings</b>	Never. May determine medically stationary date as indicated above, but must refer case to an attending physician for impairment findings.	May write final report with impairment findings if authorized by MCO.	May write final report with impairment findings if authorized by MCO.*
<b>ANP treats on aggravation</b>	Never. First visit on aggravation will be paid for by insurer, but ANP must refer to an attending physician for treatment.	First visit on aggravation will be paid for by insurer, but thereafter, ANP may treat aggravation only if authorized by MCO.	First visit on aggravation will be paid for by insurer, but thereafter, ANP may treat aggravation only if authorized by MCO.*
<p>* The authorized nurse practitioner (ANP) must agree to abide by the rules, terms, and conditions regarding services performed by the MCO. The ANP also must agree to refer the worker to providers within the MCO for any needed specialized treatment, including physical therapy. (See ORS 656.245 and OAR 436-015-0070).</p>			

notice of the decision it disputes. Mediation is available to resolve disputes between parties.

## Summary of terms

### accepted condition

A medical condition for which an insurer accepts responsibility for the payment of benefits on a claim filed by an injured worker. Insurer provides written notice of accepted conditions (ORS 656.262). The insurer generally will accept specific conditions based on the diagnosis by the physician or nurse practitioner. It is important that the health care provider report a diagnosis rather than a symptom.

### aggravation claim

A claim for further benefits because of a worsening of the claimant's accepted medical condition after the claim has been closed. An aggravation is established by medical evidence supported by objective findings observed or measured by the physician. Aggravation rights expire five years after first closure on disabling claims or five years from date of injury on nondisabling claims (ORS 656.273). An attending physician who is an MD, podiatric physician, or DO must file Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claim," and a medical report with the insurer within five consecutive calendar days of the worker's visit to make a claim for aggravation. The insurer has 60 days to accept or deny a claim for an aggravation.

### ancillary care

Care such as physical or occupational therapy provided by a health care provider other than the attending physician, specialist physician, or authorized nurse practitioner.

### attending physician (AP)

A health care provider primarily responsible for the treatment of an injured worker (ORS 656.005).

### bulletin

A director/administrator-approved release of

information outside the agency regarding legal provisions, requirements, and administrative rules.

### claim

A written request by the worker, or on the worker's behalf, for compensation (ORS 656.005). The insurer has 60 consecutive calendar days from the employer's date of knowledge to accept or deny the claim. (See also disabling claim and nondisabling claim.)

### claim disposition agreement (CDA and C&R)

An agreement between the parties to a workers' compensation claim. The worker agrees to sell back his or her rights (e.g., rights to compensation, attorney fees, and expenses) except rights to medical benefits or preferred-worker benefits on an accepted claim. Also known as a "C&R" or a "compromise and release" (ORS 656.236).

### closing examination

A medical examination to measure a worker's impairment, which occurs when the worker is medically stationary.



**Note:** Bulletin 239 outlines the requirements for performing a closing examination.

### compensable injury

An accidental injury to a person or prosthetic appliance, arising out of and in the course of employment that requires medical services or results in disability or death (ORS 656.005). A claim is compensable when the insurer accepts it.

### consulting physician

A physician who advises the attending physician or authorized nurse practitioner regarding the treatment of a worker's injury. A consulting physician is not considered an attending physician, and, therefore, the worker should not

complete Form 827, “Worker’s and Health Care Provider’s Report for Workers’ Compensation Claims,” for the consultation.

### **curative care**

In the workers’ compensation system, treatment to stabilize a temporary waxing and waning of symptoms after a worker is medically stationary. Curative care does not require the attending physician to request approval from the insurer.

### **denied claim (denial)**

Written refusal by an insurer to accept compensability or responsibility for a worker’s claim of injury (ORS 656.262). If the insurer is aware that you are treating a worker at the time the insurer issues a denial, the insurer will notify you that it has issued a denial. Only a worker can appeal a denial of a claim.

### **disabling claim**

Any injury is classified as disabling if it causes the worker temporary disability (time loss), permanent disability, or death. The worker will not receive time-loss benefits for the first three days unless he or she is off work and not released to return to any work for the first 14 consecutive days or is admitted to a hospital as a worker during the first 14 consecutive days. The claim also is classified as disabling if there is a reasonable expectation that permanent disability will result from the injury.

### **disputed claim settlement (DCS)**

A DCS is a settlement of a workers’ compensation claim in which, for a sum of money, the worker gives up all rights to benefits for the entire claim or for a specific medical condition. If the DCS settles the entire claim, the claim remains forever denied, the worker has no right to any medical benefits, and medical bills are not paid by the insurer except as specified in the DCS or unless they were paid as interim medical benefits.

### **Form 801 — First Report of Injury or Illness**

A form used by workers and employers to report a work-related injury or occupational disease.

### **Form 827 — Worker’s and Health Care Provider’s Report for Workers’ Compensation Claims**

A form used by workers and physicians to report a work-related injury or illness to insurers. It can be used as a first report of injury, report of aggravation, notice of change of attending physician, progress report, closing report, and palliative care request.

### **health care provider**

A person duly licensed to practice one or more of the healing arts.

### **impairment findings**

A permanent loss of use or function of a body part or system as measured by a physician. (OAR 436-035-0005).

### **independent medical examination (IME)**

A medical examination of an injured worker by a physician other than the worker’s attending physician performed at the request of the insurer. This does not include a consultation arranged by an MCO for an enrolled worker.

### **initial claim**

The first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared medically stationary by an attending physician or authorized nurse practitioner.

### **major contributing cause (MCC)**

A cause deemed to have contributed more than 50 percent to an injured worker’s disability or need for treatment.

### managed care organization (MCO)

An organization that contracts with an insurer to provide medical services to injured workers (OAR 436-015, ORS 656.260).

### medical arbiter

A physician selected by the director to perform an impartial examination for impairment findings (ORS 656.268).

### medical sequela

A condition that originates or stems from the accepted condition, as determined by a health care provider (ORS 656.268).

### medical service

Medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, drug, prosthetic, or other physical restorative services (ORS 656.245).

### medically stationary

The point at which a worker's medical condition is not expected to improve any further, either from more medical treatment or the passage of time (ORS 656.005). Please use the term "medically stationary" when the worker reaches this point rather than such terms as "return PRN," "fully recovered (or released)," "no further treatment needed," etc.

Once a worker's condition becomes medically stationary, his or her entitlement to certain medical benefits changes. Workers remain entitled to the following treatment and services related to the accepted condition without prior approval from the insurer:

- Prescription medication and office visits to monitor, administer, or renew prescriptions.
- Prosthetic devices, braces, and supports, including replacement, repair, and monitoring.
- Services necessary to diagnose the worker's condition.
- Life-preserving modalities such as insulin therapy, dialysis, and transfusions.
- Curative care to stabilize temporary and

acute waxing and waning of symptoms.

- Care for a worker who has been granted a permanent and total disability award under a workers' compensation claim.
- With approval of WCD, treatment available because of advances in medical technology since the worker's claim was closed.

Additionally, the worker is entitled to:

- With the approval of the insurer or the director, palliative care to enable the worker to continue employment or vocational training. (See also the back of Form 827.)
- Medical services provided under an aggravation claim.

### new medical condition claim

A worker's written request that the insurer accept a new medical condition related to the original occupational injury or disease. The insurer has 60 days to accept or deny a new condition.

### nondisabling injury

An injury is classified as nondisabling if it does not cause the worker to lose more work time than the three-day waiting period, it requires medical services only, and the worker has no permanent impairment (ORS 656.005).

### objective findings

The indications of an injury or disease that are measurable, observable, and reproducible, used to establish compensability and determine permanent impairment (ORS 656.005).

**Examples:** range of motion, atrophy, muscle strength, palpable muscle spasm, etc.

### occupational disease

A disease or infection, arising out of and occurring in the course and scope of employment. It is caused by substances or activities to which an employee is not ordinarily subjected or exposed to other than during employment and requires medical services or results in disability or death (ORS 656.802).

### Ombudsman for Injured Workers

The Department of Consumer and Business Services office that serves as an independent advocate for injured workers in the workers' compensation system.

### omitted medical condition

A worker's written request that the insurer accept a medical condition the worker believes was incorrectly omitted from the Notice of Acceptance. The insurer has 60 days to accept or deny an omitted condition. Medical services for omitted conditions are not compensable unless conditions are accepted.

### palliative care

Medical services rendered to reduce or temporarily moderate the intensity of an otherwise stable condition to enable the worker to continue employment or training (ORS 656.005, 656.245). (See also the back of Form 827.)

### partial denial

Denial by the insurer of one or more conditions of a worker's claim, leaving some conditions of the claim accepted as compensable.

### permanent partial disability (PPD)

The permanent loss of use or function of any portion of the body as defined by ORS 656.214.

### physical capacity evaluation (PCE)

The measurements of a worker's ability to perform a variety of physical tasks.

The insurer may request you to complete a physical capacity or work capacity evaluation. If this occurs, you must complete the evaluation within 20 consecutive calendar days or refer the worker for such an evaluation within seven consecutive calendar days.

### pre-existing condition

A medical condition that existed before the compensable injury or disease.

### prosthetic appliance

The artificial substitution for a missing body

part, such as a limb or eye, or any device that augments or aids the performance of a natural function, such as a hearing aid or glasses (ORS 656.005, 656.245).

### regular work

The job the worker held at the time of injury.

### request for records or reports

Generally, when the insurer or the director requests any records or reports needed to review the frequency, necessity, and efficacy of treatment, you must respond within 14 days. Additionally, if the worker chooses a new attending physician or authorized nurse practitioner that then requests copies of your records, you are required to forward those to the new attending physician or authorized nurse practitioner within 14 days.

### temporary partial disability benefits (TPD)

Payment for wages lost when a worker is only able to perform temporary modified or part-time work because of a compensable injury. (See also time-loss benefits.)

### temporary total disability benefits (TTD)

Payment for wages lost when a worker is unable to work because of a compensable injury. (See also time-loss benefits.)

### time-loss authorization

When time loss is authorized, the insurer may request periodic progress reports. Form 827 is not required if the chart notes provide the information requested.



**Note:** Time loss cannot be authorized retroactively for more than 14 consecutive calendar days.

### time-loss benefits

Compensation paid to an injured worker who loses time or wages because of a compensable injury. Time-loss benefits include temporary partial disability and temporary total disability. A worker who is not physically capable of returning to any employment is entitled to benefits for temporary total disability (time loss).

A worker who can return to modified work may be entitled to benefits for temporary partial disability if his or her wages or hours of modified work is reduced.

### **treatment plan**

A treatment plan for ancillary care must contain the following four elements:

- Objectives (e.g., decreased pain, increased range of motion, etc.).
- Modalities (e.g., ultrasound, chiropractic manipulation, etc.).
- Frequency of treatment (e.g., once per week).
- Duration (e.g., four weeks).

### **“type A” attending physician**

A medical doctor, doctor of osteopathy, or oral and maxillo-facial surgeon as defined in ORS 656.005(12)(b)(A).

### **“type B” attending physician**

A chiropractic physician, naturopathic physician, or physician assistant as defined in ORS 656.005(12)(b)(B).

### **work capacity evaluation (WCE)**

A physical-capacity evaluation that focuses on the ability to perform work-related tasks.

### **worker-requested medical examination (WRME)**

An impartial examination available to an injured worker when an insurer has issued a denial of compensability based on an independent medical exam, and the injured worker’s physician does not concur with the findings.

### **Workers’ Compensation Board (WCB)**

The part of the Oregon Department of Consumer and Business Services responsible for conducting hearings and reviewing legal decisions and agreements affecting injured workers’ benefits.

### **Workers’ Compensation Division (WCD)**

The division of the Oregon Department of Consumer and Business Services that administers, regulates, and enforces Oregon’s workers’ compensation laws.

# Self-test

Test your understanding of the information provided in this guide.

**1. What is an “accepted condition” in the workers’ compensation system?**

*Answer:* Any condition the workers’ compensation insurer has accepted through a Notice of Acceptance or through litigation.

**2. For what period can you (or multiple authorized nurse practitioners) treat a worker without oversight of an attending physician?**

*Answer:* On an initial claim, you can treat a worker who is not enrolled in an MCO for no more than 180 days from the first visit with an authorized nurse practitioner. If the worker chooses subsequent authorized nurse practitioners, they must share the 180-day period that began with the first visit to the first authorized nurse practitioner.

After the worker is medically stationary or after the insurer closes the claim, you may not treat the worker without authorization from an attending physician.

If the worker is enrolled in an MCO, and you are on the MCO panel, you may treat the worker for 180 days from the first visit on an initial claim, and possibly longer, depending on the MCO.

If the worker has a documented history with you, then gets enrolled in an MCO, and chooses you to be responsible for treatment, you may treat the worker for 180 days from the first visit on an initial claim, and possibly longer, depending on the MCO. You must agree to certain conditions. (See question 5.)

**3. For what period can you (or multiple authorized nurse practitioners) authorize temporary disability (time loss from work) payments?**

*Answer:* You can authorize time-loss payments for a worker, who is not enrolled in an MCO, for no more than 180 days from the first visit to an authorized nurse practitioner on the initial claim. If the worker chooses subsequent authorized nurse practitioners, they must share the 180-day period that began with the first visit to the first authorized nurse practitioner.

If the worker is enrolled in an MCO, and you are on the MCO panel, you may authorize time-loss payments for the worker for 180 days from the first visit on the initial claim, and possibly longer, depending on the MCO.

If the worker has a documented history with you, then gets enrolled in an MCO, and chooses you to be responsible for treatment, you may authorize time-loss payments for the worker for 180 days from the first visit on an initial claim, and possibly longer, depending on the MCO. You must agree to certain conditions (See question 5.)

**4. Are you authorized to make impairment findings?**

*Answer:* No. As an authorized nurse practitioner you are not authorized to make impairment findings. If a worker may have permanent impairment, you must refer the worker to an attending physician who is an MD, podiatric physician, or a DO. MCOs may allow authorized nurse practitioners to make impairment findings; check with your MCO.

**5. If a worker with whom you already have an established history is enrolled in an MCO for treatment, under what conditions may you treat the worker for the on-the-job injury?**

*Answer:* You must agree to refer the worker to an MCO panel provider for any specialized treatment that the worker

requires, including physical therapy, and agree to comply with all the rules, terms, and conditions regarding services performed by the MCO.

**6. What must you do during a worker's initial visit?**

*Answer:* At the worker's initial visit you must:

- Determine if you are the first provider on the initial claim.
- If so, complete Form 827 (First report of injury or disease), and give a copy of the form to the worker. Mail the completed form to the employer's workers' compensation insurer within 72 hours of the visit and include chart notes or report as needed.
- If you are not the first provider, the 180-day period\* has not expired, and you intend to assume responsibility for the worker's care, complete Form 827 with the worker (Notice of change of attending physician or nurse practitioner.) Mail the completed form to the employer's workers' compensation insurer within five days of the visit and include chart notes or report as needed.
- Inform the worker of the medical services the authorized nurse practitioner can provide and the limitation for authorizing time-loss payments, taking into account how much, if any, of the 180-day period, respectively has expired. Document in the chart notes that this was done.
- Refer the worker to an attending physician if:
  - The 180 day period has expired.
  - If the worker is seeking treatment for the aggravation of a work injury on a claim that is closed.\*

**7. How should you respond when an employer asks you to review and approve specific job descriptions before returning a worker to suitable work?**

*Answer:* You should comply with the employer's request within the requested time frame. Timely response to this request assists the worker in returning to work as quickly as possible.

**8. What are the required response times for you in the following situations?**

- a. To notify the insurer you are assuming primary treatment responsibility for a worker who was being treated by another provider.

*Answer:* Five consecutive calendar days.

- b. To forward requested information to the new attending physician or author-rized nurse practitioner when primary responsibility is transferred from one attending physician or authorized nurse practitioner to another.

*Answer:* 14 consecutive calendar days.

- c. To sign a copy of the treatment plan and provide it to the insurer when ancillary treatment is prescribed by a nurse practitioner.

*Answer:* 30 consecutive calendar days.

- d. To respond to a request by the director or the insurer for progress reports, narrative reports, and other necessary records needed to review the frequency, necessity, and efficacy of treatment.

*Answer:* 14 consecutive calendar days.

- e. To complete an insurer-requested physical-capacity or work-capacity evaluation or to refer the worker for a physical-capacity or work-capacity evaluation when one is requested by the insurer.

\*The 180-day period may not apply if the worker is enrolled in an MCO. If in doubt, check with the MCO.

*Answer:* 20 consecutive calendar days to complete the evaluation or seven consecutive calendar days to refer.

- f. **To forward original imaging films or diagnostic studies to the insurer or the director upon request.**

*Answer:* 14 consecutive calendar days.

9. **Where can information about medical fees in the workers' compensation system be found?**

*Answer:* OAR 436-009 establishes medical fees within the workers' compensation system. These rules are updated yearly and can be obtained from WCD or at the following Web site: [www.cbs.state.or.us/external/wcd/policy/rules/rules.html#permrules](http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html#permrules)

10. **If an employer requests a bill for medical service, what should you do?**

*Answer:* Do not bill the employer, unless it is a certified self-insured employer. Health care providers are required to bill the workers' compensation insurer. Although Oregon law allows an employer to pay up to \$1,600 for medical services for a nondisabling workers' compensation claim, the employer must make such payments to its insurance company and not to the health care provider.

11. **When a worker's claim is denied, who should be billed for medical services provided to the worker?**

*Answer:* If the worker's claim was denied, bill the worker's health-benefit plan, and send a copy of the denial. Once you receive payment, submit your bills with copies of the Explanation of Benefits from the health-benefit plan to the workers' compensation insurer for balances that would have been paid under workers' compensation laws and rules, including diagnostic services to identify appropriate treatment or to prevent disability, medication to alleviate pain, and services to stabilize the worker's condition and to prevent further disability.

If the claim was denied, charges for other medical services do not qualify as interim medical benefits and the workers' compensation insurer is not obligated to pay any portion of those bills. However, you may bill the health-benefit plan if the worker has such insurance. If the worker does not have a health-benefit plan, you may bill the worker for the services provided, but you may not attempt to collect until the appeal process, if any, is completed and the denial is final.

12. **If a worker returns to you after recovery and claim closure with complaints that the condition has worsened, what must you do?**

*Answer:* If the worker is not enrolled in an MCO, you must refer the worker to an attending physician and you will be paid for the office visit.

If you are treating the worker as an MCO panel provider, the MCO determines whether you may treat a worker on aggravation.

If the worker is enrolled in an MCO, has a documented history with you, and chooses you to be responsible for treatment, the MCO determines whether you may treat a worker on aggravation.

## Appendix

Sample notification to worker

Worker's and Health Care Provider's Report for Workers' Compensation Claims — Form 827

Request for Dispute Resolution of Medical Issues and Medical Fees — Form 2842

Medical Fee Dispute Resolution Request and Worksheet — Form 2842a

Return-to-Work Status — Form 3245

Nurse Practitioner's Statement of Authorization — Form 2882

Current forms are available on WCD's website: [www.wcd.oregon.gov](http://www.wcd.oregon.gov).

# Sample

## Notification to worker regarding treatment as required by OAR 436-010-0240(4)

Oregon workers' compensation law requires me to notify you at the time of your first visit of the manner in which I can provide compensable medical treatment and authorize time loss.

As your authorized nurse practitioner, I am responsible for providing and directing treatment for your injury.

As an authorized nurse practitioner, I can be your attending physician for up to 180 consecutive calendar days from the date you saw any other nurse practitioner on the initial claim. Furthermore, as a nurse practitioner, I can authorize time-loss benefits for up to 180 calendar days from your first visit to any other nurse practitioner.

**If you have seen any other nurse practitioner for your injury, or if you are enrolled in an MCO, please inform me immediately.**

Your benefits may be affected if you fail to follow medical advice or maintain contact with your health care providers. You may be required to pay for medical services if you do any of the following:

- If you seek treatment for conditions that are not related to the accepted compensable injury or illness.
- If you seek treatment from a chiropractic physician, naturopathic physician, or physician assistant after the 60 days or 18 visits without authorization from a qualified attending physician, specialist physician, or authorized nurse practitioner.
- If, after your claim has been closed, you seek palliative care without obtaining prior approval from the insurer or the Workers' Compensation Division.
- If you have been enrolled in an MCO and seek treatment from a provider who is not a panel provider for that MCO.
- If you seek treatment after having been notified that the treatment is experimental, outmoded, unscientific, or unproven.

In most cases, there are limits to the medical services that a nurse practitioner can provide. It is important that you inform any nurse practitioner that is treating you of prior services provided to you by another nurse practitioner.

## Worker's and Health Care Provider's Report for Workers' Compensation Claims

### Health care provider instructions

The worker **should** complete the worker section of this form for the following:

- First report of injury or disease
- Request for acceptance of a new or omitted medical condition ("Omitted" refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.)
- Report of aggravation of original injury ("Aggravation" means the actual worsening of a compensable condition resulting from the original injury.)
- Notice of change of attending physician or nurse practitioner.\* This means the new provider will be primarily responsible for treatment.  
Being primarily responsible does NOT include:
  - *Treatment on an emergency basis*
  - *Treatment on an "on-call" basis*
  - *Consulting*
  - *Specialist care (unless the specialist assumes complete control of care)*
  - *Exams done at the request of the insurer or the Workers' Compensation Division*

\*Oregon nurse practitioners, chiropractic physicians, naturopathic physicians, and physician assistants must certify with the Workers' Compensation Division to treat workers' compensation patients and get paid.

After the worker has completed and signed Form 827, give the worker copies of Form 827 and Form 3283 (included with this packet) immediately.

The worker **should NOT** complete the worker section of this form if you choose to use it for the following:

- Progress report
  - Closing report
  - Palliative care request  
(Palliative care makes the worker feel better but does not cure a condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care.)  
The following are not palliative care:
    - *Prescriptions, prosthetics, braces, and doctors' appointments to monitor them*
    - *Diagnostic services*
    - *Life-preserving treatments*
    - *Curative care to stabilize an acute waxing and waning of symptoms*
    - *Services to a permanently and totally disabled worker*
- When requesting palliative care approval from the insurer, include the following in your request:
- *Who will provide the care*
  - *Modalities ordered, including frequency and duration*
  - *How the need for care is related to the accepted conditions*
  - *How the care will enable the worker to continue current work or vocational training*

For these reports, you have the option of filing Form 827, submitting chart notes, or submitting a report that includes data gathered on Form 827.

**Questions about name/address of insurer:** 503-947-7814 or [WorkCompCoverage.wcd.oregon.gov](http://WorkCompCoverage.wcd.oregon.gov)

**Questions about medical issues:** Contact the medical resolution team at 503-947-7606

**For health care providers:** [www.oregonwcdoc.info](http://www.oregonwcdoc.info)



Workers' Compensation Division

# Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL	WCD employer no.:
	Policy no.:

Worker or provider	<b>Note to Provider:</b> Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.			Dept. Use	
				Ins. no.	
	Worker's legal name, street address, and mailing address:	Language preference:	Male/female <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security no. (see Form 3283):	Occ.
	Phone:	Claim no. (if known):	Date/time of original injury:		Nature
		Date of birth:	Occupation:	Last date worked:	Part
	Employer at time of original injury — name and street address:	Health insurance company name and phone:			Event
	Workers' compensation insurer's name, address:			Source	
	Phone:			Assoc. object	

Worker	<b>Worker: Check reason for filing this form, answer questions (if any), and sign below.</b>	
	<input type="checkbox"/> <b>First report of injury or disease</b> (Do not complete or sign if you do not intend to make a claim.) Have you injured the same body part before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____	Check here if you have more than one job. <input type="checkbox"/> <b>Describe accident:</b>
	<input type="checkbox"/> <b>Request for acceptance of a new or omitted medical condition on an existing claim</b> Condition: _____	
	<input type="checkbox"/> <b>Notice of change of attending physician or nurse practitioner</b> Reason for change: _____	
	<input type="checkbox"/> <b>Report of aggravation of original injury (actual worsening of a compensable condition)</b>	
By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)		
<input checked="" type="checkbox"/> _____ <b>Worker's signature</b> <span style="margin-left: 100px;"><b>Date</b></span>		

Provider	<b>Provider: If worker initiated this report, give worker a copy immediately.</b>																				
	<b>If the worker filed this report for:</b>																				
	<ul style="list-style-type: none"> <li>• <b>First report of injury or illness</b> – Send this form to the workers' compensation insurer within 72 hours of visit.</li> <li>• <b>New or omitted medical condition</b> – Attach chart notes, including diagnostic codes. Send this form to the insurer within five days of visit.</li> <li>• <b>Change of attending physician or nurse practitioner</b> – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. Send this form to the insurer within five days after the change or the date of first treatment. Check the following, if applicable: <input type="checkbox"/> I request insurer to send its records.</li> <li>• <b>Aggravation of original injury</b> – Sign this form and send it to insurer within five days of visit.</li> </ul>																				
	<b>If filing for progress report, closing report, or palliative care request, check the appropriate box below.</b>																				
	<input type="checkbox"/> <b>Progress report</b> OR <input type="checkbox"/> <b>Closing report</b> (See instructions in Bulletin 239.) <input type="checkbox"/> <b>Palliative care request</b> – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.																				
	<table border="1"> <tr> <td>a</td> <td>Date/time of first treatment:</td> <td>Last date treated:</td> <td>Was worker hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name hospital:</td> </tr> <tr> <td></td> <td>Next appointment date:</td> <td>Est. length of further treatment:</td> <td>Current diagnosis per ICD-10-CM codes:</td> </tr> <tr> <td>b</td> <td colspan="2">Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown</td> <td>Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____</td> </tr> <tr> <td></td> <td colspan="3"> <b>Work ability status:</b>  <input type="checkbox"/> Regular work (job at injury) authorized start (date): _____ through (date, if known): _____  <input type="checkbox"/> Modified work authorized from (date): _____ through (date, if known): _____  <input type="checkbox"/> No work authorized from (date): _____           </td> </tr> <tr> <td>c</td> <td colspan="3"><b>Chart notes:</b> Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).</td> </tr> </table>		a	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name hospital:		Next appointment date:	Est. length of further treatment:	Current diagnosis per ICD-10-CM codes:	b	Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown		Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____		<b>Work ability status:</b> <input type="checkbox"/> Regular work (job at injury) authorized start (date): _____ through (date, if known): _____ <input type="checkbox"/> Modified work authorized from (date): _____ through (date, if known): _____ <input type="checkbox"/> No work authorized from (date): _____			c	<b>Chart notes:</b> Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).	
a	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name hospital:																		
	Next appointment date:	Est. length of further treatment:	Current diagnosis per ICD-10-CM codes:																		
b	Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown		Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____																		
	<b>Work ability status:</b> <input type="checkbox"/> Regular work (job at injury) authorized start (date): _____ through (date, if known): _____ <input type="checkbox"/> Modified work authorized from (date): _____ through (date, if known): _____ <input type="checkbox"/> No work authorized from (date): _____																				
c	<b>Chart notes:</b> Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).																				
Provider's name, degree, address, and phone: ( <i>print, type, or use stamp</i> )  <input checked="" type="checkbox"/> _____ <b>Provider's signature</b> <span style="margin-left: 100px;"><b>Date</b></span>																					
— Original and one copy to insurer — Retain copy for your records — Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner																					

# 827

## Notice to worker

### Claim acceptance or denial

In most instances, you will receive written notice from your employer's insurer of the acceptance or denial of your claim within 60 days. If your employer is self-insured, your employer or the company your employer has hired to process its workers' compensation claims will send the notice to you. If the insurer or self-insured employer denies your claim, it will explain the reason for the denial and your rights.

### Medical care

The health care provider must tell you if there are any limits to the medical services he or she may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses up to a maximum established rate. You must make a written request for reimbursement and attach copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

### Payments for time lost from work

**In order for you to receive payments for time lost from work, your health care provider must notify the insurer or self-insured employer of your inability to work.** After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your health care provider verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

### Authorization to release medical records

By signing this form, you authorize health care providers and other custodians of claim records to release relevant records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

### Caution against making false statements

Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment commits a Class A misdemeanor under ORS 656.990(1).

### Palliative care

Palliative care is care that makes you feel better, but does not cure you of an unwanted condition. You must be in the workforce, or in a vocational program, to be allowed to have palliative care.

The following are **not** palliative care:

- Prescriptions, prosthetics, braces, and doctors' appointments to monitor them
- Diagnostic services
- Life-preserving treatments
- Curative care to stabilize an acute waxing and waning of symptoms
- Services to a permanently and totally disabled worker

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

**Workers Compensation Division**  
**(División de Compensación para Trabajadores)**  
P.O. Box 14480, Salem, OR 97309-0405  
Salem: 503-947-7585  
Toll-free: 800-452-0288

**Ombudsman for Injured Workers**  
**(Ombudsman para Trabajadores Lastimados)**  
350 Winter Street NE, Salem, OR 97301-3878  
Salem: 503-378-3351  
Toll-free: 800-927-1271

## A Guide for Workers Recently Hurt on the Job

### How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

### How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

### Are there limitations to my medical treatment?

- **Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

### If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

### What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

#### **Ombudsman for Injured Workers:**

##### **An advocate for injured workers**

Toll-free: 800-927-1271

Email: [oiw.questions@oregon.gov](mailto:oiw.questions@oregon.gov)

#### **Workers' Compensation Resolution Section**

Toll-free: 800-452-0288

Email: [workcomp.questions@oregon.gov](mailto:workcomp.questions@oregon.gov)

**Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?** You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).



DEPARTMENT OF  
CONSUMER  
& BUSINESS  
SERVICES

Workers' Compensation Division

# Request for Dispute Resolution of Medical Issues and Medical Fees

Complete this form to request medical dispute resolution services from the Workers' Compensation Division. You must notify all parties to the dispute about this request and provide the parties copies of any information submitted to the director. Copies must be provided free of charge to all other concerned parties. **Unrepresented workers may call the Medical Resolution Team for help in completing the form.** As an alternative to the administrative review process, a less formal dispute resolution process may resolve your issue. This process allows you to work with a trained facilitator on the Medical Resolution Team. The parties work with a facilitator collaboratively to reach agreement. A medical reviewer may contact you about this process, or you may contact the Medical Resolution Team at 503-947-7606.

## Directions

---

Indicate below what issues you are submitting for review:

- |  |   |
|--|---|
| <input type="checkbox"/> Medical services (palliative care, medical services after medically stationary, out-of-pocket expenses, unpaid bills, etc.) ORS 656.245 | <input type="checkbox"/> Medical rules violation (requests re: elective surgery, treatment plans, etc.) ORS 656.327   |
| <input type="checkbox"/> Managed care organization (MCO) dispute ORS 656.260   | <input type="checkbox"/> Appropriateness of medical treatment ORS 656.327   |
| <input type="checkbox"/> Change of attending physician or nurse practitioner ORS 656.245   | <input type="checkbox"/> Medical fee dispute (reduced payment) ORS 656.248<br><b>(Note: For medical fee disputes, complete both Form 2842 and Form 2842a)</b> |

## Worker information

---

Worker name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Date of injury: \_\_\_\_\_ Claim no.: \_\_\_\_\_

## Employer/insurer information

---

Employer name: \_\_\_\_\_

Employer's workers' compensation insurer: \_\_\_\_\_

Insurer address: \_\_\_\_\_

Insurer phone: \_\_\_\_\_

## Provider information

---

Medical provider name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Contact person: \_\_\_\_\_

Are you the attending physician (AP)?  Yes  No    Are you the nurse practitioner (NP)?  Yes  No

If no, indicate name of AP or NP: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

**(continued on back)**

# 2842

## Managed care organization (MCO) information

---

Yes  No Is the worker covered by an MCO contract?

If yes, MCO name: \_\_\_\_\_ Enrollment date: \_\_\_\_\_

Yes  No Does MCO have a dispute resolution process?

If yes, date on which process was initiated: \_\_\_\_\_ Date completed: \_\_\_\_\_

If yes, all documents generated for the MCO review must be submitted with this form.

## Dispute information

---

What is the specific medical issue in dispute? \_\_\_\_\_

Dates of services in dispute: \_\_\_\_\_

Why is the medical issue in dispute? \_\_\_\_\_

Accepted conditions (medical conditions the insurer accepted in writing or by litigation):

\_\_\_\_\_  
Dates of written acceptance, including Updated Notice of Acceptance: \_\_\_\_\_

## Review requested by

---

Worker

Worker's attorney

Insurer

Insurer's attorney

Medical service provider

Managed care organization

Other: \_\_\_\_\_

Please attach copies of all relevant medical information or records to this form.  
Failure to comply with these requirements may result in dismissal of your request.

**Insurer:** Please complete the following certification statement.

## Insurer's certification statement

---

By signing below, I certify that relevant medical and claim information has been provided with this request and that copies have been sent to all parties, required by OAR 436-010-0008.

Insurer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send the completed, signed original of this form and all accompanying documents to:**

Workers' Compensation Division  
Resolution Section  
Medical Resolution Team  
350 Winter St. NE  
P.O. Box 14480  
Salem, OR 97309-0405

**Or fax it to: 503-947-7629**

**For help or more information, please call the Medical Resolution Team, 503-947-7606.**



Return form to:

# RETURN-TO-WORK STATUS

Worker's name: \_\_\_\_\_ Claim number (if known): \_\_\_\_\_

Next scheduled appointment date: \_\_\_\_\_

Is the worker expected to materially improve from medical treatment or the passage of time?  Yes  No

## WORK STATUS *(Select one option)*

**OPTION 1 – Released to Regular Work** Status from (date): \_\_\_\_\_  
Released to the *hours routinely worked and tasks routinely performed in the job held at the time of injury.*

**OPTION 2 – Not Released to Work** Status from (date): \_\_\_\_\_ to: \_\_\_\_\_  
The worker is *not capable of performing any work activities.*

**OPTION 3 – Released to Modified Work** Status from (date): \_\_\_\_\_ to: \_\_\_\_\_  
Released to work, *subject to the following work restrictions (note only those that are applicable):*

Total work hours: \_\_\_\_\_ hours/day

### Lift/carry/push/pull restrictions

	One-time	≤1/3 of workday	1/3-2/3 of workday	≥2/3 of workday	Duration	
<b>Lift:</b>	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time
<b>Carry:</b>	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time
<b>Push:</b>	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time
<b>Pull:</b>	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time

### Activity restrictions

<b>Stand:</b>	_____ hrs./day	_____ hrs./one time	<b>Twist:</b>	_____ hrs./day	_____ hrs./one time	<b>Crawl:</b>	_____ hrs./day	_____ hrs./one time
<b>Walk:</b>	_____ hrs./day	_____ hrs./one time	<b>Climb:</b>	_____ hrs./day	_____ hrs./one time	<b>Crouch:</b>	_____ hrs./day	_____ hrs./one time
<b>Sit:</b>	_____ hrs./day	_____ hrs./one time	<b>Bend:</b>	_____ hrs./day	_____ hrs./one time	<b>Balance:</b>	_____ hrs./day	_____ hrs./one time
<b>Drive:</b>	_____ hrs./day	_____ hrs./one time	<b>Above-shoulder-reach:</b>	_____ hrs./day	_____ hrs./one time	<b>Below-shoulder-reach:</b>	_____ hrs./day	_____ hrs./one time
<b>Kneel:</b>	_____ hrs./day	_____ hrs./one time						

### Hand use restrictions

<b>Fine actions:</b>	_____ hrs./day L hand	_____ hrs./day R hand
<b>Keyboarding:</b>	_____ hrs./day L hand	_____ hrs./day R hand
<b>Grasp:</b>	_____ hrs./day L hand	_____ hrs./day R hand

### Foot use restrictions

<b>Raise:</b>	_____ hrs./day L foot	_____ hrs./day R foot
<b>Push:</b>	_____ hrs./day L foot	_____ hrs./day R foot

Notes / other restrictions: \_\_\_\_\_

Medical provider's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print medical provider's name: \_\_\_\_\_

Phone no.: \_\_\_\_\_



## Publications

- Oregon Administrative Rules, Chapter 436, Division 009, Oregon Medical Fee and Payment
- Oregon Administrative Rules, Chapter 436, Division 010, Medical Services
- Current Procedural Terminology (CPT), available from the American Medical Association  
515 North State St.  
Chicago, IL 60610  
Phone: 800-621-8335
- ICD-10-CM, available from the American Medical Association  
515 North State St.  
Chicago, IL 60610  
Phone: 800-621-8335
- American Society of Anesthesiologists (ASA) Relative Value Guide, available from ASA  
520 N. Northwest Highway  
Park Ridge, IL 60068-2573  
Phone: 847-825-5586
- Billing forms: CMS 1500 — medical;  
UB 04 — hospital; ADA — dental;  
NCPDP — pharmacy
- The following WCD bulletins and forms are available from the WCD website ([www.wcd.oregon.gov](http://www.wcd.oregon.gov)) or by calling 503-947-7627\*

### Form 827

- B 239 (Closing Exam and Report)
- B 281 (Release of Medical Records)
- B 292 (Medical Reporting Forms)
- B 293 (Request for Review of Medical Issues)

Medical forms also are available in the Appendix of this guide.

\*Some forms are available in Spanish.

## Resources

### Phone numbers

Medical service/fee info.....	503-947-7606
MCO information .....	503-947-7697
Workers' Compensation Information Line.....	800-452-0288 *
Injured Worker Help Line (Ombudsman).....	800-927-1271 *
Employer Index.....	503-947-7814
Investigations – Fraud Hotline .....	800-452-0288
WCD Publications.....	503-947-7627

\*Spanish-speaking help lines are available.

### WCD website

Oregon Workers' Compensation Division  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

Health Care Providers  
[www.oregonwcdoc.info](http://www.oregonwcdoc.info)

These topics can be visited (and bookmarked) from our main page:

- Health Care Providers
- Managed Care Organizations
- Laws & Rules
- Bulletins (includes forms)
- Información en Español

### Time frames for filing Form 827

File	→	Within
New injury or disease	→	3 days of treatment
New attending physician	→	5 days of treatment
Aggravation of existing injury	→	5 days of treatment
Send closing report to insurer	→	14 days of date declared medically stationary

Do you need an insurer reference list with address and phone numbers?

Do you need additional coverage information reference cards?

Call WCD Publications, 503-947-7627

# How to Find Workers' Compensation Coverage Information

- **First** — Call the employer for information about insurance coverage.
  
- **If you need more help** — Contact the Employer Compliance Unit of the Workers' Compensation Division (WCD) by phone, fax, email, or Internet. For five or more requests at once, please use fax, email, or Internet.
  - Online search: [www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm](http://www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm)
  - Phone: 503-947-7814
  - Fax: 503-947-7718
  - Email: [wcd.employerinfo@oregon.gov](mailto:wcd.employerinfo@oregon.gov)
  
- **Provide this information to WCD:**
  - Employer's legal business name, street address, city, and phone number.
  - Coverage inquiry date.
  - Worker's name, social security, and date of birth.
  
- **If necessary, the Employer Compliance Unit will conduct further research.** Please send a copy of Form 827, "*Worker's and Health Care Provider's Report for Workers' Compensation Claims*," or Form 801, "*Report of Injury or Illness*" to:

Workers' Compensation Division  
Employer Compliance Unit  
350 Winter St. NE  
P.O. Box 14480  
Salem, OR 97309-0405

