

Oregon Workers' Compensation Overview

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Workers' Compensation



For Hospitals


What we'll cover

- Compensable claims and Form 827
- Billing
- How claim status affects your bills
- Requests for administrative review
- Inpatient vs. Outpatient
- Resolving disputes
- Expediting payment
- What the MRT can do
- Reimbursement
- Resources
- Important timelines



Oregon Revised Statutes (ORS) Oregon Administrative Rules (OAR)

- ✓ The Oregon Revised Statutes (ORS) are the codified laws of the State of Oregon, which are enacted by the Legislative Assembly.
 - ORS 656 → Worker's Compensation Statutes
- ✓ State agencies adopt administrative rules to implement statutes or policies, or describe procedural requirements.
 - OAR 436 → Worker's Compensation Division's rules
Division 009, Division 010, Division 015
 - OAR 438 → Workers' Compensation Board's rules



Compensable injury

- ▶ An accepted worker's compensation injury is known as a **"Compensable Injury"**
- ORS 656.005(7) defines "compensable injury" as an accidental injury or an accidental injury to a prosthetic appliance arising out of and in the course of employment requiring medical services resulting in disability or death.
- You will not be compensated for treating more than the accepted condition/compensable injury



Intake/First visit

- Find out both private insurance company and workers' compensation insurer. www4.cbs.state.or.us/ex/wcd/cov/
 - Keep your search simple – less is more
 - Call Employer Compliance Unit for help: 503-947-7814
- Is the worker enrolled in a managed care organization (MCO)?
 - Ask the worker
 - Contact the workers' compensation insurer to find out
 - Clinic vs. provider credentialing
- Obtain referral source and purpose if applicable



Intake/First visit

On the first visit, you must notify the patient, preferably in writing, that he or she may have to pay for medical services that are not covered. When you provide medical services to a workers' compensation patient, you shouldn't bill the patient for any services related to an accepted compensable injury or illness unless:

- The patient **seeks** treatment for conditions that are not related to the accepted compensable injury or illness.
- The patient has been enrolled in an MCO and **seeks** treatment from you and you are not a panel provider for that MCO.



Intake/First visit

(Continued)


- The patient **seeks** treatment after having been notified that the treatment is experimental, outmoded, unscientific, or unproven.
- The patient **seeks** treatment for a service that has not been prescribed by the attending physician, authorized nurse practitioner, or specialist physician.
- The patient **seeks** palliative care after it has been disapproved by the insurer or the director.



Form 827

"Worker's and Physician's Report for Workers' Compensation Claim"


- If you are the first medical service provider the worker sees for his or her injury, Form 827 needs to be filled out, signed by the worker, and submitted to the insurer within 3 days.
- Fill out this form immediately upon treating the worker.
- Give a copy of completed Form 827 to the worker and file Form 827 along with chart notes or a report that includes data gathered on Form 827.
- Form 827 can be found online. Select the *Forms and bulletins* link located across the top of this page: www.oregonWCdoc.info



Form 827

ONLY ask the worker to sign Form 827 under these circumstances:


- You are the very first health care provider the worker sees for his or her work related injury or disease (First report of injury or disease).
- To help the worker request that the insurer accept a new or omitted medical condition. Attach chart notes that explain how this condition is causally related to the compensable injury. If the worker checks this box it initiates a claim processing decision by the insurer that may negatively affect the worker's benefits.
- To report an aggravation of the original injury
- The worker changes his or her attending physician to you



Form 827


Do **NOT** ask the worker to sign Form 827 for the following:

- Progress report
- Closing report
- Palliative care request
(Just checking the box does not meet the requirements for requesting palliative care.)



New/Omitted conditions

- ▶ The worker may initiate a new medical or omitted condition claim at any time.
- ▶ If a worker believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, the worker must file his or her objections with the insurer in writing.
- ▶ The insurer has 60 days from receipt of the worker's objections to revise or clarify the notice.
- ▶ A new/omitted condition is NOT made by the receipt of medical billings, requests for authorization to provide medical services, or by actually providing medical services.




Referrals Out

Consultation exam:

- Document in the chart notes who you're referring to, and
- What type of service (consult only or specialized care).



Referrals for therapy – sign and approve the treatment plan received from the ancillary medical service provider and forward to insurer within 30 days of receipt.

If the worker is enrolled in an MCO, you **must** refer to MCO panel provider (This includes labs, DME, etc.).




How claim status affects your bill

- ▶ Deferred claim
- ▶ Accepted claim
- ▶ Denied claim



Deferred claims

- What is a deferred claim?
- How does it impact your bill?
- Is anything paid during this status?
- Can the worker be billed?
- How long does it take to make a decision?



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Accepted claims

- What is an accepted claim?
- Do I bill again?
- How long before I get paid?
- What is a denied claim?
- How will I know if the claim is denied

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Managed Care Organizations (MCOs)

At **every visit, including the first visit**, find out if the patient is enrolled in an MCO. You may contact the insurer to find out whether or not the patient is enrolled in an MCO.

If you treat an MCO enrolled patient and you're not on that MCO's panel, the insurer will not have to pay you.

In addition, if you refer an MCO enrolled patient, you must make sure the provider you are referring to is also on that MCO's panel.

- Off-panel referrals need pre-approval by the MCO.

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Attending physician status

The Oregon workers' compensation system places considerable responsibility on the attending physician for:

- Directing and managing treatment of patients
- Authorizing time-loss
- Determining the patient's physical ability to stay-at-work and return-to-work
- Deciding when the patient becomes medically stationary
- Making impairment findings



Attending physician status

- An attending physician is primarily responsible for treatment and authorizing time-loss for a workers' compensation patient.
- The patient may choose to treat with an authorized nurse practitioner instead of an AP for 180 consecutive days or longer if authorized by an AP
- Generally, a medical doctor, doctor of osteopathy, podiatric physician and surgeon, or oral or maxillofacial surgeon qualifies as an attending physician.
- A chiropractic physician, naturopathic physician, and physician assistant also may qualify as an attending physician, but only for a limited period. (See attached matrix for specifics.)



Ancillary providers

As an ancillary care provider you will only be paid if an attending physician, specialist physician, or authorized nurse practitioner prescribes the services and you carry them out under a treatment plan. You are not allowed to authorize time-loss benefits.

Examples of ancillary care providers are:
Physical therapists, acupuncturists, Oregon licensed massage therapists, and, when they no longer qualify as attending physicians, chiropractic physicians and naturopathic physicians.



Ancillary providers

The treatment plan **must** contain the following four elements:

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



Ancillary providers

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




Surgery

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

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



Surgery



The notice must include:

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

When you give notice to the insurer that you intend to perform surgery, **the insurer must, within seven days:**

- Approve the surgery, or
- Use Form 3228 "Elective Surgery Notification" to disapprove the surgery or to request a second opinion exam.

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Elective surgery

When the insurer requests a second opinion exam on the Form 3228, it must be completed within 28 days. The insurer must send the second opinion report to you within seven days of the exam.

As the surgeon, if you disagree with the insurer's decision or the second opinion report, you should try to resolve the issues with the insurer. If 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 the surgery is excessive, inappropriate, or ineffectual, the insurer must request Administrative Review within 21 days.



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Elective surgery

Action	Within
You give notice of surgery to insurer	7 days prior to surgery
The insurer must approve surgery or send you Form 3228 and may request a second opinion exam	7 days
The second opinion exam must be completed	28 days
The insurer must send you the second opinion report	7 days
If you disagree with the insurer's decision or the second opinion and you can't resolve the disagreement with the insurer, notify the insurer in writing or sign Form 3228	N/A
The insurer must request Administrative Review	21 days

Prescriptions


- Physician dispensed – 10 day supply max
- Must use Form 4909 to justify first prescription over 5 days for any of the following drugs:
 - Celebrex,
 - Cymbalta,
 - Fentora,
 - Kadian,
 - Lidoderm,
 - Lyrica, or
 - OxyContin
- Filled as generic unless specified "brand only" or "do not substitute"



Special equipment needs justification



"Articles" are items like beds, hot tubs, chairs, Jacuzzis, and gravity traction devices.

- In a report, justify why worker needs it when others with similar impairments don't need it.
- Explain why the patient's recovery process requires the article.



Important timelines

- Timely submissions
 - Submitting treatment plans
 - Submitting bills within 60 days of date of service
 - Submitting bills after 12 months from date of service
- Timely payments
- Not enough information
- Turn-around time



436-009-0020 Hospital billing

Inpatient vs. Outpatient

- Inpatient services are those billed with codes 0111 through 0118 on the UB-04
- Outpatient services are those billed with codes 0131 through 0138 on the UB-04.

Inpatient- paid according to Bulletin 290

- Amount billed multiplied by the cost-to-charge ratio.

Outpatient Pull-Out/Extracted Codes

- Revenue codes that are NOT paid according to Bulletin 290, but specifically listed in the rule
- Amount paid is the lesser of Non-facility seen in the maximum payment calculator, or the amount billed.



What to bill?

- Compensable medical services
- Services must be rendered before payment will be made
- Always bill your **usual and customary fees**



Billing form CMS 1500/UB-04

Fill out the CMS 1500/UB-04 completely, legibly, and accurately.


(See www.oregonWCdoc.info, click on *Billing & payment* for more information.)

- Include patient's complete name, date of injury, claim number if known, and employer name.
- Submit the CMS 1500/UB-04 within 60 days of date of service.
- Attach a copy of the corresponding chart note with every bill.





How to expedite payment

- Clean bills
- Provide supporting documentation
- If submitting corrected billing, clearly indicate this on the billing form
- Remember to forward the worker's demographics to the ER physician's billing service




What else can be done to expedite payment?

- Use a legend
- Use correct forms
- SOAP



What is a clean bill?

- Correct form
- Includes claim-specific information
- Uses correct ICD-10 and CPT codes
- Who
- Where
- Remittance address
- Timely
- Supporting documentation



When can I bill the worker?

You may be able to bill the worker in following six situations:

- Final denial
- Not compensable
- Not prescribed
- Outside of MCO
- Unscientific, unproven
- Palliative care – not compensable or not authorized

Not sure? Call the Medical Questions Line at 503-947-7606.



Reimbursement

Charge your usual fee.

You should be compensated according to:

- OAR Division 009, Appendix B-E
- Bulletin 290, cost-to-charge
- <http://www4.cbs.state.or.us/ex/wcd/maxpaycalc/>



<http://www4.cbs.state.or.us/ex/wcd/maxpaycalc/index.cfm?fuseaction=home.input>

Department of Consumer and Business Services
 Physician Fee Schedule Calculator
 You may return to the copyright statement or the calculator menu at any time.

Service Code: Anesthesia Service Date (mm/dd/yyyy): Must be 7012000 or later * Modifier: Modifier 22

Articles required field

The five character codes included in the Max Payment Calculator for Oregon are obtained from Current Procedural Terminology (CPT), copyright 2014 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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Disputed Claim Settlement (DCS)

A DCS is a settlement of a workers' compensation claim in which 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 cannot exceed 40 percent of the total settlement unless approved by the injured worker. Effective Jan. 1, 2012, if a provider receives payment up to the workers' compensation fee schedule, it cannot collect a balance from the worker.



Administrative review

- WCD Medical Resolution Team (MRT) may attempt informal resolution of the dispute
- Formal review may result in a Stipulated Letter of Agreement, General Letter, or an Administrative Order
- Parties have 30 days to dispute an Administrative Order
- Insurers have 14 days after the Administrative Order is final to comply



MRT - Processes

Informal Alternative Dispute Resolution (ADR) process


- Dispute involves potentially less complex issues
- Primarily non-payment or underpayment of medical bills
- Mostly submitted by medical providers and involve billing errors, processing errors, provider unfamiliarity with Oregon Worker's Comp rules or fee schedules, etc.
 - Ex: processing agent/3rd party bill review errors, ancillary certification, treatment plans, etc.
- Small percentage submitted by worker's attorney, unrepresented workers, or insurers
- High probability of resolution within 72 hours



MRT - Processes

Resolution by Administrative Order


- Reserved for issues that are too complex or multi-faceted for informal resolution.
- May involve an appeal of a Managed Care Organization's (MCO) final decision on medical necessity
- Files are "set-up" based on issue type and assigned on a rotation basis to the six reviewers.
 - E.g., Medical Fee, Treatment, MCO, Medical Service



MRT - Processes


Resolution by Administrative Order

- Each reviewer independently prepares a Notice of Required Action Letter (NORA) and a Specification of Disputed Medical Issues Form.
- Issue is formally stated and specified records are requested.
- Ability to tailor NORA to dispute, improved specificity of records requested.
- **Each NORA letter is different. Read the bulleted items carefully to make sure your response includes ALL documents requested.**
- **Per OAR 436-009-0008 and OAR 436-010-0008 "the packet must include certifications stating that there is an issue of compensability of the underlying claim or condition OR stating that there is not an issue of compensability of the underlying claim or condition."**



Disputing payment amount

- First, contact insurer or insurer's representative at number listed on the EOB to attempt resolution
- If unsuccessful, submit request to the director of the Department of Consumer and Business Services (MRT) for dispute resolution within 90 days of the date on the EOB or the date you knew or should have known there was a dispute.
 - Use Form 2842 to ensure the request is complete.
 - Be sure to provide a copy of the CMS 1500/UB-04, chart notes, and EOBs with request. Include any documentation of bill submission to the insurer/TPA (fax transmittal).
 - **Send a copy of all documents sent to the director to the insurer at the same time.**



Resource materials

Oregon Administrative Rules:

- ✓ Division 009
- ✓ Division 010
- ✓ Division 015
- ✓ Division 060



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Additional resources

Find out both private insurance company and workers' compensation insurer.

If workers' comp coverage is unknown, try the **WCD employer coverage index**: <http://www4.cbs.state.or.us/ex/wcd/cov/>

Oregon Workers' Compensation Division: www.wcd.Oregon.gov

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Contact MRT

Phone: 503-947-7606

Fax: 503-947-7629

E-mail: wcd.medicalquestions@oregon.gov

Web: www.oregonWCdoc.info

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Matrix for health care provider types*

	Attending physician status (<i>primarily responsible for treatment of a patient</i>)	Provide compensable medical services for initial injury or illness	Authorize payment of time loss (<i>temporary disability</i>) and release the patient to work	Establish impairment findings (<i>permanent disability</i>)	Provide compensable medical services for aggravation of injury or illness
Type A attending physician » Medical doctor » Doctor of osteopathy » Oral and maxillofacial surgeon » Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician » Chiropractic physician » Naturopathic physician » Physician assistant	Yes , for a total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician.	Yes , unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or if authorized by an attending physician and under a treatment plan.	Yes , 30 days from the date of the first visit with any type B attending physician on the initial claim, if within the specified 18-visit period.	No , unless the type B attending physician is a chiropractic physician.	No , unless authorized by attending physician and under a written treatment plan. (Note: Physician assistants are not required to have a written treatment plan.)
Emergency room physicians	No , if the physician refers the patient to a primary care physician.	Yes	ER physicians may authorize time loss for up to 14 days only, including retroactive authorization.	No , if patient referred to a primary care physician.	Yes
Authorized nurse practitioner	No	Yes , for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician.	Yes , for 180 days from the date of the first visit on the initial claim.	No	No , unless authorized by the attending physician.
“Other Health Care Providers” e.g. acupuncturists	No	Yes for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any “Other Health Care Providers.” Thereafter, services must be provided under a treatment plan and authorized by the attending physician.	No	No	No , unless referred by the attending physician and under a written treatment plan.

*This matrix does not apply to Managed Care Organizations

This matrix is located in: OAR 436-009, Appendix A
OAR 436-010, Appendix A

Effective 4/1/15



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.

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: _____

(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.

Review requested by

Worker

Worker's attorney

Insurer

Insurer's attorney

Medical service provider

Managed care organization

Other: _____

- ❖ Attach copies of all relevant medical information or records to this form.
 - ❖ Provide a copy of the completed request and supporting documentation to all parties.
- Failure to comply with these requirements may result in dismissal of your request.

Insurer's certification statement (required only if the insurer requests review)

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.

Perform one-time exams with guaranteed payment

The Oregon workers' compensation system needs more providers to perform one-time exams to help injured workers get back to work. When you perform any of these exams, you are guaranteed payment, the process is straight forward, and the system benefits from your professional opinion. Although the insurer pays for these exams, the insurer is not involved in coordinating the exams. If you have any issues, contact the Workers' Compensation Division for assistance at 503-947-7606.

Medical Arbiter Exams

These exams help the Workers' Compensation Division Appellate Review Unit resolve disagreements over impairment findings. The division will provide you with resources on how to perform arbiter exams and will work with your office and the worker to schedule the exams. Arbiter exams are paid by complexity, from \$467 to \$1,628.

Physician Review Exams

These exams help the Workers' Compensation Division Medical Resolution Team resolve whether a specific treatment is appropriate given the worker's accepted condition. The physician reviewer provides a one-time evaluation, which includes a review of the medical record, an exam, and a report that answers three standard questions. Physician reviews are paid at an hourly rate up to six hours for the record review and exam.

Worker-Requested Medical Exams

These exams are also called WRMEs and are available to an injured worker whose workers' compensation claim has been denied based on an Independent Medical Exam (IME). A WRME is an objective and impartial one-time exam. Upon completing the exam, your report needs to address the questions asked during the original IME and address any questions submitted by the worker or the worker's attorney. WRME exams are paid at your usual fee.

For more information about these types of exams, visit www.oregonWCdoc.info. If you have questions or are interested in performing any or all of these exams, please call the Workers' Compensation Division at 503-947-7606.