

# Agenda

## Rulemaking Advisory Committee

Workers' Compensation Division Rules  
OAR chapter 436, division 060  
Claims Administration

<b>Type of meeting:</b>	Rulemaking advisory committee
<b>Date, time, &amp; place:</b>	Aug. 23, 2016, 1:30 to 4:30 p.m. Room 260, Labor and Industries Building, Salem, Oregon Dial-in number: 1-213-787-0529   Access code: 9221262#
<b>Facilitators:</b>	Fred Bruyns and Chris Clark, Workers' Compensation Division
<b>1:30 to 1:45</b>	Welcome and introductions; meeting objectives
<b>1:45 to 3:00</b>	Discussion of issues
<b>3:00 to 3:15</b>	Break
<b>3:15 to 4:15</b>	Discussion of issues
<b>4:15 to 4:30</b>	Summing up – next steps – thank you!

### Attachments:

[Issues document](#)

[Form 801, Report of Job Injury or Illness](#)

[Form 827, Worker's and Health Care Provider's Report for Workers' Compensation Claims](#)

[Form 3283, A Guide for Workers Recently Hurt on the Job](#)

## **ISSUE #1: OAR 436-060-0010: Notice of treatment rights to injured workers.**

### **Description:**

An injured worker has the right to receive treatment from a medical service provider of their choice under ORS 656.245, but this right may not always be fully understood or acknowledged, and in some cases an employer may direct them to a specific provider.

### **Background:**

A worker may choose their attending doctor, physician, or nurse practitioner, subject to the requirements of ORS 656.245, 656.260, and OAR 436-010. Some stakeholders have expressed concerns that workers do not always understand these rights, or are sometimes directed to receive care from a medical service provider by their employer. The division receives roughly 14 complaints per year about direction of care issues, including complaints about employers directing workers to a specific medical service provider. Between 2012 and 2015 the division did not assess any civil penalties for intentional or repeated direction of care violations, although letters of education were issued to a few employers.

Over the past 10 years, several efforts have been made to address this problem (see Appendix.) The division has revised forms provided to the worker to emphasize the worker's right to choose their medical service provider, and has revised rules to require that those forms are made available to workers by insurers and employers. In addition, the division has provided information to employers and insurers about proper use of the forms through industry notice and increased education and enforcement activities.

Currently, workers are provided with information about their right to choose a medical service provider at several points prior to a claim and at the time of injury. Provider choice information is included in all of the following situations:

- Employers are required to post Form 1188, "Notice of Compliance" in a central gathering area in the workplace.
- Employers are required to provide Form 3283, "A Guide for Workers Recently Hurt on the Job" to workers at the time the worker reports an accident. The employer may print the information on the back of Form 801, "Report of Job Injury or Illness" which must be readily available and provided to the worker upon request under OAR 436-060-0010.
- Medical service providers are required to give Form 3283 along with Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," to the worker when the worker seeks treatment for their workplace injury or illness. See OAR 436-010-0241.
- The insurer or service company is required to provide Form 1138, "What Happens if I'm Hurt on the Job" to every injured worker with a disabling claim at the time of the first time-loss payment or provide Form 3283 to every worker with a non-disabling claim. See OAR 436-060-0015.

While the worker may be informed of their right to choose a medical service provider, there is currently no mechanism in place to verify that the worker has understood and acknowledged it. The division would appreciate stakeholder feedback on the appropriate time and method of obtaining verification from the worker and the employer that they understand and acknowledge their rights.

In previous discussions with the division, stakeholders identified the following issues while evaluating possible alternatives:

#### *Delivery of information:*

- Any acknowledgment of rights that fits into current claims processing requirements may be preferable to creating a new form or process as workers can be overwhelmed by the amount of paperwork they receive at the time of injury or claim.
- The acknowledgment should be compatible with paperless claims processing, including forms that are completed electronically or by telephone.
- Some stakeholders suggested the employer should also be required to acknowledge the worker's right to choose a medical service provider.

#### *Timing:*

- Ideally, the acknowledgment would be secured before the worker receives treatment; in many cases, however, the worker is unable to complete any paperwork before they seek medical attention.
- The acknowledgement should be secured simultaneously with the notice of their right to choose a medical service provider, and as close to the time the worker seeks treatment as possible.

#### *Enforcement:*

- The director must be able to monitor and access the acknowledgement, either at the time the claim is reported or at audit.
- It should be clear who is responsible for securing and keeping records of the acknowledgement. One option is to require the insurer to maintain the documents with the other claims records.

#### *Access to care:*

- The acknowledgement process must not prevent the worker from accessing care in a timely manner. If a worker requires emergency or urgent care, there may be constraints on their choice or ability to fill out a form before receiving care.
- Referrals between medical service providers are often considered to be a necessary part of the treatment process.
- The acknowledgement process should not impose prohibitive financial costs on any party, particularly costs that may discourage medical service providers from treating injured workers.
- Regardless of the acknowledgement process selected, language or educational barriers may still need to be addressed through education and outreach.

#### **Alternatives:**

1. Make no changes
2. Add worker/employer acknowledgement to Form 801.
3. Add worker/provider acknowledgement to Form 827.
4. Add worker/employer acknowledgement to Form 3283.
5. Create a new form that is delivered to all workers pre-injury (i.e. at the time of hire.)
6. Create a new form that is delivered to worker at time of injury

#### **Discussion:**

Some of the pros and cons of using each form are discussed below:

**Form 801:** Form 801 is required to be filed with most claims. Analysis of WCD data for 2010-2015 showed that 86% of claims entered into our claims information system were set up using the Form 801, suggesting that Form 801 is available at the time the insurer reports the claim to the division for the vast majority of disabling and denied nondisabling claims (the insurer is not required to report accepted nondisabling claims to the division.) Form 801 is usually filled out by the worker and the employer, but sometimes it may be filled out by the insurer if the worker is not available, or if the employer and worker provide the information. Under ORS 656.265, the worker may provide notice up to 90 days after the

accident occurred, and the notice is not required to be provided using any particular form. This means that using Form 801 would be effective for reaching many, but not all workers.

In some cases, the Form 801 may be completed electronically, or the insurer may complete the Form 801 using information provided by the worker and the employer. Any process to obtain acknowledgement would need to address these situations.

Form 801 should be accompanied by Form 3283 in most cases, and the Form 3283 may be printed on the back of Form 801, so it may be possible to use the Form 801 to verify that the Form 3283 was actually delivered and read.

Stakeholders have also suggested that in addition to obtaining acknowledgement from the worker, Form 801 could also be used to obtain acknowledgement from the employer that they understand they may not direct the worker to see a specific medical service provider.

**Form 827:** Form 827 is filled out by the worker and the medical service provider. Form 3283 is considered to be part of Form 827, and a copy of it is provided with Form 827 when the Form 827 is used as the initial report of a claim, to report new or omitted conditions, aggravations, or changes in medical service provider. However, Form 827 is also used for many other purposes, including progress reports, closing reports, or palliative care requests.

One drawback of using Form 827 is that by the time the worker receives Form 827, they have already chosen or been directed to a medical service provider for initial treatment. While it may be beneficial to have the medical service provider discuss additional treatment options with the worker, the choice may have already been made for all practical considerations.

**Form 3283:** Form 3283 is required to be given to the worker by the employer when the worker files a claim (nearly always using Form 801) for workers' compensation benefits and when the worker completes Form 827 with a medical service provider. Form 3283 provides workers with information about their rights, but currently, no signature or acknowledgement is required and the form is not required to be retained by the employer, insurer, worker, or medical service provider.

Stakeholders have commented that Form 3283 is not consistently provided, and even when it is, it is not always read carefully by the worker. Adding a signature block may increase the likelihood that the form is delivered. However, because the form is required to be given to the worker at several points in the lifecycle of the claim, it would be necessary to specify if the worker should be required to sign the form each time it is provided, or only with the initial Form 801 or 827.

**New Form:** Creation of a new form would allow the division to design a form specifically to acknowledge the worker's understanding of their right to choose their medical provider, and potentially other rights and responsibilities of workers and employers. Creating a separate form would also provide the division with flexibility about when the form is delivered to workers, potentially reaching workers before an injury occurs. However, creation of a new form could be costly, and could place an administrative burden on employers and insurers. It is also not clear how effective a new form would be in ensuring workers understand their rights. If a new form was provided at the time of hire, a worker may forget the content before an accident or injury occurs. If it is provided at injury, having another form to sign may overwhelm the worker and lessen their ability to understand and absorb the new information.

**Recommendation:**

**Amend Form 801 to include an acknowledgement from the worker and employer that the worker has received Form 3283 and understands their right to choose their medical service provider.**

Amending Form 801 to include an acknowledgement from the worker and employer that the worker has received and understands Form 3283 has been suggested as an acceptable alternative by many stakeholders at previous advisory committee meetings that would help reduce the number of workers who are directed to a specific provider by their employers. Form 801 is well suited to this purpose because a large percentage of initial claims are reported using the form, it is delivered through many platforms, and would have a low cost of implementation.

Additional feedback is needed on the precise wording and form of the acknowledgment (i.e. checkbox, signature line, initial line). For insurers and service companies, we would also like feedback on any impact on the claims process.

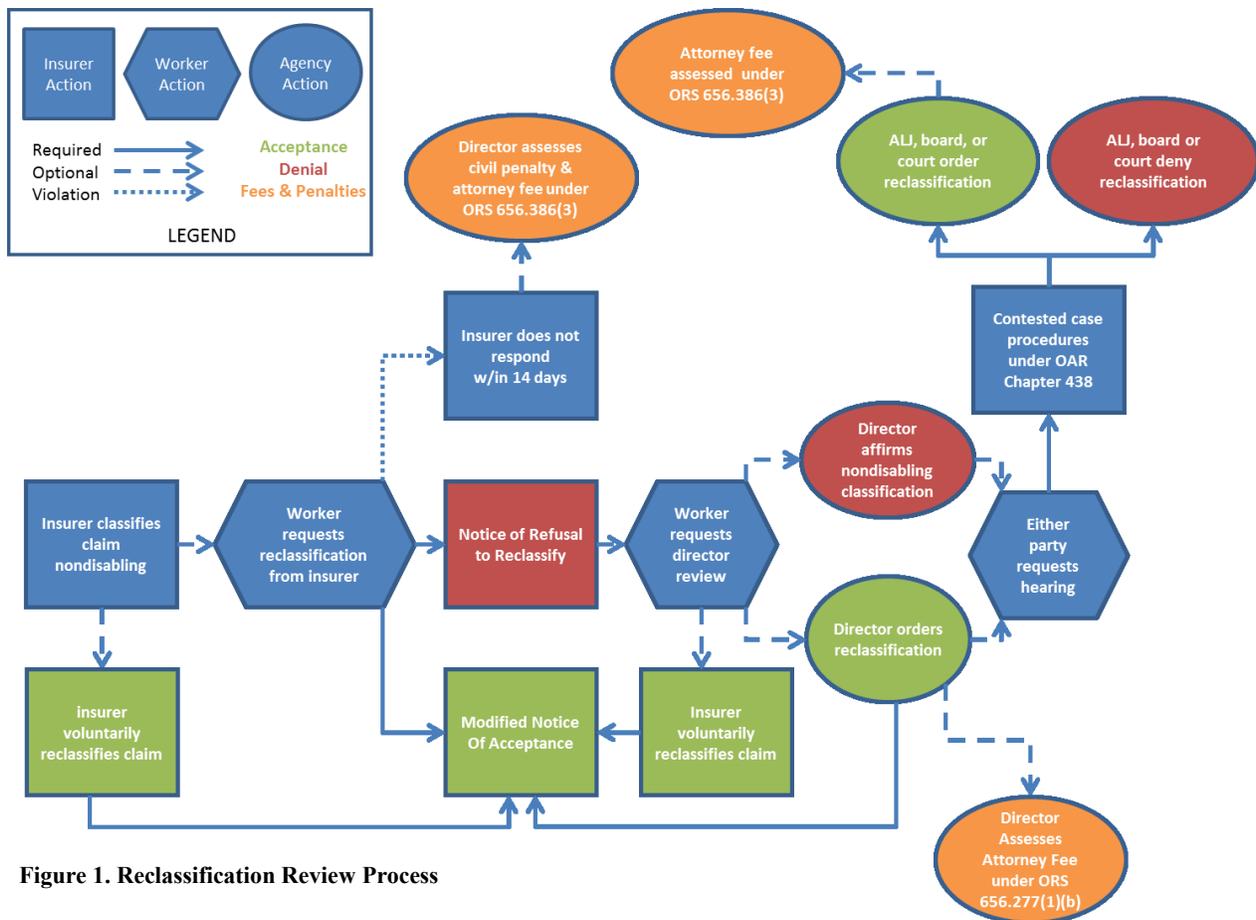
**ISSUE #2 – OAR 436-060-0018 – Attorney fees for claims reclassification.**

**Issue:**

Under ORS 656.277(1)(b), the director may award an attorney a reasonably assessed attorney fee when the attorney is instrumental in obtaining an order from the director reclassifying a claim from nondisabling to disabling. Insurers, however, may voluntarily reclassify a claim, or otherwise resolve a contested decision in a “Notice of Refusal to Reclassify” after a worker has appealed the decision, but before the director orders reclassification. A stakeholder raised the issue that when this occurs, the worker’s attorney does not receive an attorney fee, even when the attorney was instrumental in reclassifying the claim to disabling.

**Background:**

A simplified overview of the reclassification process is provided in Figure 1. Under ORS 656.277 and OAR 436-060-0018, a worker may submit a request to reclassify a nondisabling claim to the insurer if the claim has been classified as nondisabling for one year or less. Within 14 days of the worker’s request, the insurer must review the claim and either issue a Modified Notice of Acceptance changing the classification to disabling, or send a Notice of Refusal to Reclassify. If the insurer does not respond within 14 days, the director may assess a civil penalty under ORS 656.745 and attorney fees under ORS 656.386(3).



**Figure 1. Reclassification Review Process**

If the insurer sends a Notice of Refusal to Reclassify, the worker can request review from the director under ORS 656.277(1)(a). The director will issue a director’s review order either reclassifying the claim or affirming the insurer’s classification decision. Either party can request a hearing on the director’s order. Under ORS 656.277(1)(b), which became effective January 1, 2016, if the worker’s attorney “is instrumental in obtaining **an order from the director that reclassifies the claim from nondisabling to disabling**, the director may award the attorney a reasonable assessed attorney fee.” (Emphasis added).

In some cases, however, the insurer may voluntarily reclassify the claim as disabling after the worker has requested review, but before the director issues an order. In these cases, the director dismisses the worker’s request because the worker has already obtained the relief requested and there is no substantive issue for the department to review. The language of ORS 656.277(1)(b) does not provide for an attorney fee to be assessed in these circumstances even if the attorney was instrumental in the reclassification of the claim, because it is the insurer’s action that reclassifies the claim, not an order from the director. It should be noted, however, that even when the attorney is not awarded a fee under ORS 656.277, it is possible that a fee could be awarded under ORS 656.262(11) if the delay in payment of temporary disability as a result of the refusal to reclassify is found to be unreasonable.

As shown in Table 1, the division received an average of 10 requests for reclassification review each month between 2010 and 2015. Roughly 43% of these requests resulted in orders reclassifying the claim from nondisabling to disabling. Another approximately 32% resulted in orders affirming the insurers nondisabling classification, and approximately 25% resulted in dismissal orders. This general pattern appears to be continuing in 2016; the division received 93 requests for reclassification review between January and August, with roughly 32% of requests resulting in a reclassification, 35% in an affirmation of the insurer’s classification and 32% in dismissals. A director’s classification review dismissal order may be issued for several reasons, including if the insurer voluntarily reclassifies the claim after the worker’s request for review, if the parties reach a settlement, or if the insurer fails to respond to the reclassification request. There has been a slight increase in the proportion of dismissal orders this year, but there is not enough data to determine if this is part of a larger trend resulting from the changes to statute. There was also no evidence to suggest that any insurer was responsible for a disproportionate amount of dismissal orders.

**Table 1. Orders on reclassification 2010-2016.**

<b>Order Type</b>	<b>Order Title</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016 YTD</b>	<b>Total</b>
<b>2345</b>	Affirming insurer’s nondisabling classification.	53	22	29	36	52	51	33	276
<b>2348</b>	Modifies insurer nondisabling classification to disabling.	68	65	72	44	23	55	30	357
<b>2349</b>	Director’s classification review dismissal order.	37	33	26	30	23	40	30	219
<b>2351</b>	Director’s classification review denial order.	1	0	0	0	0	0	0	1
<b>2378</b>	Director classification review abate and withdraw.	1	1	1	0	0	0	0	3
<b>TOTAL</b>		<b>160</b>	<b>121</b>	<b>128</b>	<b>110</b>	<b>98</b>	<b>146</b>	<b>93</b>	<b>856</b>

ORS 656.277(1)(b) was enacted as part of HB 2764 (2015) which modified the circumstances under which attorney fees may be awarded and amount of attorney fees awarded under several statutes in ORS chapter 656. The bill was intended to ensure that worker’s attorneys were compensated for services

performed while representing workers. The division is considering alternatives to improve the worker's attorney's ability to receive a fee when the attorney is instrumental in reclassifying the claim to disabling after the worker has submitted a request for claim classification review.

**Alternatives:**

1. Make no changes.
2. Amend OAR 436-060-0018(6) to provide that an insurer may only voluntarily reclassify a claim on or before the day the director receives a request for claim classification review.
3. Establish a clear process for review of reclassification when the insurer does not respond to the worker's initial request for review.

**Discussion:**

**Alternative 2** would add language similar to OAR 436-030-0023(1), which provides that "an insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that Notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure." This alternative would establish a cutoff point where the insurer may no longer voluntarily reclassify a claim after the worker has requested review by the director, and reduce the number of dismissal orders.

There are concerns, however, that restricting the insurer's ability to reclassify claims would delay payment of benefits to the worker. In many cases, the insurer has legitimate reasons to voluntarily reclassify a claim after the worker has requested the director's review, and under OAR 436-060-0018 the insurer is required to reclassify a claim to disabling within 14 days of receiving information that any accepted condition meets the disabling criteria. The director's classification review process takes around 50 days on average, and even if the director issues an order reclassifying the claim the worker may still have to wait until the expiration of the 30-day appeal period to receive compensation. On the other hand, increasing the likelihood that an attorney fee will be awarded after the reclassification review may incentivize insurers to be more proactive about gathering information regarding classification decisions earlier in the process.

During the analysis of this issue, the division also found that because the director's authority to reclassify a claim stems from the insurer's refusal to reclassify the claim under ORS 656.277, current practice is to dismiss a request for classification review if the insurer fails to respond to the worker's initial request for reclassification. The division would appreciate stakeholder input on what, if any, actions should be taken to move the worker's request forward in addition to penalties and fees authorized under ORS 656.386(3).

**Recommendation:**

**ISSUE #3 - OAR 436-060-0035 - Notice to worker of ineligibility for supplemental disability benefits.**

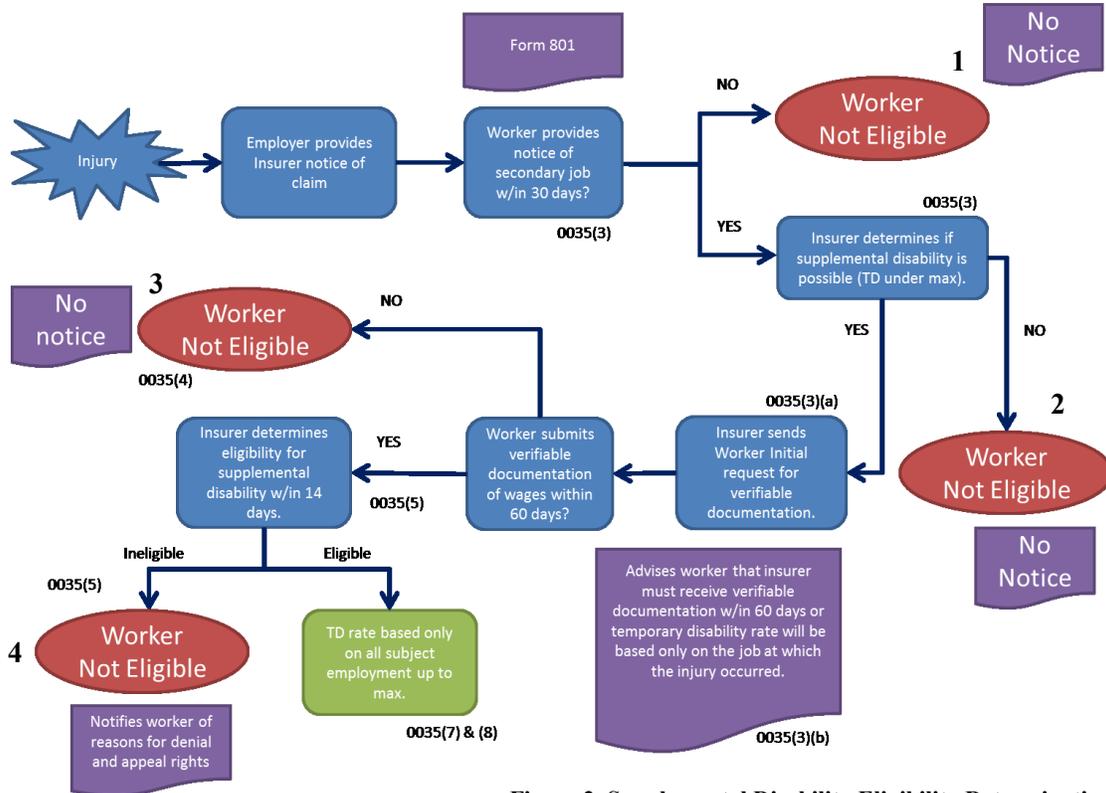
**Issue:**

Under OAR 436-060-0035, an insurer is not required to notify a worker of a determination that the worker is ineligible for supplemental disability until the insurer has received verifiable documentation of the worker’s wages from their secondary job. It is unclear if the insurer has a responsibility to inform the worker that they have been determined to be ineligible for supplemental disability benefits in other situations, and when the worker’s appeal rights begin and end when notification is not provided.

**Background:**

As illustrated in Figure 2, there are several scenarios where the insurer may determine that the worker is ineligible to receive supplemental disability benefits:

1. The worker does not provide notification of the secondary job to the insurer within 30 days of the insurer’s receipt of the initial claim;
2. The insurer or service company determines that the worker is already receiving the maximum allowable benefit under ORS 656.210 based on the wages from their primary job prior to requesting verifiable documentation;
3. The worker does not provide the verifiable documentation of their wages from their secondary employment within 60 days after the insurer’s request; or
4. The insurer, service company, or assigned processing administrator determines that the worker is ineligible for supplemental disability based on the worker’s verifiable documentation.



**Figure 2. Supplemental Disability Eligibility Determination**

OAR 436-060-0035(5) provides that within 14 days of receiving a worker's verifiable documentation of wages from a secondary job, an insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability and communicate the decision to the worker and advise the worker how to appeal the decision (Scenario 4). In the request for verifiable documentation, the insurer is required to inform the worker that they will be determined to be ineligible if they fail to respond, but it is not clear what, if any, responsibility the insurer has to notify the worker after such a determination has been made, or when the period to appeal the determination begins or ends (Scenario 3). It is also unclear when the worker should be informed of an eligibility determination that occurs before the request for verifiable documentation is sent (Scenario 1 and 2).

The Department of Justice (DOJ) recommended the division adopt clearer guidelines for when an insurer, service company, or assigned processing administrator must notify the worker that they are ineligible for supplemental disability benefits and of their appeal rights. The division would appreciate any suggestions for implementing this recommendation.

The DOJ has also recommended the division clarify who must receive the verifiable documentation when the insurer has elected to not process and pay supplemental disability. Under 656.210(2)(b), the verifiable documentation must be received by "the insurer, self-insured employer or assigned claims agent for a noncomplying employer" for the worker to be eligible for supplemental disability benefits. This list does not include an assigned processing administrator, yet the worker is directed to send the verifiable documentation to the assigned processing administrator in the notice sent under OAR 436-060-0035(3)(c). The requirement for assigned processing administrators and insurers to cooperate and share documentation to coordinate benefits under OAR 436-060-0035(18) may be sufficient to establish that if the assigned processing administrator has received the documentation, the insurer should as well, but it is unclear if that is true in practice. The division would appreciate any additional suggestions to make the rules more consistent with statute.

**Alternatives:**

1. Make no changes
2. Amend OAR 436-060-0035(2) to require the insurer to notify the worker of the determination that the worker is not eligible for supplemental disability benefits because they are already receiving the maximum benefit under ORS 656.210, and their right to appeal within 14 days of the determination.
3. Remove OAR 436-060-0035(2) and require the insurer to make an eligibility determination only after requesting verifiable documentation from the worker and follow the notification procedures under OAR 436-060-0035(5).
4. Amend OAR 436-060-0035(5) to require the insurer to notify the worker of the ineligibility determination and of their right to appeal within 14 days after the end of the 60-day period after the request for documentation, or within 14 days after receiving verifiable documentation.
5. Amend OAR 436-060-0035(3)(c) to provide that the notice sent to the worker must advise them to send the verifiable documentation to the insurer and the assigned claims administrator.
6. Amend OAR 436-060-0035(3)(c) to require the worker to send the verifiable documentation to the insurer and require the insurer to forward it to the assigned processing administrator.
7. Amend OAR 436-060-0018 to clarify that the assigned claims processing administrator is responsible for providing the insurer with the verifiable documentation provided under OAR 436-060-0035(3)(c).

**Discussion:**

The division did not consider any alternatives that would require the insurer to notify the worker when they are determined to be ineligible for supplemental disability if the insurer does not receive notice or knowledge of the workers employment at a secondary job. All alternatives seek to inform the worker of the determination of ineligibility and the reasons why after the worker has provided notice of the secondary job under scenarios 2 to 4.

**Alternatives 2 and 3** would inform workers of their ineligibility for supplemental disability if they are determined to already be receiving the maximum benefit under ORS 656.210. Informing the worker of the reason why their request is denied in these cases will reduce the likelihood of confusion and litigation later in the claim, and clearly communicate what benefits the worker can expect. **Alternative 2** could be issued through a separate notice, or by including the eligibility determination for supplemental disability in the Notice of Acceptance. It may be desirable for the insurer to request verifiable documentation in every case they have knowledge of secondary employment as suggested in **Alternative 3**, however, the increase in reporting may increase administrative costs to the insurer with limited benefit to the worker.

**Alternative 4** would reduce uncertainty about the timing of the appeal period by providing the worker notice of the determination that they are ineligible for supplemental disability because they did not provide the requested verifiable documentation within the 60-day timeframe. While the worker is already provided notice of the consequences of not providing the documentation under OAR 436-060-0035(3), providing notice after the determination has occurred may improve transparency in the process and give the worker the opportunity to appeal in a timely manner.

**Alternative 5 to 7** address the secondary problem of meeting the requirement of ORS 656.210(2)(b). **Alternative 5 or 6** would be most consistent with the statutory requirement for the documentation to be received by the insurer, but **Alternative 5** would add some costs to the worker. **Alternative 6** would not add costs to the worker, but may result in delays if the assigned processing agent does not receive the documentation in a timely manner. **Alternative 7** has the least costs for all parties, but is dependent on cooperation between the assigned processing administrator and the insurer. It is possible that this issue could be addressed through education efforts; however there may still be some benefit to clarifying the expectation in the rule.

**Recommendation:**

## **Appendix: Timeline of Notice of Treatment Rights Activities.**

- In 2006, WCD held a stakeholder advisory committee meeting to discuss providing notice of an injured worker's right to choose a medical provider. Several changes to rules, forms, and division processes were made including:
  - Revision of Form 3283 to emphasize that that “[the worker] may receive medical treatment from the health care provider of their choice”
  - Issuance of an industry notice advising insurers and self-insured employers of their responsibilities.
  - Revision of Form 1138 to emphasize a workers' right to choose their provider
  - Providing messages on the worker's right to choose a health care provider on the Workers' Compensation Info-line.
- In 2007, the division mailed the revised Form 3283 to approximately 90,000 Oregon employers, along with a cover letter explaining workers' rights to choose their providers.
- In 2009, a rulemaking process was started in response to introduction of HB 2044. The bill proposed to add language to statute prohibiting employers (except employers with an MCO) from directing care and requiring the division to assess a civil penalty of \$2000 for each violation. No action was taken on the bill, but WCD made several more revisions to rule:
  - OAR 436-060-0015 was amended to provide that, in addition to the requirement for insurers to provide Form 3283 to employers, the employer must provide the form to the worker at the time the worker files a claim for compensation benefits.
  - OAR 436-010-0240 was revised to provide that all medical service providers must provide Form 3283 to workers at the time they provide Form 827.
- In 2011, a rulemaking process was started in response to the introduction of HB 2346, a bill which contained similar provisions as the 2009 bill, and would have required that the director to adopt by rule a form to be used by employers to give workers notice of their medical treatment rights. The form, to be provided when the worker gives notice of injury, would have included an explanation of the workers rights, and would required a signature from both the employer and injured worker. No action was taken on the bill. After several stakeholders raised concerns about requiring additional forms, the WCD administrator issued a letter stating that the division would focus on additional education and enforcement efforts.
- Also in 2011, HB 2093 was enacted, providing among other things, that only a managed care organization certified by the director may restrict the choice of a health care provider or medical service provider by a worker; restrict the access of a worker to any category of medical service providers; and that the director may impose sanctions against any person who violates these provisions, including a civil penalty of up to \$2000 per violation. The division has assessed at least one penalty under this rule since the law came into effect.
- In 2015, HB 2032 was introduced. The bill would have prohibited employers or insurer from requiring injured worker to obtain nonemergency medical services from a specific provider, except employers or insurers that had a managed care organization contract. The bill would have required employers to provide injured worker with written notice of medical treatment rights in workers' compensation claim and for the director to adopt a form by rule. No action was taken on the bill.
- In 2016, HB 4052 was introduced. The bill was similar to the 2015 bill, with additional clarifying amendments. The bill was not enacted.

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

# Report of Job Injury or Illness

## Workers' compensation claim

### Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Regularly scheduled days off: <input type="checkbox"/> <input type="checkbox"/> M T W T F S S	<b>DEPT USE:</b>
Time of injury or illness: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Time you left work: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Check here if you have more than one job: <input type="checkbox"/>		Emp
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) <input type="checkbox"/> Left <input type="checkbox"/> Right				Ins
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Occ
				Nat
				Part
				Ev
				Src
				2src

**Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.**

Your legal name:	Language preference:	Birthdate:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Your mailing address:		Home phone:	
Social Security no. (see Form 3283):	Occupation:	Work phone:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p><b>By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. <b>Notice:</b> 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 requires separate authorization.</b></p>			
Worker signature:	Completed by (please print):	Date:	

### Employer

Complete the rest of this form and give a copy of the form to the worker. Notify your workers' compensation insurance company within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. Box):		Insurance policy no.:
Street address from which worker is/was supervised:	ZIP:	Nature of business in which worker is/was supervised:
Address where event occurred:		
Was injury caused by failure of a machine or product, or by a person other than the injured worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No		OSHA 300 log case no:
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: \$
		Date worker hired:
		If fatal, date of death:
Employer signature:	Name and title (please print):	Date:

**OSHA requirements:** Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

# 801

### Health care provider instructions

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

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

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

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

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

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

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

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

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

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

# 827



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.

Worker	<input type="checkbox"/> <b>First report of injury or disease</b> (Do not complete or sign if you do not intend to make a claim.) Have you injured the same body part before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____	Check here if you have more than one job. <input type="checkbox"/>
	<input type="checkbox"/> <b>Request for acceptance of a new or omitted medical condition on an existing claim</b> Condition: _____	<b>Describe accident:</b>
	<input type="checkbox"/> <b>Notice of change of attending physician or nurse practitioner</b> Reason for change: _____	
	<input type="checkbox"/> <b>Report of aggravation of original injury (actual worsening of a compensable condition)</b>	

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

X \_\_\_\_\_  
Worker's signature Date

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

Provider	<b>If the worker filed this report for:</b>		To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: <a href="http://WorkCompCoverage.wcd.oregon.gov">WorkCompCoverage.wcd.oregon.gov</a> To order supplies of this form, call 503-947-7627.
	<ul style="list-style-type: none"> <li><b>First report</b> of injury or illness – Send this form to the workers' compensation insurer within 72 hours of visit.</li> <li><b>New or omitted</b> medical condition – Attach chart notes, including diagnostic codes. Send this form to the insurer within five days of visit.</li> <li><b>Change of attending physician</b> 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: <input type="checkbox"/> I request insurer to send its records.</li> <li><b>Aggravation of original injury</b> – Sign this form and send it to insurer within five days of visit.</li> </ul>		
	<b>If filing for progress report, closing report, or palliative care request, check the appropriate box below.</b>		
	<input type="checkbox"/> <b>Progress report</b> OR <input type="checkbox"/> <b>Closing report</b> (See instructions in Bulletin 239.) <input type="checkbox"/> <b>Palliative care request</b> – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.		

Provider	<b>a</b>	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>b</b>	Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown		Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____
		<b>Work ability status:</b> <input type="checkbox"/> Regular work (job at injury) authorized start (date): _____ through (date, if known): _____ <input type="checkbox"/> Modified work authorized from (date): _____ through (date, if known): _____ <input type="checkbox"/> No work authorized from (date): _____ through (date, if known): _____		
	<b>c</b>	<b>Chart notes:</b> Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).		

Provider's name, degree, address, and phone: ( <i>print, type, or use stamp</i> )  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
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## Notice to worker

### Claim acceptance or denial

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

### Medical care

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

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

### Payments for time lost from work

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

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

### Authorization to release medical records

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

### Caution against making false statements

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

### Palliative care

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

The following are **not** palliative care:

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

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

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

**Workers Compensation Division**  
**(División de Compensación para Trabajadores)**

P.O. Box 14480, Salem, OR 97309-0405

Salem: 503-947-7585

Toll-free: 800-452-0288

**Ombudsman for Injured Workers**  
**(Ombudsman para Trabajadores Lastimados)**

350 Winter Street NE, Salem, OR 97301-3878

Salem: 503-378-3351

Toll-free: 800-927-1271

## A Guide for Workers Recently Hurt on the Job

### How do I file a claim?

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

### How do I get medical treatment?

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

### Are there limitations to my medical treatment?

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

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

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

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

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

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

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

Toll-free: 800-927-1271

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

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

Toll-free: 800-452-0288

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

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