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Health Care Providers' Guide to Oregon On-the-Job Injuries

community
Workers' Compensation

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Health Care Providers' Guide to Oregon On-the-Job Injuries

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.

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Health care providers' roles and limits

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 website for updates, www.cbs.state.or.us/wcd/policy/rules/oarors.html.

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

Attending physician

An attending physician is primarily responsible for the treatment of an injured worker unless the worker chooses to treat with a nurse practitioner. Generally, a medical doctor, doctor of osteopathy, or oral surgeon qualifies as an attending physician. A chiropractic physician, naturopathic physician, and physician assistant also may qualify for a limited period. Only a medical doctor, doctor of osteopathy, oral surgeon, or chiropractor can make impairment findings. Emergency room physicians 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 workers, authorizing time-loss benefits, commenting on the physical suitability of jobs for workers, and evaluating workers' conditions when they are medically stationary.

If you are the attending physician and you refer the worker to an ancillary care provider (e.g., physical therapist), the ancillary care provider should send a treatment plan for your signature within seven days. As the attending physician, 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.

Chiropractic physicians, naturopathic physicians, and physician assistants are "Type B" attending physicians and 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 an injured 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 benefits for a maximum of **180 calendar days** from the date of the first authorized nurse practitioner visit on the initial claim. Authorized nurse practitioners, naturopathic physicians, and physician assistants are not allowed to make impairment findings.

Specialist physician

When you qualify to be an attending physician but do not assume that role, you may provide services as a specialist physician upon referral of the attending physician. As a specialist physician, you examine an injured worker or provide specialized treatment at the request of the attending physician or authorized nurse practitioner. During the time you provide specialized treatment, the attending physician continues to monitor the injured worker and authorize any time-loss benefits.

Ancillary care provider

As an ancillary care provider, you only will be reimbursed if an attending physician, specialist physician, or authorized nurse practitioner prescribes the services you provide and you carry them out under a treatment plan. Examples of ancillary care providers are: physical therapists, acupuncturists, and, when they no longer are attending physicians, chiropractic physicians, and naturopathic physicians.

Managed care organization (MCO)

An MCO is a health care provider group that contracts to provide a wide variety of medical services to enrolled injured workers through participating providers. Generally, only MCO panel providers are allowed to treat MCO-enrolled workers.

Insurers may enroll workers into a managed care organization and you should ask the worker if he or she is enrolled in an MCO. Your rights and duties as an MCO panel provider may differ from those described in this guide. Therefore, if you are an MCO panel provider you should refer to your 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, it determines what conditions to accept based on information you provide in your chart notes.

Compensable injury is defined as 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 defined as 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 attending physician status

First visit

Attending physician

The injured 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."

On the first visit, you must notify the worker, preferably in writing, that he or she may personally be liable for noncompensable 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 a type B attending physician after the 60 consecutive days or 18 visits without authorization from a qualified attending physician, specialist physician, or authorized nurse practitioner.

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, "Worker's and Health Care Provider's Report For Workers' Compensation Claims," to the insurer within **three days.**
- You assume the role of attending physician.
- You file a claim of aggravation on the worker's behalf.
  - In this case send Form 827 to the insurer within **five days.**

Give the worker a copy.

Progress reports

Ongoing progress reports regarding the worker's condition are essential for the insurer to provide accurate and timely benefits to the injured worker. Using **Form 827** is optional for progress reports, closing reports, and palliative care requests.

For additional information on Form 827, see Appendix.

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.

Because the insurer uses your chart notes to determine what condition to accept, it is important that your chart notes are comprehensive and clear.

Chart notes

Chart notes must be legible and include pertinent worker information such as:

- Worker's 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, 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.
- Objective findings should include comments on what is reproducible, measurable, or observable.

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 cannot be authorized retroactively for more than **14 days**.

Return to work

As an attending physician, you have 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 attending physician, to contact the employer and discuss potential modified work duties the worker is able to perform.

One of your primary responsibilities as the attending physician is authorization of time-loss benefits. Workers who are not physically capable of returning to any employment for a period of time are entitled to temporary total disability. Workers who can return to modified work (light duty) may be entitled to temporary partial disability. 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.

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.

Specifics for ancillary care provider status

If you are treating as an ancillary care provider, you must provide treatment under a treatment plan. An attending physician or specialist physician (or, on an initial claim, an authorized nurse practitioner) must prescribe all treatment. You are not allowed to authorize time-loss benefits.

Before you begin treating the worker as an ancillary care provider, you must make a treatment plan that contains the following four elements:

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

You must send the treatment plan within seven days to the insurer and the referring physician or authorized nurse practitioner. (You don't need to send a copy of the treatment plan that is signed by the referring physician to the insurer. The referring physician should sign the treatment plan within **30 days** and send the signed copy to the insurer.)

Note: As an ancillary care provider, you must carry out the treatment under a treatment plan. It is your responsibility to make the treatment plan and send it to the insurer and referring physician or authorized nurse practitioner within seven days. Failure to do this could affect payment for your services. However, failure by the attending physician or authorized nurse practitioner to sign the treatment plan within 30 days shall not affect payment to you.

Hint: Fax the treatment plan to the insurer and keep a copy of the confirmation page in the worker's file.

If you continue treatment beyond the duration outlined in the treatment plan, you will need a new order from the attending physician to continue treatment. You also must send a new treatment plan to the insurer and referring physician or authorized nurse practitioner within **seven days**.

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 an injured worker. The insurer provides written notice of the accepted conditions. The insurer generally will accept specific conditions based on the diagnoses by the attending physician or 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. 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 will 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 injured 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.

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 pre-existing condition that 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

Filing a workers' compensation claim 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 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

If you assume responsibility from another 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.

Under Oregon law, the worker may choose the first attending physician and may change attending physicians 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, any change of physician is governed by the MCO contract.

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.

If you are seeing the worker solely for a consultation or as a specialist physician, it is not considered a change of physician and the worker should not complete **Form 827**.

You may not authorize the worker's temporary disability benefits (time loss) unless you are the worker's attending physician.

Surgery

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, you, the surgeon, should notify the insurer of the need for emergency surgery.

Timeline summary for elective surgery

Elective surgery timeline	Within
You give notice of surgery to insurer	7 days prior to surgery
The insurer approves surgery or sends you Form 3228 and may request a consultation	7 days*
Complete consultation	28 days
Insurer sends you the completed consultation report	7 days
If you disagree with the consultation and you can't resolve the disagreement with the insurer, notify the insurer 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.

Elective surgery

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 is elective surgery. 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 give notice to the insurer that you intend to perform surgery. Within seven days* the insurer must approve the surgery or send Form 3228 "Elective Surgery Notification" to you and state whether it wants to request a consultation. The consultation must be completed within 28 days. The insurer must send the consultation report to you within seven days.

If you disagree with the consultation report, you should try to resolve the issues with the insurer. If you determine no agreement can be reached, you 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*.

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, the worker 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. If you do not want to conduct the closing evaluation, you may refer the worker to another provider. Contact the insurer if you want the insurer to schedule the evaluation. If another physician completes the closing evaluation, you will be asked to review the report and comment on the findings.

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

Medical care after medically stationary

It is helpful to use the term "medically stationary" to convey this concept 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 the following:

- 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.

The attending physician or specialist physician must prescribe all treatment after the worker is declared medically stationary.

Treatment after medically stationary

After the worker is declared medically stationary, the attending physician may prescribe curative care or palliative care that you provide.

Curative care is care provided to a worker to stabilize a temporary and acute waxing and waning of symptoms. Treatment plan requirements are the same as described previously. Curative care does not require the attending physician to request approval from the insurer.

Palliative care is treatment rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition and is necessary to enable the worker to continue current employment or a vocational training program. In this case, ancillary care providers will not need to make a treatment plan because the required elements are part of the palliative care request the attending physician sends to the insurer for approval. A palliative care request, prepared by the attending physician, must contain the following elements:

- A description of any objective findings.
- An ICD-10-CM diagnosis for dates of service on or after Oct. 1, 2015.
- A treatment plan containing the name of the provider who will provide the care, specific treatment modalities, frequency, and duration (up to 180 days) of the care.
- An explanation of how the requested care is related to the compensable condition.
- A description of how the requested care will enable the worker to continue current employment or a vocational training program and any possible adverse effects if the care is not approved.

Note: Ask for a copy of the palliative care request from the attending physician because if he or she fails to complete and send it to the insurer for approval, the insurer doesn't have to pay you for the service you provide.

Hint: Make sure the palliative care request contains all the required elements. If not, talk to the attending physician.

Aggravation

To qualify as an aggravation, an accepted condition must have pathologically worsened. A claim for aggravation may be made by filing **Form 827** anytime within five years after first closure or the date of injury on a nondisabling claim. The attending physician must include medical evidence supported by objective findings of an actual worsening of the accepted claim. The attending physician files on the worker's behalf. Temporary waxing and waning of symptoms is not considered an aggravation; however, the worker may qualify for additional curative treatment.

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

general 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.
- 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.

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.oregon.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 the 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.
- You provide treatment as an ancillary care provider without a treatment plan sent to the insurer within seven days or without a palliative care request from the attending

physician.

- The worker is enrolled in a managed care organization (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 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 such a settlement is reached, 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 DCS, health care providers be reimbursed for medical services at half the amount allowed by the fee schedule, and total reimbursement to health care providers cannot exceed 40 percent of the total settlement without the worker's approval. However, the worker may choose to reimburse health care providers directly from the settlement proceeds at 100 percent of the Oregon workers' compensation fee schedule amount. 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. However, if the worker chooses to reimburse health care providers directly from the settlement proceeds at the Oregon workers' compensation fee schedule amount, the provider must accept this as payment in full (ORS 656.313).

Claims disposition agreements (CDA)

A CDA 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.

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 Claims," 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.

combined condition

A combined condition occurs when a pre-existing condition combines with a compensable condition. A combined condition may cause disability or prolong treatment. However, a combined condition is only compensable if the compensable injury is the major contributing cause of the disability or the need for prolonged 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.

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.

consequential condition

A condition arising after a compensable injury of which the major contributing cause is the injury or treatment rendered that increases either disability or need for treatment (ORS 656.005). A consequential condition is only compensable if the compensable injury or disease contributes more than 50 percent of the worker's disability or need for treatment.

Example: Use of crutches due to a compensable knee condition may cause a consequential shoulder condition that requires treatment or leads to disability.

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 Physician'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 (ORS 656.245).

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 an injured 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 an occupational disease.

Form 827 — Worker's and Physician's Report for Workers' Compensation Claims

A form used by workers and physicians to report a work-related injury or occupational disease 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. For additional information on Form 827, see Appendix.

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.

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 condition is not expected to improve any further, either from more medical treatment or the passage of time (ORS 656.005).

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 are 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.

release of medical records

Filing a workers' compensation claim authorizes health care providers to release relevant medical records to the insurer, self-insured employers, 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.

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.

specialist physician

A specialist physician is a physician who qualifies as an attending physician but does not assume the role of attending physician.

A specialist physician examines the worker or provides specialized treatment, such as surgery or pain management, at the request of the attending physician or authorized nurse practitioner. During the time you provide specialized treatment, the attending physician continues to monitor the worker and authorizes any time loss.

Note: As a specialist physician you cannot authorize time loss, and the worker should not complete Form 827 at your office.

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.

"type-A" attending physician

A medical doctor, doctor of osteopathy, podiatric physician, 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 claim based on an independent medical exam and the injured worker's physician does not concur with the findings (ORS 656.325).

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.

Timeline summary

Action/Status	Days
File Form 827 for new injury or disease	3 days
File Form 827 for change of attending physician	5 days
Submit treatment plan when you are the ancillary care provider	7 days
Submit elective surgery request	7 days prior to surgery
Refer worker for a closing examination	8 days
Respond to records request from insurer or director	14 days
Complete an insurer-requested PCE or WCE	20 days
Sign copy of treatment plan when attending physician	30 days

Appendix

Sample notification to worker

Worker's and Health Care Provider's Report for Workers' Compensation Claims — Form 827 (currently being revised)

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

Elective Surgery Notification — Form 3228

Current forms are available on WCD's Web site: www.wcd.oregon.gov.

Sample

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

Under Oregon workers' compensation law, I am required 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 attending physician, I am responsible for providing and directing treatment for your injury. I am also responsible for authorizing any time-loss benefits for your compensable condition.

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 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.

DEPARTMENT OF CONSUMER & BUSINESS SERVICES *Workers' Compensation Division*

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*
Questions about medical issues: *Contact the medical resolution team at 503-947-7606*
For health care providers: *www.oregonwcdoc.info*

DEPARTMENT OF CONSUMER & BUSINESS SERVICES — Workers' Compensation Division

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

OPTIONAL: WCD employer no.: ____ Policy no.: ____

Note to Provider: **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. / Occ. / Nature / Part / Event / Source / Assoc. object

Worker or provider

Worker's legal name, street address, and mailing address:

Phone:

Language preference: | Male/female ☐ ☐ | Social Security no. (see Form 3283):

Claim no. (if known): | Date/time of original injury:

Date of birth: | Occupation: | Last date worked:

Employer at time of original injury — name and street address:

Phone:

Health insurance company name and phone:

Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Have you injured the same body part before? ☐ Yes ☐ No If yes, when: _____

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Condition: _____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: _____

☐ **Report of aggravation of original injury (actual worsening of a compensable condition)**

Check here if you have more than one job. ☐
Describe accident:

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.)

X _____ ***Worker's signature*** _____ ***Date***

Provider

Provider: If worker initiated this report, give worker a copy immediately.

If the worker filed this report for:

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes, including diagnostic codes. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – 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: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit.**

If filing for progress report, closing report, or palliative care request, check the appropriate box below.

☐ **Progress report** *OR* ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Palliative care request –** 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.

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online:
WorkCompCoverage.wcd.oregon.gov

To order supplies of this form, call 503-947-7627.

a

Date/time of first treatment: | Last date treated: | Was worker hospitalized as an inpatient? ☐ Yes ☐ 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?
☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ☐ No (anticipated date): (Attach findings of impairment, if any.)

Work ability status:
☐ Regular work (job at injury) authorized start (date):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date): through (date, if known):

c

Chart notes: 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: *(print, type, or use stamp)*

X _____ ***Provider's signature*** _____ ***Date***

— 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

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

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

  Workers' Compensation Resolution Section
  Toll-free: 800-452-0288
  Email: 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).

440-3283 (07/10/DCBS/WCD/WEB)

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:

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

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)

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
☐ Insurer
☐ Medical service provider
☐ Other: _____
☐ Worker's attorney
☐ Insurer's attorney
☐ Managed care organization

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.

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Workers' Compensation Division

Medical Fee Dispute Resolution Request and Worksheet

Notice

ORS 656.248 and OAR 436-009-0008 provide that when a dispute about fees exists between a medical provider and an insurer, the insurer, medical provider, or worker may request review by the director of the Department of Consumer and Business Services. The request for review must be submitted to the division within 90 days of the time the aggrieved party knew or should have known about the dispute. The insurer or medical provider should use both Forms 2842 and 2842a to request review of fee disputes. An injured worker may elect to use these forms, or may call the Medical Resolution Team at 503-947-7606 for assistance.

If you are aggrieved because of nonpayment or reduction of payment, you should do the following ***before*** submitting this form:

1. Contact the insurer to determine why payment has not been made or why payment has been reduced. Please provide the insurer's explanation.
2. Wait at least 45 days from the date the insurer received your billing, OAR 436-009-0030.

In all cases of an accepted compensable injury or illness under workers' compensation law, the injured worker is not liable for payment for any services for the treatment of that injury or illness, except as provided in OAR 436-009-0010.

Worker information

Worker name: _____ Phone: _____

Provider name: _____ Claim no.: _____

Provider phone: _____

Attention providers: List specific CPT codes and dates of services in dispute

Service dates	CPT code	Amount billed	Amount paid

Attach copies of this sheet if more lines are needed

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*	
Lift:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Carry:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Push:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Pull:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time

Activity restrictions

Stand:	____hrs./day	____hrs./one time	***Twist:***	____hrs./day	____hrs./one time	***Crawl:***	____hrs./day	____hrs./one time
Walk:	____hrs./day	____hrs./one time	***Climb:***	____hrs./day	____hrs./one time	***Crouch:***	____hrs./day	____hrs./one time
Sit:	____hrs./day	____hrs./one time	***Bend:***	____hrs./day	____hrs./one time	***Balance:***	____hrs./day	____hrs./one time
Drive:	____hrs./day	____hrs./one time	***Above-shoulder-reach:***	____hrs./day	____hrs./one time	***Below-shoulder-reach:***	____hrs./day	____hrs./one time
Kneel:	____hrs./day	____hrs./one time						

Hand use restrictions

Fine actions:	____hrs./day L hand	____hrs./day R hand
Keyboarding:	____hrs./day L hand	____hrs./day R hand
Grasp:	____hrs./day L hand	____hrs./day R hand

Foot use restrictions

Raise:	____hrs./day L foot	____hrs./day R foot
Push:	____hrs./day L foot	____hrs./day R foot

Notes / other restrictions: _____

_____

Medical provider's signature: _____ Date: _____

Print medical provider's name: _____ Phone no.: _____

{Date}

{Physician's or authorized nurse practitioner's name}
{Street address}
{City, state, ZIP}

Elective Surgery Notification

Re: Worker name: _____ Claim number: _____

Insurer's response to elective surgery notification

We received your request for elective surgery for this worker (check one box).

Box #1 ☐
We approve your request for (list specific surgery): _____

Box #2 ☐
We have scheduled a consultant exam with _____ on _____ to evaluate whether the proposed treatment is medically reasonable to treat the compensable injury. The consultation must be completed within 28 days from the date of this notice. We will notify you of the consultant's findings within seven days of the completed consultation.

Box #3 ☐
We disapprove the proposed surgery and no consultant exam is requested (list specific surgery):

_____

Physician or authorized nurse practitioner

If the insurer checks:

Box #1 You may proceed with the proposed surgery.

Box #2 When you receive the consultant's findings and the consultant physician agrees with the proposed surgery, you may proceed with the surgery. If the consultant physician disagrees with the proposed surgery, you may contact the insurer to try to reach an agreement about the proposed surgery. **If you do not reach an agreement and continue to recommend the proposed surgery, sign and date below, and return this form to the insurer** (keep a copy).

_____ _____
Physician's or authorized nurse practitioner's signature *Date*

Box #3 You may contact the insurer to try to reach an agreement about the proposed surgery. **If you do not reach an agreement and continue to recommend the proposed surgery, sign and date below, and return this form to the insurer** (keep a copy).

_____ _____
Physician's or authorized nurse practitioner's signature *Date*

If the insurer believes the proposed elective surgery is excessive, inappropriate, or ineffectual, the insurer must request administrative review by the director of the Department of Consumer and Business Services within 21 days of the date the medical provider signs this form. Failure by the insurer to timely respond to the physician's or authorized nurse practitioner's elective surgery request, or to timely request administrative review, bars the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

{Insert insurer's name, address, and phone number}

cc:

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) 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

Health Care Providers
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
  - Phone: 503-947-7814
  - Fax: 503-947-7718
  - Email: 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

440-3248 (3/16/COM)