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Physician Assistants' Guide to Oregon On-the-Job Injuries



community
Workers' Compensation

Physician Assistants' 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:

- Patient information — worker's name and insurer claim number
- History — if part of a closing report
- Examination — date, symptoms, objective findings, type of treatment, current diagnosis (ICD-10-CM codes for dates of service on or after Oct. 1, 2015), and physical limitations. Objective findings should include comments on what is reproducible, measurable, or observable
- Other findings — laboratory and X-ray results
- Ability to work — the dates for which no work is authorized, the date on which return to modified work is authorized, the date on which the worker can return to regular work, and description of any limitations
- Medically stationary status — medically stationary or anticipated medically stationary date and estimated length of further treatment
- Other — information regarding surgery or hospitalization, palliative care plan, and justification for palliative care
- Next appointment date
- Referrals to other providers

The insurer may request periodic progress reports. Form 827 is not required if chart notes provide the information requested. You must respond within 14 days of receipt of such a request.

Workers' Compensation Division

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Health care providers' roles and limits

The Workers' Compensation Division (WCD) developed this guide for physician assistants who treat workers' compensation patients.

STARTING JAN. 2, 2008, IF YOU ARE TREATING PATIENTS FOR OREGON ON-THE-JOB INJURIES, YOU WILL HAVE TO CERTIFY TO THE DIRECTOR OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES (DIRECTOR) THAT YOU HAVE REVIEWED THE MATERIALS SUPPLIED IN THIS GUIDE.

Note: You must read and understand this guide before you certify to the director.



Certification

You must review this guide and enclosed materials, which are also available on WCD's Web site, www.wcd.oregon.gov. You must certify to the director that you are a licensed physician assistant and that you have reviewed the guide and enclosed materials.

To certify to the director using our easy online process, visit WCD's Web site at www.wcd.oregon.gov and click on "Health Care Providers." You also may sign and submit Form 3650 (Physician Assistant's Statement of Certification) found in the back of this guide.



You are not allowed to treat patients for Oregon on-the-job injuries unless you have certified to the director.

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 can qualify as an attending physician. A physician assistant, chiropractic physician, or naturopathic physician may be an attending physician for a limited period. Only an attending physician who is a medical doctor, doctor of osteopathy, oral surgeon, or chiropractic physician is allowed to make impairment findings.

As a physician assistant, you can be an attending physician for up to 60 consecutive calendar days or 18 visits (whichever occurs first) and authorize time-loss benefits for up to 30 calendar days from the first day the patient sees you or any physician assistant, chiropractic physician, or naturopathic physician on the initial claim. During that period, you do not need a referral from an MD, podiatric physician, DO, or authorized nurse practitioner. After a patient is medically stationary, you are no longer allowed to serve as an attending physician. As a physician assistant, you are not allowed to make impairment findings.

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 may also 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.

Non-attending physician status

Once you no longer are an attending physician, i.e., after the 60 days or 18 visits or after the worker becomes medically stationary, you can only treat an injured worker as directed by an attending physician.

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.

Out-of-state physician assistant

You are not allowed to treat patients for Oregon on-the-job injuries unless you certify to the director. Additionally, you must have approval of the insurer to assume the role of attending physician and be willing to comply with Oregon Administrative Rules, Chapter 436, Divisions 009, 010, 015, and 060.

Specifics for attending physician status

First visit

Attending physician

When a worker wishes to choose you as his or her attending physician, you need to establish whether or not you can assume the role of an attending physician.

- You are only allowed to be the attending physician on the initial claim, i.e., before the worker has been declared medically stationary.
- Further, before you can assume the role of attending physician, you need to find out whether the worker has previously seen a physician assistant, chiropractic physician, or naturopathic physician on the current claim.
 - If yes, determine when the worker saw one of the above providers for the first time. If it has been more than 60 consecutive calendar days or 18 visits, you cannot assume the role of an attending physician and must provide services as directed by the attending physician (also see example under time-loss benefits).
 - If no, you are allowed to serve as the attending physician for up to 60 consecutive calendar days or 18 visits, whichever comes first.



Note: The worker may change attending physician or nurse practitioner two times after the initial choice.

Generally, changes outside the worker's control do not count toward the three choices. If the insurer objects to the change, the worker may request approval from the director.

Time-loss benefits/Return to work

An attending physician or authorized nurse practitioner has a primary responsibility to authorize temporary disability benefits and describe for the insurer any limits on the worker's ability to perform work activities.

As a physician assistant, you are allowed to authorize time-loss benefits, if you are the worker's attending physician, for up to 30 calendar days from the date of the first visit to any physician assistant, chiropractic physician, or naturopathic physician.

Example: The worker went to see a naturopathic physician on April 1. The naturopathic physician was the worker's attending physician for 30 days and authorized time-loss benefits from April 1 through April 15. Today, May 1, you become the worker's attending physician. Because it has now been 30 days since the worker first saw the naturopathic physician, you are not allowed to authorize any further time-loss benefits. Additionally, remember that physician assistants, chiropractic physicians, and naturopathic physicians are only allowed to serve as the attending physician for up to 60 calendar days or 18 visits from the first visit to any of those providers. Since the worker saw a naturopathic physician the first time on April 1, you are now only allowed to serve as the attending physician until May 30 (60 days from April 1).

If you release a worker back to any type of work, you must inform the worker immediately and notify the insurer in writing within five consecutive calendar days. 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.

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.
 - In this case send Form 827 to the insurer within **five days**.

Give the worker a copy.

For additional information on Form 827, see Appendix.

Worker notification

On the first visit, you must notify the worker, preferably in writing, of the following:

- That you are only allowed to provide treatment as an attending physician for up to 60 consecutive calendar days or 18 visits from the date of the first visit to any physician assistant, chiropractic physician, or naturopathic physician.
- That you are only allowed to authorize time-loss benefits for a period of up to 30 calendar days from the worker's first visit to any physician assistant, chiropractic physician, or naturopathic physician.
- That the worker may be personally 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 seeks treatment from you after the 60 days or 18 visits without authorization from a qualified attending physician, specialist physician, or authorized nurse practitioner.
 - If a worker who has been enrolled in an MCO seeks treatment from you and you are not a panel provider for that MCO.
 - If a worker seeks treatment after having been notified that the treatment is experimental, outmoded, unscientific, or unproven.

You can find a sample worker notification in the Appendix.

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.

Ongoing treatment

Make sure you keep track of the 60-day/18-visit limit for attending physician status and the 30-day limit for time-loss benefits.

If you refer the worker to an ancillary care provider (e.g., physical therapy), 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.

End of attending physician status

After your 60 days or 18 visits of attending physician status, the worker has to change to an attending physician who is an MD, podiatric physician, DO, or to an authorized nurse practitioner. If the worker's newly selected attending physician prescribes continued services by you, you may provide those as directed by the attending physician.

(See page 5.)

Additionally, since you are only allowed to be an attending physician on the initial claim, the worker has to change to an attending physician who is an MD, podiatric physician, DO, or when the worker becomes medically stationary. You can continue to treat the worker as directed by the newly selected attending physician. (See page 5.)

If you determine that the worker requires time-loss benefits beyond the 30 days you are allowed to authorize, you must refer the worker to an attending physician who is an MD, podiatric physician, DO, or an authorized nurse practitioner.

When you determine that the worker has become medically stationary from the compensable injury or illness, you must notify the insurer and tell the insurer the date the worker became medically stationary and whether or not the worker is released to any form of work.

- If the worker may have permanent impairment, you must refer the worker to an attending physician who is an MD, podiatric physician, or DO within eight days of when you declared the worker medically stationary for a closing examination. *You are not allowed to make any findings of impairment.*

- You must also refer the worker to an attending physician for a closing examination when the insurer has issued a combined condition denial (i.e., issued a denial because the accepted condition is no longer the major contributing cause of the disability or need for treatment), even if the worker is not medically stationary.

Specifics for non-attending physician status

First visit as non-attending physician

After the 60 days or 18 visits or after a worker has been declared medically stationary (i.e., the claim is closed or reopened as an aggravation), you are no longer allowed to be the attending physician. An attending physician must prescribe all treatment. Since you are no longer an attending physician, you are not allowed to authorize time-loss benefits.

Ongoing treatment

Make sure you provide care as directed by the attending physician.

Treatment after medically stationary

Although you are no longer allowed to assume the role of attending physician, you may continue to treat a patient with an Oregon on-the-job injury if you are working within the scope of your license and as directed by the attending physician.

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. 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. The attending



physician must submit a palliative care request 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 provider's name (i.e., your name), 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 a palliative care request and send it to the insurer for approval, the insurer does not have to pay you for the service you provided.



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

Billing

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 been accepted yet. Charge your usual fees that you charge to the general public. Here are some additional tips for a smoother billing process:

- 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.
- Include legible chart notes with all your billings.
 - Chart notes may only be in a coded or semi-coded manner if you provide a legend with each set of records.
 - The chart notes must document which services have been provided by a physician assistant.
 - 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 7.)



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.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>.

Payment for physician assistants is 85 percent of a physician's allowable fee. For surgical procedures, physician assistants will be paid at the rate of 15 percent of the surgeon's allowable fee.

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.
- After the 60 days or 18 visits, you provide treatment without authorization from the attending physician.
- If you provide palliative care 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, and
 - 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.

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.

Surgery

Emergency surgery

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, is not considered elective surgery. In such cases, the surgeon should notify the insurer of the need for emergency surgery.

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 prior to 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 they want 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.

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 the 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 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.



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 a 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.



Note: Since you are not authorized to be the attending physician after a worker is declared medically stationary, you cannot file a claim of aggravation on the worker's behalf.

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.

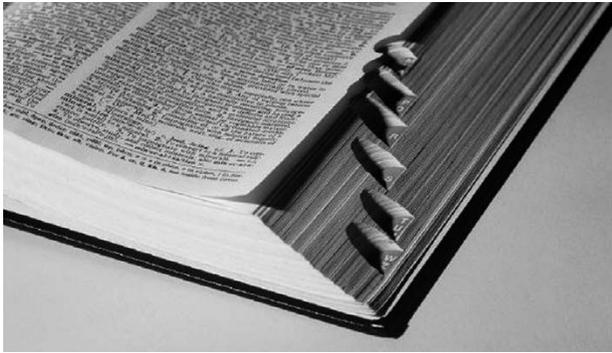


Note: Bulletin 239 outlines the requirements for performing a closing examination.

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 of 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 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 (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 inpatient during the first 14 consecutive days. The claim is also 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.

Oregon law requires that, under a DCS, 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, the health care provider can submit the unpaid bills to the worker's health insurer. If there is no health insurer, the worker may be billed (ORS 656.289).

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 Health Care Provider'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.

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 medical condition is not expected to improve any further either from more medical treatment or the passage of time (ORS 656.005). 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 eligible for 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 the 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 consecutive calendar days to accept or deny a new condition.

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 a new condition claim is made in writing by the injured worker for that herniated disk. (See also omitted medical condition claim.)

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).

Example: Range of motion, atrophy, muscle strength, and 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 claim

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 consecutive calendar 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.

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 the 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 measurement 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 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.
 - 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.

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 who 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 an injured 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 a specialist physician provides specialized treatment, the attending physician continues to monitor the

injured worker and authorizes any time loss.

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 as a result 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, 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 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
Authorize time loss	*30 days
Attending physician status	*60 days/18 visits



***Note:** Remember, as a physician assistant you can be an attending physician for up to 60 calendar days or 18 visits (whichever comes first) and authorize time-loss benefits for up to 30 calendar days

from the first day the patient sees you or any physician assistant, chiropractic physician, or naturopathic physician on the initial claim.

Self-test

Use the self-test to check 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 a physician assistant be an attending physician for an injured worker?

Answer: On an initial claim, a physician assistant can be the attending physician for up to 60 days or 18 visits from the worker’s first visit to any physician assistant, chiropractic physician, or naturopathic physician. These providers must share the 60 days or 18 visits they can serve as attending physician beginning with the worker’s first visit to one of them.

3. For what period can a physician assistant authorize temporary disability benefits?

Answer: A physician assistant can authorize time-loss benefits for no more than 30 calendar days from the first visit to any physician assistant, chiropractic physician, or naturopathic physician.

4. Is a physician assistant authorized to make impairment findings?

Answer: As a physician assistant you are not authorized to make impairment findings. If a worker may have permanent impairment, a physician assistant must refer the worker to an attending physician who is an MD, podiatric physician, or a DO.

5. Are you allowed to release medical information to an employer who is not a self-insured employer?

Answer: No. You are only allowed to release information for specific purposes such as return to work or modified work.

6. What are the required response

times for a physician assistant in the following situations:

A. To notify the insurer that you are assuming primary treatment responsibility for an injured worker who was being treated by another provider?

Answer: 5 consecutive calendar days.

B. To forward requested information to the new attending physician or nurse practitioner when primary responsibility for treatment is transferred from one attending physician or nurse practitioner to another?

Answer: 14 consecutive calendar days.

C. To sign a copy of the treatment plan form the ancillary care provider and provide it to the insurer when you are the attending physician and prescribe ancillary treatment?

Answer: 30 consecutive calendar days.

D. To respond to a request by the director or the insurer for progress reports, narrative reports, or 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 those evaluations when one is requested by the insurer?

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

F. To forward original X-ray films or diagnostic studies to the insurer or the director upon request?

Answer: 14 consecutive calendar days.

7. Where can information about medical



fees in workers' compensation 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 the following Web site: <http://www.cbs.state.or.us/external/wcd/policy/rules/rules.html>.

8. If an employer requests a bill for medical services, 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 \$1,700 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.

9. 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 workers' health-benefit plan, and send a copy of the denial. Once you receive payment, submit your bills with copies of the EOB 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.

10. Are you allowed to treat an injured worker on a closed claim or a claim for aggravation?

Answer: As a physician assistant you are only allowed to treat an injured worker under the direction of the attending physician if the worker's claim is closed or reopened under an aggravation. You may not assume the role of attending physician on a claim that is either closed or reopened under an aggravation.

11. Can you as a physician assistant request palliative care?

Answer: No. An attending physician can only prescribe palliative care after a worker has become medically stationary (i.e., it is no longer during the initial claim). As a physician assistant you can only be the attending physician during an initial claim.

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

Elective Surgery Notification — Form 3228

Physician Assistant's Statement of Certification — Form 3650

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.

As a physician assistant, I can be your attending physician for up to 60 days or 18 visits, whichever occurs first, from the date you saw any physician assistant, chiropractic physician, or naturopathic physician. Further, as a physician assistant, I can authorize time-loss benefits for up to 30 days from your first visit to any physician assistant, chiropractic physician, or naturopathic physician.

If you have seen any of these providers 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 physician assistant, chiropractic physician, or naturopathic physician after the 60 days or 18 visits without authorization from a qualified attending physician, specialist physician, or authorized nurse practitioner.
- 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.

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



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.

Worker or provider	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):	Dept. Use Ins. no.
	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
	Phone:	Workers' compensation insurer's name, address:			Source

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: _____ **Describe accident:** _____
- 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)**

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.)

Worker's signature _____
Date

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.

Provider	a	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Next appointment date:	Est. length of further treatment:	If yes, name hospital:
				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): _____
	Work ability status:			
	<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	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*)

- 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

Provider's signature _____
Date

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

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).



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
 - Medical rules violation (requests re: elective surgery, treatment plans, etc.) ORS 656.327
 - Managed care organization (MCO) dispute ORS 656.260
 - Appropriateness of medical treatment ORS 656.327
 - Change of attending physician or nurse practitioner ORS 656.245
 - 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)

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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-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.: _____

Elective Surgery Notification

[DATE]

[PHYSICIAN OR AUTHORIZED NURSE PRACTITIONER NAME]
[ADDRESS]

[RE: WORKER NAME:] [DOI:] [INSURER:] [CLAIM NO:]

[PROPOSED SURGERY _____]

[DEAR _____:]

Insurer's response

We received your request for elective surgery for this worker.

- We approve your request for (list specific surgery): [SPECIFIC SURGERY]
- We have scheduled a consultant examination with [CONSULTANT NAME] on [DATE] to evaluate whether the proposed treatment is medically reasonable to treat the compensable injury. The consultation should be completed within 28 days from the date of this letter. You will be notified of the consultant's findings within seven days of the completed consultation.
- No consultant examination is requested. (If the request is not approved, parties may request administrative review by the director of the Department of Consumer and Business Services, Workers' Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, Oregon 97309-0405.)

Insurer's consultant report

When you receive the consultant's findings, if you disagree and continue to recommend the proposed surgery, or wish to proceed based on the recommendations proposed by the consultant, please call or write to me using the phone number or address below.

Failure to agree

If agreement cannot be reached, and further effort to resolve the request for elective surgery appears to be futile, please sign and date below. Return a copy of this letter to me, retain a copy for your records, and provide copies to all parties listed below.

I believe further efforts to reach agreement will be futile.

X _____
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 medical provider's notice of failure to reach agreement. Failure of 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.

[INSURER SIGNATURE BLOCK]

CC: [WORKER]
[WORKER ATTORNEY] (if applicable)
[ATTENDING PHYSICIAN OR AUTHORIZED NURSE PRACTITIONER] (if applicable)





Physician Assistant's Statement of Certification

(Required to provide medical services and authorize time loss under House Bill 2756, (2007), effective 01/02/08)

By my signature below, I certify that I am a physician assistant licensed by:

Oregon Medical Board (Board of Medical Examiners) License no.: _____

Other _____ License no.: _____

and have reviewed and understand the *Physician Assistant's Guide to Oregon On-the-Job Injuries* along with the enclosed informational packet. I agree to treat patients with Oregon on-the-job injuries in accordance with Oregon law.

Signature: _____ Date: _____

(Please print)

Name: _____

Primary business address: _____

Phone no.: _____

Fax no.: _____

Business e-mail: _____

FEIN (Federal employer tax identification number) (if available): _____

NPI (National provider identifier) (if available): _____

Please return this form to: Workers' Compensation Division
Medical Section
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
Fax: 503-947-7629

Once we receive your certification statement, we will send you a confirmation notice.

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

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

